RURAL HEALTH WEST

WA RURAL GP SUMMIT

Charting a course to strengthen rural general practice

Report on the WA Rural GP Summit

Held 15 March 2024 at Optus Stadium, Perth

Published: May 2024

Contents

1.0 Executive Summary

Rural general practice remains a rewarding, albeit challenging career for those who choose to pursue it. Proponents of rural general practice highlight the breadth of practice, the diversity of clinical medicine, the development of long-standing patient relationships and the opportunity to practise 'cradle to grave' medicine as aspects of the role that set it apart from metropolitan practice.

Notwithstanding, there are worrying signs pointing to declining attractiveness of rural general practice as a preferred career choice.

By 2030, projections suggest that rural population growth and increased demand for general practice services will require an additional 300 practitioners in rural Western Australia (WA). Current analyses of Rural Health West general practice workforce trends, overlaid with data from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, paint a worrying picture of the State's readiness to meet this demand.

Compounding this challenge are rising chronic health conditions, an ageing population and concerns about the retirement of a significant portion of the rural general practice workforce. Addressing these issues requires a concerted effort from organisations across the sector.

In March 2024, Rural Health West convened the inaugural WA Rural GP Summit, gathering together over 80 stakeholders from across Australia, including the National Rural Health Commissioner, the WA Minister for Health, the Director-General of the WA Department of Health, policymakers, health professionals and sector representatives.

The Summit's purpose was to call for health agencies to elevate rural general practice in their list of priorities, in order to build rural general practice workforce in both the short and longer terms. While health workforce related summits have been convened in the past, the WA Rural GP Summit's inclusion of diverse stakeholders, and the acknowledgement of their respective roles and responsibilities in making improvements, marks a departure from previous formats.

Through extensive stakeholder engagement, including targeted conversations, surveys and literature reviews, Rural Health West identified 10 key interventions, which have the greatest potential impact to benefit general practice across rural WA.

In selecting the 10 initiatives, priority was given to interventions where stakeholder organisations could take action or make progress without significant policy reform or funding allocation. This approach ensures that progress can be made in the short term, leveraging the existing resources, capabilities and spheres of influence of each organisation to address immediate needs within rural general practice.

During the Summit, frontline perspectives from rural general practitioners (GPs), including International Medical Graduates (IMGs), underscored the importance of cultural and professional support in retaining rural practitioners. Additionally, discussions with medical students and junior doctors highlighted the need for positive exposure to rural settings to influence early career decisions.

System-level perspectives provided by key stakeholders such as the WA Department of Health Chief Medical Officer and the Director of Medical Training at WA Country Health Service (WACHS), emphasised the importance of flexible career pathways and targeted support programs.

The Summit culminated in the development of actionable plans for each of the 10 identified initiatives, with in-principle support from stakeholders to drive implementation at individual, organisational and sector-wide levels.

The identified initiatives serve as clear and practical ways to address workforce shortages, enhance training and support programs, and foster a supportive environment for rural GPs.

The future publication of a White Paper by Rural Health West, based on the insights and discussions from the Summit, aligns with the remarks made by the WA Health Minister regarding the complexities of the healthcare sector and the challenges of prioritising reforms. In a landscape where numerous disparate groups often request changes from the government, it can be challenging to determine which reforms are most meaningful and should take priority.

By seeking input on priority reforms through the Summit survey and workshops, Rural Health West has taken an important step towards building consensus among stakeholders on the most crucial areas for implementation, investment and reform.

By presenting a unified voice and a clear roadmap for action, Rural Health West and partner agencies can advocate for the necessary policy changes and funding to improve healthcare access and outcomes for rural communities.

This report encapsulates the findings, discussions and action plans generated during the WA Rural GP Summit, offering a clear guide for stakeholders to focus efforts and energies to pave the way for a robust rural general practice workforce in WA.

Rural Health West sincerely thanks those who attended the WA Rural GP Summit, as well as those who participated in stakeholder interviews or completed the survey, for the contribution of their extensive knowledge, experience and expertise.

2.0 Background

The concept of the WA Rural GP Summit emerged from increasingly worrying feedback from practice owners and GPs regarding the challenges they face. Recent years have seen Rural Health West's annual surveys and direct engagements with practices and GPs highlighting issues such as workload, recruitment and retention struggles, limited referral options, difficulty in taking leave and financial pressures. All of these factors contribute to growing concern about the future sustainability of general practice across rural WA.

While geographic and socioeconomic factors play a role in these issues, part of the problem also lies in the systemic complexity and underfunding of the primary care sector.

Policy interventions are not always appropriately targeted or adequately implemented in order to create the desired impact. Programs are too often introduced and then withdrawn just as they begin to yield results. The comparatively low remuneration of general practice continues to deter aspiring doctors. Rigid bureaucracy frequently smothers local, innovative solutions.

Each of these factors has had a role in creating the current state of play for rural general practice. Identifying solutions and a way forward requires understanding the key perceptions, experiences and systemic barriers encountered by both current and prospective GPs.

In Australia, medical student perceptions have been influenced by the continual undervaluation of general practice as a medical specialty, which has dissuaded many from pursuing careers in the field. Despite positive experiences during rural placements, ever-changing placement programs have hindered efforts to provide widespread, sustained and positive exposure to general and rural practice.

For junior doctors entering general practice training, financial implications and the loss of essential benefits further discourage them. While single employer models have been proposed as one solution to address the portability of entitlements, concerns about their implementation, scope and focus highlight the need for additional approaches.

Existing rural GPs grapple with resource shortages, isolation and work-life balance concerns. Issues such as marginal practice viability, lack of pay parity with other specialties relative to experience levels and bureaucratic hurdles often overshadow the positive aspects of rural medicine, such as its broad scope of practice and the opportunity to deliver comprehensive care. Comprehensive support systems are crucial to ensure the sustainability of rural general practice and enable GPs to focus on the aspects of their work that initially attracted them to the field.

Across rural WA, the ageing general practice workforce is a concern, and strategies must be developed to retain and support these experienced professionals as they approach retirement. The loss of retiring doctors extends beyond clinical delivery; they also serve as mentors and role models for future generations.

IMGs face unique barriers, including lengthy approval processes and a lack of community connection, which hinder their integration into rural practice. Streamlining accreditation processes and fostering community integration are essential to retaining IMGs and bolstering the rural workforce.

Addressing these challenges requires targeted interventions to elevate the priority of general practice reform within WA's health system.

The Australian Government's Stronger Rural Health Strategy and the Strengthening Medicare Taskforce are significant reform initiatives which target issues such as workforce shortages and the financial sustainability of rural practices. While these reforms hold promise for rural general practice, their full implementation will take time.

In the interim, there is significant work that can be done by health stakeholders that can have a positive impact. Key interventions such as increased rural and generalist exposure for medical students, addressing bureaucratic frustrations, improving communication between general practice and the hospital sector, and fostering community integration for IMGs can be progressed by stakeholder agencies without policy change or significant funding allocation.

What is required, and what was sought at the Summit, is recognition and commitment from those agencies present to make these interventions and actions a priority within their respective organisations.

By striking a balance between short-term interventions and long-term structural reforms, the collective rural health sector in WA can address the immediate needs of rural general practice and rural GPs, while laying the groundwork for sustainable improvements in rural healthcare delivery.

The Summit provided an opportunity for stakeholders to collaborate and develop a shared roadmap for rural general practice to address the priority interventions and actions.

Continued collaboration between all levels of government, healthcare providers and community stakeholders will be essential to effectively implement these interventions and achieve meaningful improvements for rural general practice.

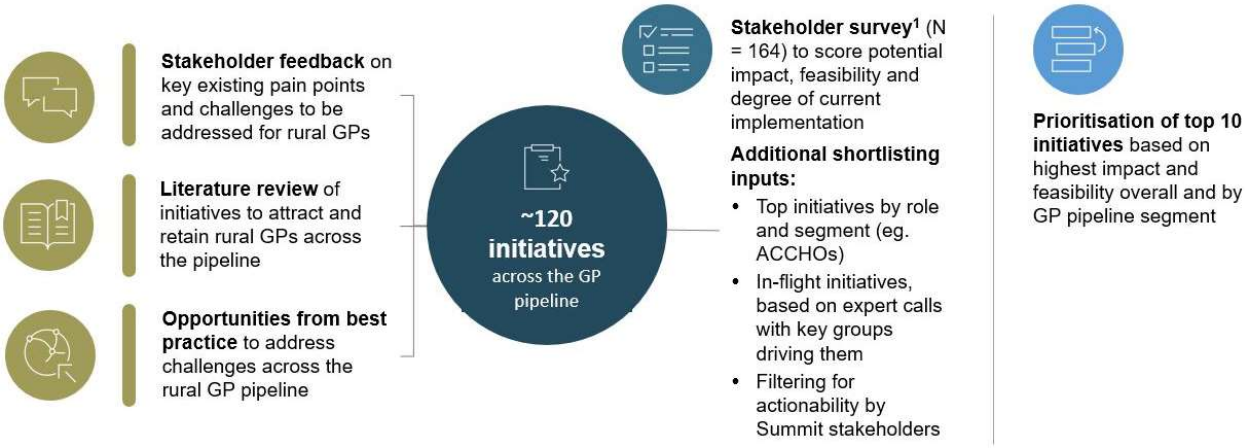
3.0 WA Rural GP Summit Research Methodology

The research methodology for the WA Rural GP Summit was designed to gather comprehensive insights from key stakeholders, including GPs. This methodology integrated multiple inputs, including stakeholder discussions, thematic analysis, literature review and a survey process. The aim was to identify priority areas for intervention and reform in rural general practice to inform the Summit agenda and discussions.

Particular attention was paid to ensuring the areas identified as priorities could be progressed, at least partially, by the stakeholders attending the Summit within the current policy and funding context. This approach aimed to maximise the feasibility and impact of proposed interventions, aligning them with the practical constraints and opportunities present in the rural primary care sector.

The approach integrated diverse inputs to ensure a comprehensive understanding of key issues and priorities in rural general practice.

By engaging stakeholders, synthesising thematic insights, conducting a literature review, and designing a focused survey instrument, the process identified critical interventions to address the challenges faced by rural GPs in WA.



1. Survey distributed to a range of respondents including Fellowed GPs, Aboriginal Community Controlled Health Service (ACCHS) employees, WACHS, GP registrars, Colleges, Junior Medical Officer (JMO) society representatives, practice owners/managers, university employees, peak bodies and advocacy organisations.

3.1 Initial Stakeholder Engagement

The process commenced with stakeholder discussions involving representatives from organisations, including:

- Aboriginal Health Council of Western Australia (AHCWA)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Government Department of Health and Aged Care (AGDoHAC)
- Australian Medical Association WA (AMA WA)
- Royal Australian College of General Practitioners (RACGP) WA Faculty
- Royal Flying Doctor Service (RFDS)
- Rural Doctors Association of Australia (RDAA)
- The Rural Clinical School of Western Australia (RCSWA)
- The University of Notre Dame Australia (UNDA)
- WA Country Health Service (WACHS)
- WA Department of Health, Office of the Chief Medical Officer (OCMO)
- WA Primary Health Alliance (WAPHA)

3.2 Key Themes Identification

These stakeholder discussions identified a number of key areas relevant to rural general practice in WA. Themes were synthesised from the meetings with representatives of each organisation, highlighting critical concerns, challenges and potential interventions.

Workforce Shortages and Distribution: There is a shortage of healthcare professionals, particularly GPs, in rural and remote areas. Efforts are needed to attract and retain medical graduates in these regions.

Challenges with Recruitment and Retention: Recruitment and retention of healthcare professionals, including GPs, specialists and support staff, pose significant challenges due to factors such as limited housing, childcare and competitive job opportunities elsewhere.

Financial Incentives and Career Perceptions: Financial incentives and societal perceptions play a role in influencing medical students' career choices. There's a need to improve the social regard for general practice and provide financial incentives to encourage graduates to choose rural practice.

Medical Education and Training: A number of stakeholders indicated they believe the medical education system should be oriented towards primary care and rural practice. This includes providing more rural placements, incorporating primary care and rural experience into the curriculum, and ensuring adequate supervision and infrastructure in rural settings.

Policy and Governance: Policy issues such as the implementation of the single employer model, rules around employee entitlements, and pay discrepancies between different healthcare settings need to be addressed to support GP trainees.

Innovation and Best Practices: Sharing successful initiatives, best practices and innovative models of care is important for informing policy decisions and driving improvements in rural healthcare delivery.

Policy Misalignment: Different sectors of the healthcare system may operate under separate policy frameworks and priorities, leading to inconsistencies and conflicting objectives. For example, policies aimed at cost containment in one sector may inadvertently impact the quality or accessibility of services in another sector.

Challenges in Garnering Support for Rural General Practice Initiatives: Difficulty convincing stakeholders to prioritise rural general practice initiatives or collaborate with proactive agencies.

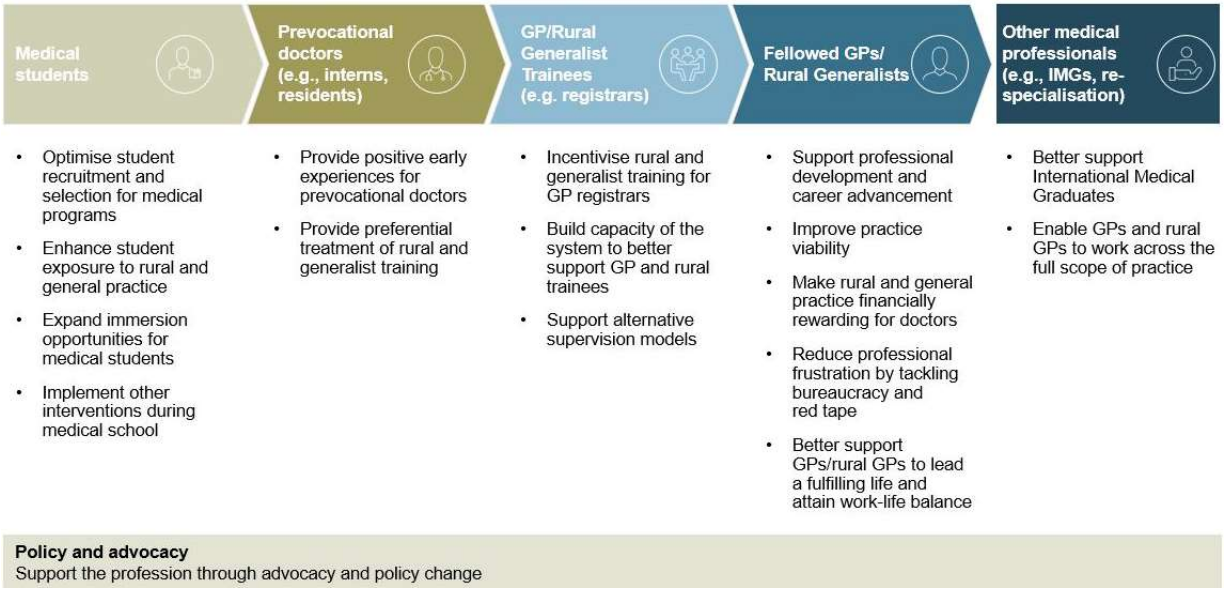
3.3 Literature Review

A literature review was conducted to collate existing recommendations from peak bodies and expert opinions regarding reforms and interventions needed to enhance rural general practice. This review encompassed a range of references from reputable sources such as the Australian Medical Students' Association (AMSA), Medical Deans Australia and New Zealand, AMA, RACGP, ACRRM, AGDoHAC, National Rural Health Alliance, Consumers Health Forum of Australia, General Practice Registrars Australia, General Practice Students Network, and the MABEL (Medicine in Australia: Balancing Employment and Life) survey.

3.4 Survey Design

The initial survey draft comprised approximately 120 strategies or interventions derived from the literature review. To streamline the survey and improve completion rates, these strategies were reviewed to identify those with potential for advancement without significant additional funding or policy reform. Approximately 60 strategies were selected for inclusion in the primary survey instrument.

Potential interventions across all GP pipeline segments



Source: Rural Health West WA Rural GP Summit stakeholder survey

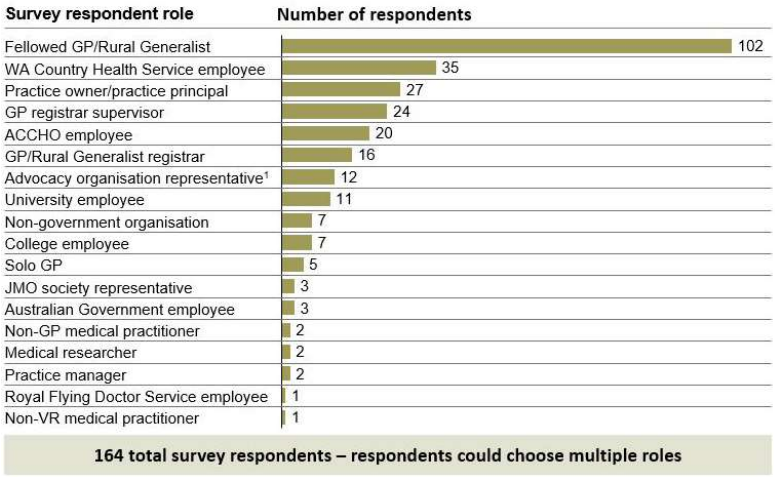
3.5 Survey Distribution and Response

The survey was distributed electronically to stakeholders, including representatives from key organisations, rural GPs and relevant government agencies. Efforts were made to ensure broad representation across geographical regions and professional roles within the rural healthcare sector.

164 completed responses were received, with approximately 30 surveys partially completed. Partially completed surveys were not included in the analysis of the quantitative data; however, any qualitative feedback provided in the comments section of partially completed surveys was reviewed and incorporated into the broader analysis.

Respondents were largely medical practitioners, many of whom may also have dual roles as WACHS employees, GP registrar supervisors or RCSWA educators.

WA Rural GP Summit respondents



Comments

Many respondents work across multiple roles, with 280 roles selected for 164 total survey responses

Most of the respondents were Fellowed GPs/rural generalists, WACHS employees[2] and practice owners

1. For example: Rural Doctors Association of Australia, Rural Doctors' Association of Western Australia, AMA WA etc.
2. Most also being Fellowed GPs/rural generalists or GP trainees

Source: Rural Health West WA Rural GP Summit stakeholder survey

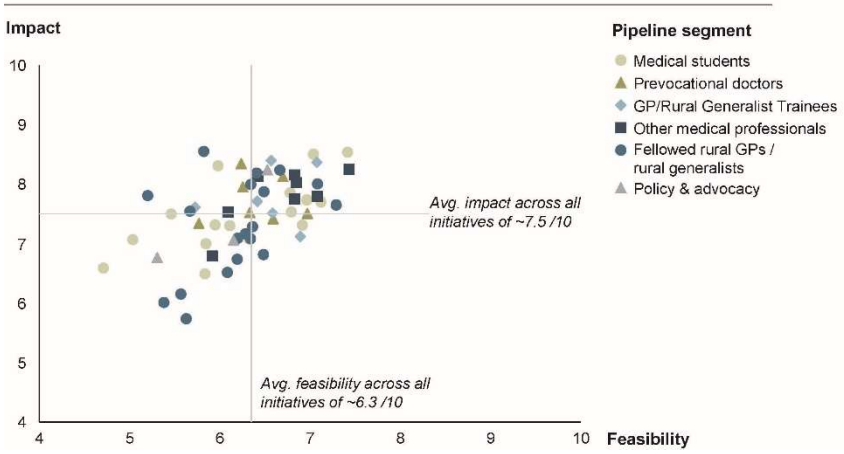
3.6 Survey Findings and Analysis

Data collected through the survey was analysed, including a quantitative breakdown of ratings provided for each strategy based on their perceived impact, feasibility and current level of implementation. Qualitative feedback and comments were also reviewed to enrich the understanding of stakeholder perspectives and priorities.

The scatter graph on the next page displays the average response in relation to the potential impact and feasibility of the interventions queried in the survey. Interventions that fell in the top right quadrant were deemed to be the most suitable for consideration to be workshopped at the WA Rural GP Summit.

Feasibility and impact of initiatives

N = 164



Comments

Survey respondents noted higher impact relative to feasibility across examined initiatives, on average

- All initiatives rated higher than 4 /10 across both feasibility and impact
- No initiative rated higher than 9 /10 in impact, or 7.5 /10 in feasibility

Other medical professional, training GP and pre-vocational doctor focussed initiatives were rated highest on average, across both potential impact and feasibility

Source: Rural Health West Rural GP Summit stakeholder survey

3.7 Summit Agenda Development

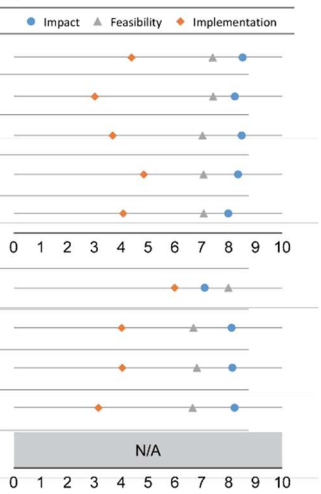
Insights gleaned from the survey, stakeholder discussions, thematic analysis and literature review were reviewed to inform the development of the Summit agenda.

Priority areas for intervention and reform were identified, and the Summit provided an opportunity to workshop these initiatives and generate actionable recommendations.

Shortlisted initiatives

Medical students · Prevocational doctors · GP/Rural Generalist Trainees · Fellowed rural GPs/rural generalists · Other medical professionals · Initiatives underway

Prioritised by overall feasibility and impact score	Timelines: Short-term	Timelines: Long-term	Average score: Combined[2]
1 Ensure generalism is strongly embedded into medical school and post-graduate training curricula, pedagogy and assessment		✓	15.9
2 Provide IMGs with financial, social, and professional supports[1] and programs that support IMGs to effectively train and work within the Australian health care system	✓		15.6
3 Increase support for rural practices to host medical students	✓		15.5
4 Ensure that GP registrars have meaningful access to leave, including parental, personal, annual, study and cultural leave	✓		15.5
5 Target financial incentives more carefully according to a town's population size, geographical remoteness and local need		✓	15.1
Prioritised within GP pipeline segment			
6 Market general practice as the 'go to' career option for medical students incl. highlighting the variety that general practice careers offer	✓		14.8
7 Scale up intern and junior doctor posts in primary care settings and rural locations		✓	14.8
8 Establish pathway to allow GPs to upgrade and maintain their advanced/procedural skills for rural general practice		✓	15.0
9 Simplify communication pathways between GPs and the hospital sector, particularly processes for escalating GP queries and concerns	✓		14.9
10 Explore the FIFO/DIDO model for persistently hard-to-serve locations[3]		✓	N/A



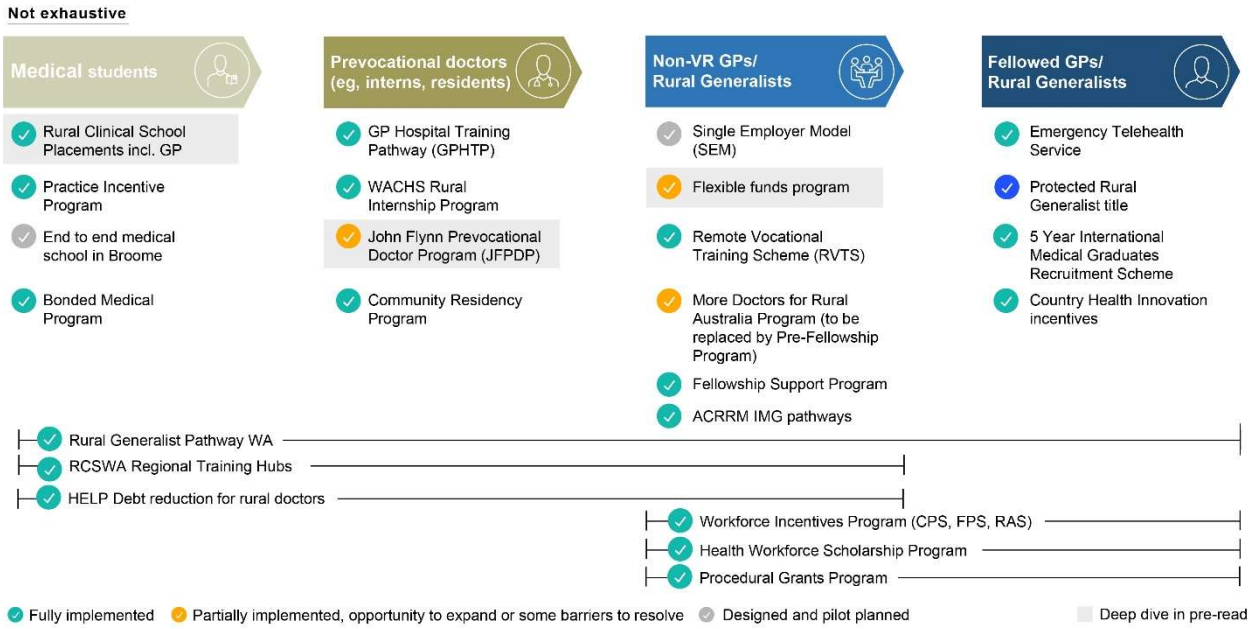
1. Such as relocation support, access to leave and subsidies for training
2. Combined feasibility and impact score
3. Fly-in fly-out and drive-in drive-out models

Source: Rural Health West WA Rural GP Summit stakeholder survey, N=164

3.8 Participant Preparation

Pre-reading materials were disseminated to Summit participants to ensure everyone understood the Summit objectives and to manage participant expectations. Additionally, a summary of existing interventions and programs aimed at addressing rural general practice issues was circulated to ensure a collective understanding of current efforts and to prevent duplication of discussions during the Summit.

Interventions in flight to strengthen rural general practice



A copy of current interventions in flight which was distributed to participants as pre-reading material is attached at Appendix 8.1.

4.0 Summit Format

The inaugural WA Rural GP Summit, convened by Rural Health West in March 2024, served as a gathering for more than 80 stakeholders invested in the future of rural healthcare provision in WA. The Summit provided a platform for robust discussions, workforce data insights and collaborative efforts aimed at addressing the challenges confronting the rural general practice workforce.

4.1 Objectives

The WA Rural GP Summit was convened with the aim of gathering stakeholders from across the sectors to collaborate on identifying high-priority areas for action, assigning ownership and delineating next steps to elevate initiatives related to rural general practice.

Summit objectives

High-level objectives

- **Establish a common understanding of the current state of rural general practice in WA, demand and supply drivers and key challenges** for rural community general practice
- **Agree priority initiatives to improve supply and retention of GPs** to be pursued in the short- and medium-term
- **Align on key actions and owners in WA** to deliver prioritised initiatives

How will we know we've succeeded?

- Agreement on priority set of initiatives to advance
- Tangible first set of milestone actions to progress each initiative
- First view of best natural owners for milestones

4.2 Agenda

WA Rural GP Summit agenda

9:00-9:30AM	Welcoming address, purpose and welcome to country
9:30-10:15AM	Review the 'state of the nation' – demand and supply drivers impacting the WA rural general practice workforce
10:15-10:35AM	Keynote speaker series – frontline perspectives
10:35-11:05AM	Morning tea
11:05-11:30AM	Keynote speaker series – system perspectives
11:30-12:30PM	Shortlisted initiatives from stakeholder survey • Review and discuss top initiatives overall and by pipeline segment
12:30-1:30PM	Lunch
1:30-3:25PM	Breakout by initiative • What are the 4-5 key milestones to deliver the initiative? • Who are the natural owners/ partners for each milestone? • What are the key barriers to overcome, or support required to take the initiative forward?
3:25-3:50PM	Reflections on the day and commitments moving forward
3:50-4:00PM	Close and next steps

4.3 Participation and Representation

The Summit achieved strong representation and active participation from a diverse array of key stakeholders, demonstrating a collective commitment to addressing the challenges faced by rural healthcare.

Key decision-makers and policy influencers such as Adjunct Professor Ruth Stewart, National Rural Health Commissioner; Dr RT Lewandowski, RDAA President; Dr Dan Halliday, ACRRM President; Dr Michael Clements, RACGP Vice President and Rural Chair; and Tessa Pascoe, Director Incentives Section, Health Workforce Division of AGDoHAC were instrumental in shaping the discourse.

Alongside them, individuals with unique perspectives were invited to ensure authenticity and depth in the discussions. This approach enabled interaction between frontline practitioners and decision-makers, enabling those most impacted by reforms and decisions to liaise directly with those responsible for shaping policy.

The Summit also welcomed representatives from various organisations, including government, representative bodies and universities, each bringing unique insights and experiences to the table.

Additionally, the presence of medical students, junior doctors and GPs from across all regions, underscored the importance of grassroots perspectives in driving meaningful change in rural healthcare delivery.

Overall, the broad representation and active participation at the Summit highlighted the collective commitment to advancing rural healthcare and fostering collaborative solutions.

A full list of Summit participants is attached as Appendix 8.2.

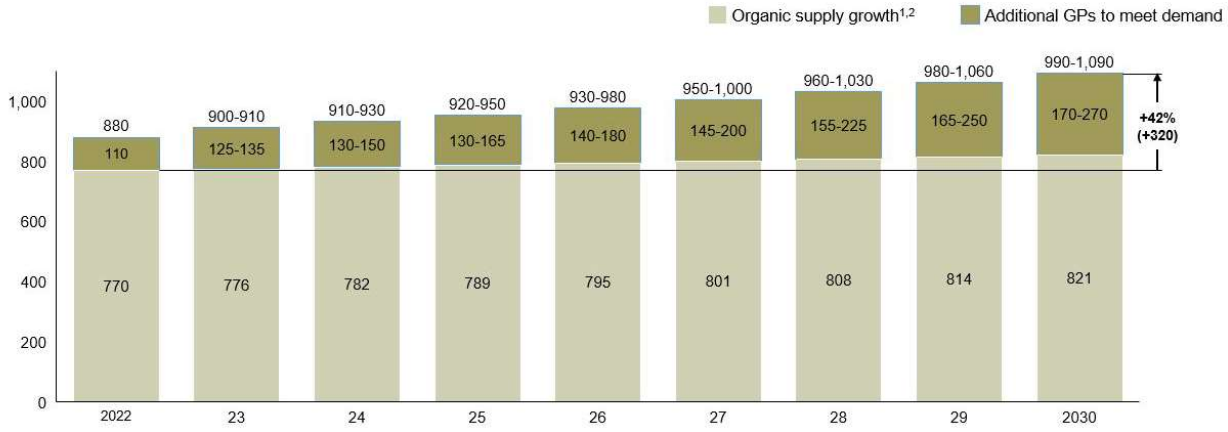
4.4 Presentation of Data and Projections

The Summit commenced with a presentation of comprehensive workforce data and projections, outlining the predicted shortfall of rural GPs in WA by 2030. Drawing upon detailed analyses of Rural Health West general practice workforce trends, as well as data from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, attendees were confronted with the concerning reality of the current landscape.

Projections indicated a growing gap between the demand for general practice services and the availability of practitioners, necessitating urgent action to bridge this gap.

Predicted GP headcount required by 2030

Estimated GP headcount required in regional and remote WA to meet projected demand, #



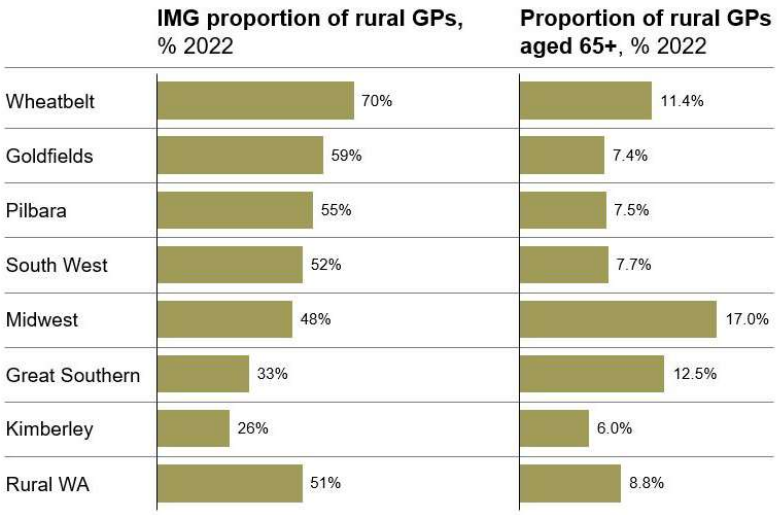
1. Based on projected GP FTE required to meet demand scenarios, adjusted by a scale factor of 0.68 GP FTE per GP based on 2022 data.
2. Current GP headcount of 770 reflects the current Rural Health West-reported rural GP headcount (911) less GP registrars (141)

Source: Rural Health West Annual Workforce Update survey data; Productivity Commision, Report on Government Services 2024; AIHW MBS services data on GP attendances; ABS regional population data; ABS Rest of WA population projections.

Key data presented included:

- Population growth projections for rural WA.
- Growing prevalence of chronic health conditions across rural WA.
- 2024 Productivity Commission Report findings on WA GP FTE compared to other jurisdictions.
- Estimated GP FTE and headcount requirements to meet population growth and increased demand.
- Rural WA reliance on IMG GPs and ageing general practice workforce.
- GP retention and destination of those leaving the workforce.
- Regional GP supply per capita.
- ‘At risk’ regions and locations.

Reliance on IMGs and ageing GPs



Comments

- **IMGs make up half of WA's rural general practice workforce**
- The rural general practice workforce is ageing, with **8.8% of the workforce aged 65+**, and **26.6% aged 55+**, with average age increasing with MMM[1] remoteness
  - **The Midwest, Great Southern and Wheatbelt** regions have the highest proportions of GPs aged 65+ (17.0%, 12.5% and 11.4% respectively)
- **~10% of rural GPs** are projected to reach retirement age[2] in the next 3 years

1. Modified Monash Model (MMM)
2. 67 assumed as retirement age, with surveyed age in 2022 taken as baseline

Source: Rural Health West Annual Workforce Update survey data

A complete set of the general practice workforce data presented at the WA Rural GP Summit is attached in Appendix 8.3.

4.5 Perspectives from the Frontline and System-Level Insights

Following the data presentation, the Summit provided a platform for frontline perspectives from rural GPs, including insights from IMGs and junior doctors, who play a crucial role in healthcare delivery in rural WA. Dr Ajit Chaurasia, Practice Principal at Wongan Hills Medical Practice, shared first-hand experiences and challenges encountered as an IMG in rural WA, underscoring the importance of cultural and professional support in retaining rural practitioners.

Dr AJ Park, a Resident Medical Officer (RMO) and Rural Generalist Pathway trainee from Broome, shared her pathway to becoming a rural doctor, citing her rural background and early experiences and exposures as key influences in her career decisions.

System-level insights were also provided by key stakeholders, including the Chief Medical Officer, Dr Simon Towler and the Director of Medical Training at WACHS, Dr Graeme Maguire. These perspectives emphasised the need for flexible career pathways, targeted support programs and collaborative efforts to bolster the rural general practice workforce.

4.6 Workshopping Actionable Solutions

Central to the Summit's agenda was the development of actionable plans to address the identified challenges and capitalise on opportunities for reform. Through group workshops, attendees collaborated to refine and prioritise the 10 key initiatives identified through stakeholder engagement and surveys. These initiatives encompassed a spectrum of interventions, ranging from enhancing medical education and training to improving support systems for practising GPs and IMGs.

4.7 Commitments and Pathways Forward

As the Summit drew to a close, stakeholders made commitments to drive the implementation of the identified initiatives at individual, organisational and sector-wide levels. These commitments were captured through online polls, reflecting a shared dedication to effecting meaningful change in rural healthcare provision.

5.0 Workshop Sessions

During the WA Rural GP Summit, participants engaged in breakout sessions tailored to address key initiatives for enhancing rural generalist practice. Led by designated facilitators, these sessions aimed to foster collaboration among individuals with specialised interests in respective subject areas.

Participants developed actionable plans for driving change, identifying key stakeholders responsible for milestone execution and discussing potential barriers to progress.

At the conclusion of the workshop session, group facilitators shared insights with the plenary, highlighting prioritised milestones and key takeaways.

Medical professionals within each of these groups were also asked to provide their feedback or views on the shared milestones.

5.1 Objectives

In order to effectively strategise and progress the implementation of the initiatives shortlisted through the WA Rural GP Summit survey, the workshop sessions at the WA Rural GP Summit aimed to:

- Envision the tangible outcomes of successfully implementing each initiative within the next one to two years.
- Describe four to five key milestones which will advance the implementation of the shortlisted initiatives.
- Identify natural owners/partners for each milestone.
- Explore the key barriers, to overcome or support, required to advance the initiative.

A secondary objective of the group workshops was to foster dialogue within groups, build connection between diverse stakeholders and form a committed coalition of willing partners dedicated to driving progress.

5.2 Group Composition and Facilitation

Group composition was designed to maximise expertise and diversity while promoting active engagement and collaboration.

For the first workshop session, group members were selected based on their expressed interest in specific initiatives or recognised subject matter expertise. While attendance in designated groups was encouraged, it was not mandatory, allowing some delegates to join alternate groups based on their interests.

Each group comprised decision-makers, frontline medical professionals and representatives from health sector organisations, ensuring a well-rounded perspective.

Groups were tasked with working on a second initiative. The second group to tackle each initiative typically comprised members who were less familiar with the initiative in order to foster diverse thinking and lay perspectives.

Facilitation was led primarily by Rural Health West senior staff or members of the Rural Health Agency Reference Group.

Facilitators outlined workshop activities, made sure that key outputs were achieved and ensured that all group members were given opportunity to engage and contribute their views.

Group composition for each initiative is attached in Appendix 8.2.

5.3 Workshop Outputs

Each group workshopped the initiatives to develop action plans outlining the steps and milestones required to address the challenges and achieve the goals outlined during the WA Rural GP Summit.

The workshop outputs have been summarised below; however, the completed milestone action plans are attached in Appendix 8.4.

5.3.1 Initiative 1: Ensure generalism is strongly embedded into medical school and postgraduate training curricula, pedagogy and assessment.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.6	7.3	4.3

Initiative Overview: In WA, only 13.3 per cent of medical students opt for general practice as their preferred specialty, with exposure to this field varying in timing and duration across universities. Accreditation standards established by the Australian Medical Council mandate a minimum of 10 weeks of clinical placement in general practice during medical training; however, this is deemed to be insufficient to develop a true appreciation of general practice.

RCSWA facilitates rural clinical placements for penultimate and final year medical students, provides career mentoring for junior doctors, and actively promotes rural medical training and practise among university and high school students.

The initiative aims to integrate generalist practice principles into medical education and training programs to cultivate a robust rural general practice workforce.

Key Areas for Success (one to two years):

- Increased emphasis on clinical placements in general practice and community health settings.
- Addressing the "hidden curriculum" and fostering positive relationships between GPs and universities.
- Enhancement of support systems and recognition for GPs as specialists.

Major Milestones:

- Documentation and analysis of current placement duration across different clinical settings eg. general practice, tertiary, community.
- Agreement on practice payments for placements.
- Implementation of purposeful teaching.
- Additional teaching for JMOs by GPs.
- Addressing training post saturation.

Potential Owners: Universities, colleges, postgraduate medical education teams, Postgraduate Medical Council of Western Australia (PMCWA)

Risks/Challenges: Funding constraints, bureaucratic hurdles and balancing supervision needs.

5.3.2 Initiative 2. Provide IMGs with financial, social and professional supports and programs.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.2	7.4	3.0

Initiative Overview: Two Commonwealth programs, the Five Year Overseas Trained Doctors Recruitment Scheme and the Pre-Fellowship Program (previously More Doctors for Rural Australia Program), aim to support IMGs through recruitment, orientation, access to specific Medicare Benefits Schedule (MBS) items, assistance in joining general practice training pathways and facilitating Permanent Residency applications.

However, there's limited longitudinal local support available for IMGs to address significant challenges such as language or cultural barriers, with minimal provision of social, community and educational programs. This lack of support may contribute to the high rate of IMGs leaving rural practice, with 42 per cent of those relocating to urban centres like Perth.

This initiative proposes the enhancement of support systems for IMGs to facilitate their integration into the Australian healthcare system.

Key Areas for Success (one to two years):

- Streamlined entry processes and removal of barriers.
- Establishment of support networks and comprehensive orientation programs.
- Active support throughout their professional journey.
- Investigation of successful induction models from other countries.

Major Milestones and Potential Owners:

- Establishment of a concierge service.
- Development of comprehensive orientation programs.
- Creation of an IMG GP Network.
- Research into successful induction models.

Potential owners: Rural Health West, colleges.

Risks/Challenges: Funding limitations, stakeholder engagement and visa complexities.

5.3.3. Increase support for rural practices to host medical students.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.3	7.2	4.2

Initiative Overview: Rural practices, although essential for medical education, encounter hurdles in hosting students. GPs, while willing, face challenges such as workload and financial disincentives. Commonwealth Practice Incentive Teaching Payments offer $200 per three-hour session, but may not fully address these barriers. Additionally, rural loading varies based on remoteness.

Unfortunately, WA lacks State-level incentives, compounding the challenges for rural practices in hosting medical students. This initiative aims to empower rural practices to offer high-quality placements for medical students.

Key Areas for Success (one to two years):

- Empowerment of GP and practice teams.
- Standardisation of curriculum and placement agreements.
- Clear expectations for practices, supervisors and students.

Major Milestones and Potential Owners:

- Establishment of a project team.
- Audit of existing resources.
- Development of training resources.
- Agreement on standard curriculum and placement expectations.

Potential Owners: GP Supervisors Australia, colleges, RCSWA.

Risks/Challenges: University ownership issues, curriculum standardisation and resource constraints.

5.3.4. Ensure GP registrars have meaningful access to leave.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.4	7.1	4.8

Initiative Overview: GP registrars employed by individual practices face challenges regarding the portability and access to leave and entitlements due to the nature of their rotations, which typically occur every six to twelve months. Personal leave is often limited, with restrictions on accrual and expiration, and annual leave accrual may not align well with rotation schedules, hindering the ability to take meaningful blocks of leave, particularly in rural settings where cover may be difficult to arrange.

Additionally, parental leave is typically not provided, given the short-term nature of employment and the challenges of backfilling roles. This initiative aims to ensure GP registrars have equitable access to leave entitlements to support their wellbeing and retention.

Key Areas for Success (one to two years):

- Comparable leave entitlements to public system registrars.
- Confidence in practice safety and guilt-free leave.
- Funding leave at the same rate of earning.

Major Milestones and Potential Owners:

- Advocacy for National Terms and Conditions for the Employment of Registrars (NTCER) increase.
- Research on leave impact.
- Model development for portable leave entitlements.
- Incentives for available Fellows.
- Establishment of relief GP pool.

Potential Owners: General Practice Registrars Australia, GP Supervisors Australia, colleges, private practices.

Risks/Challenges: Contractual complexities, funding limitations and portfolio career complexities.

5.3.5. Target financial incentives more carefully according to town demographics.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.0	7.1	4.0

Initiative Overview: Financial incentives to encourage medical practitioners to underserved communities include the Commonwealth Workforce Incentives Program (WIP), which offers varying annual payments ranging from $3.6k to $60k to GPs providing primary care in MMM 3-7 locations, along with additional incentives of $4k to $10.5k for rural advanced skills.

In WA, the Department of Primary Industries and Regional Development (DPIRD) offers incentives ranging from $10k to $82k per year for GPs in small and medium-sized health services, allocated on a first-come-first-served basis. However, State government incentives, such as those for relocation and professional development, are only accessible to directly employed individuals, excluding those on Medical Service Agreements.

This initiative seeks to tailor financial incentives to address specific town needs and improve general practice sustainability.

Key Areas for Success (one to two years):

- Improved patient access and medical officer support.
- Recognition of GPs as specialists under EBA.
- Review and revision of incentive guidelines.

Major Milestones and Potential Partnerships:

- Needs assessment tool development: Stakeholders.
- Revision of WIP rate and guidelines: Stakeholders.
- Review of incentives in other jurisdictions: Stakeholders.
- Overlay of incentive combination: Stakeholders.

Potential Owners: Rural Health West, AMA WA, WAPHA, WACHS, AGDoHAC.

Risks/Challenges: Potential adverse impacts, interagency coordination and timeline adherence.

5.3.6 Market general practice as the 'go to' career option for medical students and pre-vocational doctors, including highlighting the variety that general practice careers offer.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
7.0	7.8	6.0

Initiative Overview: Marketing general practice as an excellent career to medical students faces challenges due to the declining number of graduates applying for general practice training, with a 30 per cent decrease observed in 2023 compared to 2017. Exposure to high-quality general practice rotations during medical school and pre-vocational years is crucial in shaping students' perceptions of general practice as a career.

The WA GP Stakeholder Group, comprising organisations like AMA WA, WAGPET, Rural Health West and RACGP WA Faculty, previously promoted general practice as a profession and provided career guidance for medical students and junior doctors. However, this initiative has been discontinued.

RCSWA offers up to 120 rural medical school placements, including opportunities in general practice, which positively influences student career choices. This initiative aims to promote general practice as the preferred career choice for medical students and pre-vocational doctors, emphasising the diverse opportunities it offers

Key Areas for Success (one to two years):

- Foster collaboration among medical advocacy groups.
- Increase the appeal of general practice careers to medical students and pre-vocational doctors.

Major Milestones and Potential Partnerships:

- Advocate for halting negative narratives around general practice.
- Review existing research on medical students' career expectations.
- Conduct qualitative and quantitative research on WA medical students' career aspirations.
- Launch a 'myth-busting' campaign about the advantages of life as a GP.

Potential Owners: AMA WA, Rural Health West, universities, colleges, general practice associations, and State and Federal Governments.

Risks/Challenges:

- Perceptions on remuneration and media portrayal.
- Silos between organisations affecting collaboration.

5.3.7 Scale up intern and junior doctor posts in primary care settings and rural locations.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.1	6.7	4.0

Initiative Overview: Increasing opportunities for interns and junior doctors in rural and primary care settings remains limited in WA. With approximately 380 medical graduates annually, less than 8 per cent have access to rural internships, totalling 30 positions.

The John Flynn Prevocational Doctor Program offers 50 rotations for pre-vocational doctors employed rurally, allowing them to experience primary care settings. Additionally, the Community Residency Program provides 35 placements, offering opportunities for both metropolitan and rural-based RMOs to gain experience in community and composite (community/hospital) terms.

Despite these initiatives, the overall availability of placements in rural and primary care settings remains constrained compared to the demand. This initiative aims to expand intern and junior doctor placements in primary care and rural areas, aiming to increase positions, improve support systems and overcome limitations.

Key Areas for Success (one to two years):

- Expand intern and junior doctor placements in primary care and rural settings.
- Enhance support systems for trainees in these placements.

Major Milestones:

- Extend placements to include the Goldfields region.
- Establish new community placement positions in various rural settings.
- Consider setting up teaching practices.
- Explore CPD recognition for GPs.

Potential Owners: WACHS, general practice, universities, colleges.

Challenges: Accreditation, funding, recognition for trainees.

5.3.8 Simplify communication pathways between GPs and the hospital sector, particularly processes for escalating GP queries and concerns.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.0	6.9	4.0

Initiative Overview: Streamlining communication between GPs and hospitals is crucial for efficient patient care. Challenges include technical gaps between general practice and hospital systems, leading to delays and confusion over medication changes.

Despite recent improvements in discharge summaries, reliance on outdated methods like fax machines persists, resulting in lost referrals. Addressing these issues requires improved technology integration, clear protocols for discharge communication and consistent escalation pathways for GP concerns. Involving local GPs in hospital decision-making processes can also enhance consultation and alignment of goals.

Key Areas for Success (one to two years):

- Improve communication between GPs and hospitals.
- Foster respectful relationships across healthcare sectors.

Major Milestones:

- Enhance information systems across community/hospital interface.
- Reinstate Medical Advisory Committees and GP liaison roles.
- Strengthen GP roles in hospital settings.

Potential Owners: WACHS, WA Department of Health, private providers.

Challenges: Continuity of leadership, turnover in leadership roles.

5.3.9 Establish a pathway to allow GPs to upgrade and maintain their advanced/procedural skills for rural general practice.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
8.1	6.9	4.0

Initiative Overview: Currently, rural GPs face challenges in accessing the training and upskilling they require to maintain their skills and confidence in practice. While programs like the Supervised Clinical Attachments (SCAs) offered by Rural Health West provide valuable hands-on clinical experience, they are competitive and unfunded.

Additionally, the Advanced Skills Support Program, a partnership between WACHS and Rural Health West, offers mentoring and upskilling opportunities, but access may be limited. Financial support through initiatives like the Rural Health Workforce Scholarship program and the Rural Procedural Grants Program can assist GPs practising in rural areas, but these resources may not fully address the need for ongoing training. Overall, there is a need for more accessible and comprehensive training programs tailored to the specific needs of rural GPs.

Key Areas for Success (one to two years):

- Ensure GPs maintain procedural skills for rural practice.
- Increase SCA opportunities and support for rural GPs.

Major Milestones:

- Prioritise SCA places for procedural GPs.
- Adapt Queensland model for rural WA.
- Secure funding for locum support.
- Host planning meetings with rural GPs and WACHS.
- Arrange visiting specialists to support rural hospitals.
- Develop educational materials for visiting medical practitioners.

Potential Owners: OCMO, WACHS, rural GPs.

Challenges: Credentialing, medical indemnity insurance, practice variability.

5.3.10 Explore FIFO/DIDO-based GP servicing models for persistently hard-to-serve locations.

Survey results – average score out of 10

Potential impact	Feasibility	Current level of implementation
N/A	N/A	N/A

Initiative Overview: In regions where attracting resident GPs is challenging, FIFO/DIDO models have emerged as a crucial solution. Despite substantial financial incentives offered to attract resident GPs, some small towns still struggle. Existing FIFO/DIDO arrangements, while costly, provide vital services to rural WA communities where traditional general practices face financial difficulties.

The proportion of the rural general practice workforce, comprised of FIFO/DIDO practitioners, rose to 17 per cent in 2023, underscoring their growing significance in delivering primary care services. Established FIFO/DIDO models, such as those operated by ACCHS and RFDS, serve communities like Meekatharra, Port Hedland and Kalgoorlie.

These models potentially demonstrate the effectiveness of alternative service delivery methods in addressing healthcare access challenges in remote and underserved areas.

Key Areas for Success (one to two years):

- Ensure universal access to GP care in rural communities.
- Enhance continuity and community acceptance of FIFO/DIDO models.

Major Milestones:

- Identify at-risk communities and assess failed markets.
- Improve telehealth services for continuity of care.
- Establish stable clinician pools.
- Develop induction processes and community education programs.

Potential Owners: Regional services, telehealth providers, community organisations.

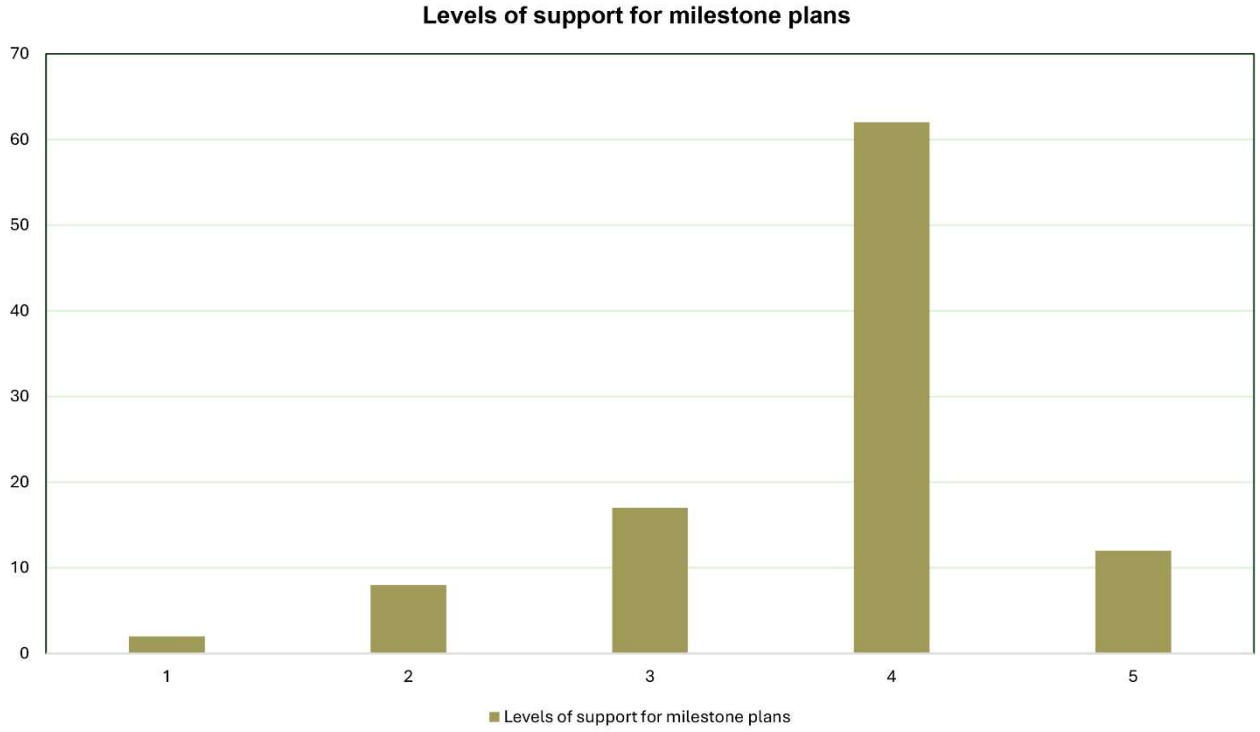
Challenges: Continuity of care, State versus Commonwealth ownership.

6.0 Responses and Commitments

At the conclusion of the workshop session, group facilitators provided an overview of the discussions held within each group regarding the initiative under review.

This included outlining the envisioned success criteria, the action plan with identified milestones and the key barriers identified. Subsequently, all participants were invited to express their level of support for the discussions and action plans.

The diagram below illustrates that, on a 5-point scale, the overall participant sentiment towards the action plans averaged 3.7. A substantial majority of participants expressed a positive outlook on the proposed milestones, believing they would be beneficial in enhancing rural general practice.



Several organisations, represented by key figures such as Dr Simon Towler, Chief Medical Officer for the WA Department of Health; Jeff Moffet, Chief Executive from WACHS; Dr Ramya Raman, Chair from RACGP WA Faculty and Dr Michael Clements, Vice President and Chair, RACGP Rural; Ms Carol Chandler, Training Network Coordinator (WA) and Dr Dan Halliday, President from ACRRM; and Dr Clark Wasiun, President from RDAWA, indicated their commitment to act upon the discussions and strategies outlined in the milestone plans.

Though specific comments were not recorded verbatim, these organisations expressed their readiness to implement initiatives aimed at addressing the identified challenges and improving healthcare access in rural and underserved areas.

Individual commitments made on the day of the Summit to actioning in the next three months were captured via the poll instrument. These commitments include:

- Developing best practice supervision resources with WA universities for quality placements.
- Advocating agreed priorities to governments.
- Improving GP placement experiences for final year medical students.
- Promoting Rural Generalist and GP careers to prospective trainees.
- Exploring support for JMOs in rural areas through the John Flynn Prevocational Doctor program.
- Introducing CPD incentives for medical student placements in general practice.
- Collaborating with universities for general practice career talks.
- Following up, and acting on, commitments made.
- Scoping increase in JMOs in WACHS sites.
- Promoting satisfaction of rural general practice.
- Forming project teams to support rural practices hosting medical students.
- Promoting general practice positively.
- Inspiring medical students with positive experiences.
- Sharing initiatives within personal spheres of influence.
- Sharing positive experiences as a rural GP trainee.
- Strengthening rural focus in general practice programs.
- Advocating for funding to employ IMGs in communities.
- Mentorship for medical students, pre-vocational doctors and registrars.
- Improving direct GP communication.
- Championing the cause and staying committed.
- Starting conversations and being joined up in efforts.

A complete account of the commitments captured in the poll is attached in Appendix 8.5.

7.0 Next Steps

The work doesn't end with the Summit; it's crucial to maintain momentum and ensure that the identified actions translate into tangible improvements.

While Rural Health West will initially oversee the discussions and outputs of the WA Rural GP Summit, it's crucial that the organisations identified as natural owners of key actions take responsibility and advance those actions.

To that end, Rural Health West commits to:

- Publishing the WA Rural GP Summit report in May 2024.
- Providing Summit participants with an organisational summary of actions where they were identified as a natural owner or as one of several organisations required to progress that action.
- Confirming with the Rural Health Agency Reference Group their willingness to be custodians of the WA Rural GP Summit outcomes and serve as the accountable authority to ensure organisations are making progress.
- Developing a draft ‘report card’ to track the progress of actions identified through the WA Rural GP Summit.
- Publishing a White Paper on the policy reforms and funding required to advance actions identified at the WA Rural GP Summit, as well as broader programs identified as critical during the WA Rural GP Summit survey and stakeholder conversations. This aligns with the remarks made by the WA Minister for Health, The Honourable Amber-Jade Sanderson, at the Summit regarding the government's preference for receiving policy and budget submissions from sectors that are unified behind a cohesive approach, rather than disparate approaches from multiple organisations.

In addition to the above, Rural Health West is progressing the initiatives where it was identified as a natural owner. Since the WA Rural GP Summit, Rural Health West has identified priority actions, particularly those related to supporting IMGs and enhancing pathways for procedural GPs' upskilling and is in the early stages of identifying resourcing requirements to advance these initiatives.

8.0 Appendices

8.1 Pre-reading – Current Interventions

Pre-reading Materials – Current Interventions

Appendix 8.1

WA RURAL GP SUMMIT

In WA, various interventions are in flight across the GP pipeline to strengthen the number of rural GPs

Sample of current initiatives underway in Western Australia by rural GP pipeline segment

Not exhaustive

Medical students

- Rural Clinical School Placements incl. GP
- Practice Incentive Program
- End to end medical school in Broome
- Bonded Medical Program

Prevocational doctors (eg, interns, residents)

- GP Hospital Training Pathway (GPHTP)
- WACHS Rural Internship Program
- John Flynn Prevocational Doctor Program (JFPDP)
- Community Residency Program

Non-VR GPs/ Rural Generalists

- Single Employer Model (SEM)
- Flexible funds program
- Remote Vocational Training Scheme (RVTS)
- More Doctors for Rural Australia Program (to be replaced by Pre-Fellowship Program)
- Fellowship Support Program
- ACRRM IMG pathways

Fellowed GPs/ Rural Generalists

- Emergency Telehealth Service
- Protected Rural Generalist title
- 5 Year International Medical Graduates Recruitment Scheme
- Country Health Innovation incentives

- Rural Generalist Pathway WA
- RCSWA Regional Training Hubs
- HELP Debt reduction for rural doctors
- Workforce Incentives Program (CPS, FPS, RAS)
- Health Workforce Scholarship Program
- Procedural Grants Program

Fully implemented | Partially implemented, opportunity to expand or some barriers to resolve | Designed and pilot planned | Deep dive in pre-read

Summary sheet: pipeline initiatives (1/5)

Initiative	Description	Implementation status and comments
Rural Clinical School (RCSWA)	Coordinates placements for **penultimate and final year medical students** across various rural and regional training sites (Broome, Derby, Karratha, Kununurra and Port Hedland)	**Delivers up to 120 placements** to medical students per annum across a network of 15 rural towns **85%** (17/20) of the students who completed the RCSWA Final Year Program in 2023 **have commenced rural internships in 2024** (15 of them with WACHS)
Practice Incentive Program (PIP)	Encourages general practices **to provide teaching sessions by compensating** them for the reduced number of consultations performed by a GP while supervising students	Pays supervising GP practices are **$200/3hr session for a maximum of 2 teaching sessions per day** (run by the Commonwealth Government)
End to End Medical School in Broome	New University of Notre Dame rural clinical school offering end to end medical school placements for **20 students**	Announced December 2023 as part of a $90 million Federal Government investment to **establish 6 new regional medical programs** and up to 80 new medical Commonwealth supported places matched by universities that must redirect an equivalent number to the new rural programs
Bonded Medical Program	**Provides a Commonwealth Supported Place** in a medical course **in exchange for participants working regional, rural and remote areas** after they graduate	**Requires participants to commit** to work in an eligible regional, rural or remote area (MMM2-7) for 3 years after they complete their course part time, full time or on a per-day basis. Aims to ensure that the medical workforce is well-distributed, flexible and targeted to areas of most need
RCSWA Regional Training Hubs	Coordinates placements out of three hubs to support medical students and junior doctors in **rural medical career development** from first year medical student with rural intention to Fellowed rural practitioner	**Provides mentorship**, facilitates placements and assists students and junior doctors to customise their pathway to best fulfil career goals incl. accessing prerequisite metropolitan terms. Three hubs: Kimberley/Pilbara, Midwest/Goldfields and Great Southern/Wheatbelt/South West

Fully implemented Partially implemented, opportunity to expand or some barriers to resolve Designed and pilot planned

Summary sheet: pipeline initiatives (2/5)

Initiative	Description	Implementation status and comments
GP Hospital Training Pathway (GPHTP)	**Unlocks preferential access to prerequisite rotations** for intending GP trainees (e.g., Paediatrics, Emergency Medicine)	**Offers ~120 prevocational doctors with GP intent preferential access** to prerequisite rotations across 7 sites
WACHS Rural Internship Program	**Provides dedicated rural internships for junior doctors** with interest in rural GP/ Generalist training in Albury, Bunbury, Broome or Geraldton	**Offers 30 placements to interns** each year (Geraldton Health Campus opened in 2023 with 5 new positions)
John Flynn Prevocational Doctor Program (JFPDP)	**Offers 10-13 week rural primary care rotations** for prevocational doctors with an interest in rural generalism and currently employed at a rural hospital	**Expanding to offer 50 rotations to prevocational doctors** in 2024 from 30 in 2023
Community Residency Program	Provides junior doctors with **access to community placement and composite terms** at different sites e.g., Silverchain (Metro) and various WACHS sites (rural)	**Offers 35 prevocational doctors the opportunity to experience a community placement (**Established by WA Health after PGPPP was defunded in 2014)
WACHS Single Employer Model (SEM)	**Aims to enable rural generalist trainees access to entitlements and remuneration** in line with hospital-based peers over a 3-year contract through employment under WACHS	**WACHS SEM pilot is in proposal phase** – all information is preliminary with no commitments made (If approved, ~20 rural generalist trainees across WA will be supported from 2025)

Fully implemented Partially implemented, opportunity to expand or some barriers to resolve Designed and pilot planned

Summary sheet: pipeline initiatives (3/5)

Initiative	Description	Implementation status and comments
Flexible Funds Payment	**Offers funding in addition to National Consistent Payments** for registrars, training practices and supervisors in 'priority workforce areas'. Four bands of support which can be used for relocation, childcare, travel, hardware for internet etc	**Incentives offered from Term 1 2024.** Will be reviewed and will inform future flexible funding policy development
WA Emergency Telehealth Service (ETS)	**Provides 24/7 access to specialist emergency physicians by video-conference** to small hospitals and nursing posts throughout WA to create equity of access for country communities and a supported environment for clinicians working remotely	**Serves more than 90 small hospitals** and nursing posts throughout WA and cited by GPs/rural generalists as an attractive feature of working rurally in a supported way
Rural Generalist Pathway WA	**Offers a supported education and training program** for doctors pursuing careers as rural generalists; and ongoing support for Fellowed Rural Generalists through mentoring and case management, networking opportunities, ongoing education programs and professional development	**96 trainees in the pathway, spread across all regions** with most in the Great Southern, South West and Perth Metro regions
Protected Rural Generalist title	**Aims to recognise rural generalism as a new field of specialty practice** within the current specialty of general practice. It would allow practitioners to use the title specialist rural generalist	**Under review by AHPRA** after a consultation process which closed in December 2023

Fully implemented Partially implemented, opportunity to expand or some barriers to resolve Designed and pilot planned

Summary sheet: pipeline initiatives (4/5)

Initiative	Description	Implementation status and comments
Country Health Innovation Incentives	**Incentivises GPs working in small and medium health services** with access to between **$10,000 and $82,000 p.a**. depending on the service. Services incentivised at this stage include emergency medicine, procedural medicine, location incentive, small town GP, Aboriginal Health community incentive	**State Government initiative** delivered by the Department of Primary Industries Royalties for Regions program, from a closed pool of funds – first come first served
Procedural Grants Program	**Helps to cover the cost of professional development** for GPs who provide **procedural and/or emergency medicine services** in unsupervised settings in rural and remote areas	**Administered through RACGP and ACCRM** for GPs working in MMM3-7 with a focus on skill maintenance and enhancement. Participants must be vocationally registered as a GP or be enrolled in a Fellowship pathway
Health Workforce Scholarship Program (HWSP)	**Provides scholarships and bursaries** to help health professionals providing primary care services in rural and remote Australia **retain and enhance their skills, capacity and scope of practice**	**Federal Government initiative administered through Rural Health West.** Health Workforce Needs Assessment is used to prioritise the health and workforce needs of communities within WA and inform priorities of allocation of scholarships. Return of Service Obligation for courses longer than 6 months
5 Year International Medical Graduates Recruitment Scheme	**Provides a recruitment and orientation program** for IMGs working in rural general practice incl. assistance with registration, immigration, reduction on access to Medicare provider numbers, education, support and training and opportunities to obtain fellowship with RACP or ACCRM	**Federal Government initiative to attract and retain** appropriately qualified and experienced International Medical Graduates (IMGs) to work in Australia's smaller rural communities. **IMGs must intend to join or be currently participating in a general practice pathway**

Fully implemented Partially implemented, opportunity to expand or some barriers to resolve Designed and pilot planned

Summary sheet: pipeline initiatives (5/5)

Initiative	Description	Implementation status and comments
Workforce Incentives Program (CPS, FPS, RAS)	**Incentivises doctors to work in regional, rural and remote areas** across three incentives streams • **Practice Stream**: pays incentives to practices to support multidisciplinary care by engaging a range of health professionals • **Doctor Stream**: pays incentives directly to doctors providing primary care in MMM3-7 locations • **Rural Advanced Skill Stream**: pays doctors directly to provide both primary care and emergency and/or advanced skills in MMM3-7 locations	**Federal Government initiative**, payment varies depending on activity level, duration of rurality and vocational registration status (non-vocationally registered doctors receive 80% of the doctor stream payments)
More Doctors for Rural Australia Program (MDRAP)	**Supports non-vocationally registered doctors to gain valuable GP experience** in rural and remote communities prior to joining a college fellowship pathway	**Federal Government initiative**, transitioning to Pre-Fellowship Program through 2024 – will also **support doctors working in areas of service access needs who are seeking to move into fellowship training.** Transition to the 2-year trial of PFP will take several months to put into place MDRAP placements are location specific
Fellowship Support Program (FSP)	**Supports non-vocationally registered doctors on their journey to fellowship (self-funded),** including self-directed learning, in-practice learning, and workplace based assessments for feedback and progress monitoring	**RACGP program** with two intakes per year **providing education and training, exam preparation and fellowship assessments.** Placements must be in a training site that provides comprehensive general practice. Participants can undertake Additional Rural Skills Training requirements over an extra 12 months to complete Rural Generalist Fellowship

Fully implemented Partially implemented, opportunity to expand or some barriers to resolve Designed and pilot planned

The Rural Generalist Pathway WA provides individualised pathways to support medical graduates grow as rural generalists

Case study: Rural Generalist Pathway WA

Preliminary – not exhaustive

Key challenge targeted

The Rural Generalist Pathway WA targets two key challenges faced by rural WA communities and junior doctors:

- Recruitment and retention of rural generalists over the medium- to long-term
- Complex, typically self-driven journey for rural generalist trainees to navigate training pathways towards rural generalism

Scope

The Rural Generalist Pathway WA is an Australian Government program hosted by the WA Country Health Service (WACHS), and is delivered in collaboration with medical colleges (RACGP and ACRRM) and other jurisdictional health departments as part of the National Rural Generalist Pathway (NRGP).

Key design elements include:

Case management	**Individualised** case management, support and mentoring for pathway participants
Access to benefits	**Dedicated education and training program**, networking opportunities and professional development support
Community services	**Training is tailored** to the needs of rural communities
Broad eligibility	Pathway can be joined at **various entry points** – as a medical student, pre-vocational doctor, GP registrar or fellow

Status

The Rural Generalist Pathway WA commenced in 2020 in WA, with the first trainees starting in 2021

There are now 96 trainees in the pathway, spread across all regions with most in the Great Southern, South West and Kimberley regions

The John Flynn Prevocational Doctor Program provides doctors an early opportunity to experience rural primary care

Case study: John Flynn Program

Preliminary – not exhaustive

Key challenge targeted

The John Flynn Prevocational Doctor Program (the Program) aims to address two challenges by increasing exposure of prevocational doctors to rural general practice:

- Recruitment and retention of doctors in rural primary care
- Increased rural medical training capacity incl. practices operating as integrated training units for students, prevocational doctors and GP registrars

Scope

The Program is an Australian Government program delivered in WA by a consortium of WA Health, WACHS and Pioneer Health Albany

It aims to give hospital-based doctors in rural areas more opportunities to undertake rural primary care rotations, and deliver benefit to communities through an increased level of health services, and a more stable, locally trained workforce

The program is fully subscribed and in high demand, with rotations increasing from 30 in 2023 to 50 in 2024, providing opportunity for up to 50 doctors to participate in 2024.

Key design elements include:

Early Exposure	**Increased opportunity for prevocational doctors (PGY 1-5) working in rural hospitals** (MMM 2-7) to experience rural primary care early in their careers
Supported training	**Intended to build prevocational doctors' confidence**, exposure and interest in rural general practice
Broad experience	**Offers a range of different rural rotations to apply for**, with a mix of ACCHOs, private GPs and RFDS teams hosting rotating junior doctors for the Program
Community engagement	**Recognises the importance of the rural community**, with strong emphasis on community engagement throughout the 10-13 week rotations
Narrow eligibility	**40% of rotations must go to those with GP intent** and 40% to those with rural generalist intent with the remaining 20% going to those who are unsure

Status

Current Grant agreement ends in 2025, requiring further applications to continue the program

While there is strong practice interest to expand the program, changes to eligibility criteria would be required – **currently limited by the number of junior doctors working in rural hospitals** compared to other States (only doctors employed rurally can participate)

The Rural Clinical School of WA has strengthened rural intention amongst students and junior doctors

Case study: The Rural Clinical School of Western Australia

Preliminary – not exhaustive

Key challenge targeted

The Rural Clinical School of WA (RSCWA) was established in 2002 to train future rural doctors and academics to ensure equitable access to high quality, culturally appropriate healthcare for all Western Australians.

Doctors who attend rural clinical schools are more likely than their peers to work rurally as prevocational doctors, and to have a preference for primary care[1]. RCSWA aims to:

- Create opportunities for students and medical professionals to lead successful careers in rural medicine
- Help rural communities sustain a locally trained and dedicated medical workforce

Scope

A joint venture between The University of Western Australia, The University of Notre Dame and Curtin University, **RCSWA delivers 12-24 month placements for penultimate and final year medical students** across a network of 15 sites in three regional training hubs (Kimberley/Pilbara, Midwest/Goldfields and Wheatbelt/South West/Great Southern).

It currently **offers up to 120 medical school placements** across these sites. Students who have completed a placement with RCSWA have demonstrated significant personal commitment to rural medicine

Key design elements include:

Practical experience	**Exposure to a wide range of patient presentations**, clinical situations and community visits in a supported environment
Close mentorship	**One-on-one mentorship** with their clinical supervisors who are passionate about supporting junior doctors in rural medicine
Community engagement	**Students live within their host town and are involved in a range of community activities**, gaining a true understanding of continuity of care
Continuity of training	**Important experience to aid applications for the competitive WACHS Intern or RMO placements** to continue working rurally after graduation
Research opportunity	**Opportunity to participate in high-quality, supervised research** on rural and First Nations health in WA

Status

RCSWA has demonstrated success in strengthening rural intention, particularly for students with rural backgrounds, who are four times more likely to return to work in regional areas after undertaking a placement with RCSWA compared to others[1]

85% (17/20) of the students who completed the RCSWA Final Year Program in 2023 **have commenced rural internships in 2024** (15 of them with WACHS)

Since 2019, the RCSWA Regional Training Hubs team has supported junior doctors with career mentoring, training pathway creation, supervision training, accreditation assistance and supported rural doctor organisations.

The team also inspires university and high school students to choose rural medical training and practice.

1. https://www.mja.com.au/journal/2014/200/2/impact-rural-clinical-school-western-australia-work-location-medical-graduates

The Rural Clinical School of WA has strengthened rural intention amongst students and junior doctors

Case study: The Rural Clinical School of Western Australia

Preliminary – not exhaustive

Key challenge targeted

The Flexible Funds Policy aims to attract GP trainees to rural areas of workforce need by meeting two challenges:

1. Provide continuing professional development for supervisors and address specific needs to build training capacity in areas of need
2. Incentivise registrars to undertake GP training in catchments that have been identified as 'priority workforce needs'

1. Workforce Prioritisation Planning Organisation

Scope

The Commonwealth Government have provided funding to the RACGP **to support supervisors** to develop and maintain skills needed to supervise registrars, and to **incentivise registrars to work in areas of priority workforce need**

Payments are made across 4 bands, determined by historical registrar placement, evidence that GP catchment will not attract registrars without incentives, availability of accredited training sites and supervisors and other relevant data incl. WPPO[1] ranking, population of GP catchment and remoteness (MMM)

Flexible Fund

Band 1: Up to $5000	Band 2: Up to $15,000	Band 3: Up to $25,000	Band 4:Up to $45,000

Funding may be used for:

1. Relocation costs
2. Housing rental assistance
3. Increased childcare/education costs
4. Additional training costs needed by training delivery site
5. Travel for personal health care or wellbeing (respite)
6. Hardware for internet connectivity

Status

Incentives commenced in **Term 1 2024** according to the 4 bands

Current incentivised placements in WA include:

The WA Emergency Telehealth Service supports WA country clinicians to access specialist support

Case study: WA Emergency Telehealth Service

Preliminary – not exhaustive

Key challenge targeted

Rural GPs and Generalists are faced with a broad range of patient presentations daily, including life-threatening emergencies. This can be a detractor for clinicians considering rural or remote work. The WA Emergency Telehealth Service (ETS) provides 24/7 access to specialist emergency physicians by video-conference to small hospitals and nursing posts throughout the state, improving:

- Equity of access for country communities
- A supported environment for GPs, Rural Generalists and nurses working remotely

Scope

Introduced in 2012, ETS uses high-definition videoconferencing technology to link doctors and nurses in rural and remote sites to specialist emergency doctors and nurses who assist with the diagnosis, treatment and transfer of critically ill and injured emergency patients.

Key design elements include:

Greater support	**Provides increased specialist emergency medical support** to clinicians working in regional, rural and remote areas incl. video-conferenced history-taking or patient examination for high acuity or complex/ low-volume cases
Professional development	**Supports professional development** and builds knowledge of rural GPs/generalists through access to emergency medicine specialists on an ad hoc basis
Virtual classroom	**Educational and upskilling opportunities** for nurses and GPs working in rural emergency departments using a state-wide ‘virtual classroom’ and simulation exercises
Reduced isolation	**Reduces professional isolation through 24/7** support for emergency presentations as well as learning opportunities
Command Centre	**Additional support** through Command Centre for inpatient care, acute specialist care and mental health presentations

Status

Provides support to more than 90 small hospitals and nursing posts throughout WA.

Almost 250,000 patient consultations have been conducted through ETS since its introduction.

8.2 WA Rural GP Summit Group Membership

8.2 WA Rural GP Summit Group Membership

INITIATIVE: Ensure generalism is strongly embedded into medical school and post-graduate training curricula, pedagogy and assessment

Group facilitator: Dr Ramya Raman, Chair WA Faculty, Royal Australian College of General Practitioners

INITIATIVE: Market general practice as the 'go to' career option for medical students and pre-vocational doctors, including highlighting the variety that general practice careers offer

Group facilitator: Paul Plowman, Advocacy Advisor, Rural Health West

- Jessica Adams, President, SPINRPHEX
- Juliet Bateman, Project Officer, RCSWA-Regional Training Hubs
- Adjunct Professor Janice Bell, Chief Executive Officer, WA General Practice Education and Training
- Marita Cowie, Chief Executive Officer, Australian College of Rural and Remote Medicine
- Dr Brendan McQuillan, Dean of Medical School, The University of WA
- Dr AJ Park, Resident Medical Officer – Rural Generalist Trainee, WA Country Health Service
- Dr Jonathan Blundell, Senior Medical Officer, Broome Regional Aboriginal Medical Service
- Carol Chandler, WA State Manager, Australian College of Rural and Remote Medicine
- Dr Michael Clements, Vice President and Rural Chair, Royal Australian College of General Practitioners
- Sanjeev Kabir Singh, President, Curtin Association of Medical Students
- Dr Bennie Ng, Chief Executive Officer, Australian Medical Association (WA)

INITIATIVE: Explore FIFO/DIDO-based GP servicing models for persistently hard-to-serve locations

Group facilitator: Dr Kieran Hennelly, General Manager, Aeromedical Royal Flying Doctor Service, Western Operations

INITIATIVE: Target financial incentives more carefully according to a town's population size, geographical remoteness and local need

Group facilitator: Chris Kane, General Manager General Manager, Strategy and Engagement, WA Primary Health Alliance

- Dr Seema Basil, Senior Medical Officer, Mawarnkarra Health Service Aboriginal Corporation
- Mark Connolley, General Manager Finance, Rural Health West
- Dr Cherelle Fitzclarence, Regional Medical Director, WA Country Health Service
- Tessa Pascoe, Director, Incentives, Department of Health and Aged Care
- Dr Michael Page, President, Australian Medical Association (WA)
- Cr Liz Guidera, Board member, Rural Health West
- Winsome Henry Executive Manager Operations Pilbara Aboriginal Health Alliance
- Dr Michael Livingston, Practice Principal, Livingston Medical
- Annie Rowe, Business Systems Manager, Rural Health West
- Dr Cara Sheppard, Senior Medical Officer Puntukurnu Aboriginal Medical Service

INITIATIVE: Provide IMGs with financial, social and professional supports as well as programs that support IMGs to effectively train and work within the Australian health care system

Group facilitator: Beth McEwan, Manager Workforce Solutions, Rural Health West

INITIATIVE: Ensure that GP registrars have meaningful access to leave, including parental, personal, annual, study and cultural leave

Group facilitator: Linda Jackson, Human Resources Manager, Rural Health West

- Dr Ajit Chaurasia, Practice Principal, Wongan Hills Medical Centre
- Kate Daunt, Senior Policy Officer Medical, Ahpra
- Tanvi Haria, Company Secretary, Rural Health West
- Dr RT Lewandowski, President, Rural Doctors Association Australia
- Rachel Livingston, Chief Executive Officer, Livingston Medical
- Dr Sandra Thompson, Director, WA Centre for Rural Health
- Jo-Anne Chapman, Chief Executive Officer, General Practice Registrars Australia
- Dr Aleeta Fejo, GP Locum, Wirraka Maya Health Service
- Jodie Holbrook, State Manager, Ahpra
- Rachel Howden, Senior Development Officer, Medical Workforce Unit, Office of the Chief Medical Officer
- Dr Caitlyn White, Public Health Medical Officer, Aboriginal Health Council of WA

INITIATIVE: Increase support for rural practices to host medical students

Group facilitator: Hamish Milne, WA State Manager, Royal Australian College of General Practitioners WA

INITIATIVE: Scale up intern and junior doctor posts in primary care settings and rural locations

Group facilitator: Dr Andrew Kirke, Director, The Rural Clinical School of WA

- Fraser Adam, Team Leader, RCSWA Regional Training Hubs
- Chantal Bachere, Board member, Rural Health West
- Marlon Fernando, Chief Operations Officer, Bega Garnbirringu Health Service
- Dr Graeme Maguire, Director Medical Education, WA Country Health Service
- Cara Taylor, Chief Executive Officer, General Practice Supervisors Australia
- Dr Stephanie Trust, Practice Principal, Wunan Health
- Annie Young, A/Chief Executive Officer, Moorditj Koort Aboriginal Corporation
- Tara Delaney, Rural Program Training Advisor, Royal Australian College of General Practitioners
- Jodie Green, Program Manager - Workforce Planning And Prioritisation, WA Primary Health Alliance
- Dr Vinod Pushpalingam, Director of Rural Generalist Training, WA Country Health Service
- Dr Simon Towler, Chief Medical Officer, WA Department of Health
- Tony Trevaskis, Operations Manager, Remote Vocational Training Scheme

INITIATIVE: Establish a pathway to allow GPs to upgrade and maintain their advanced/ procedural skills for rural general practice

Group facilitator: Kelli Porter, Deputy Chief Executive Officer and General Manager Workforce, Rural Health West

INITIATIVE: Simplify communication pathways between GPs and the hospital sector, particularly processes for escalating GP queries and concerns

Group facilitator: Karen Bradley, Board member, Rural Health West

- Dr Kath Atkinson, Executive Director, Medical Services, WA Country Health Service
- Dr Paddy Glackin, Rural Generalist
- Dr Dan Halliday, President, Australian College of Rural and Remote Medicine
- Dr Peter Smith, Senior Medical Practitioner, WA Country Health Service
- Dr Scott Teasdale, Medical Educator
- Leesa Thomas, General Manager, Education and Engagement Rural Health West
- Dr Olga Ward, WA Representative, Royal Australian College of General Practitioners Rural Faculty
- Dr Kees Bakker, GP, Carnarvon Medical Centre
- Judith Barker, Chief Executive Officer Royal Flying Doctor Service, Western Operations
- Dr Andrew Jamieson, Executive Director, Medical Services, WA Country Health Service
- Dr Brenda Murrison, GP and Founder, Brecken Health Group
- Adjunct Professor Ruth Stewart, National Rural Health Commissioner
- Dr Simon Torvaldsen, Chair, Australian Medical Association Council of General Practice
- Dr Clark Wasiun, President, Rural Doctors Association WA

8.3 Data Presentation

Data Presentation

Appendix 8.3

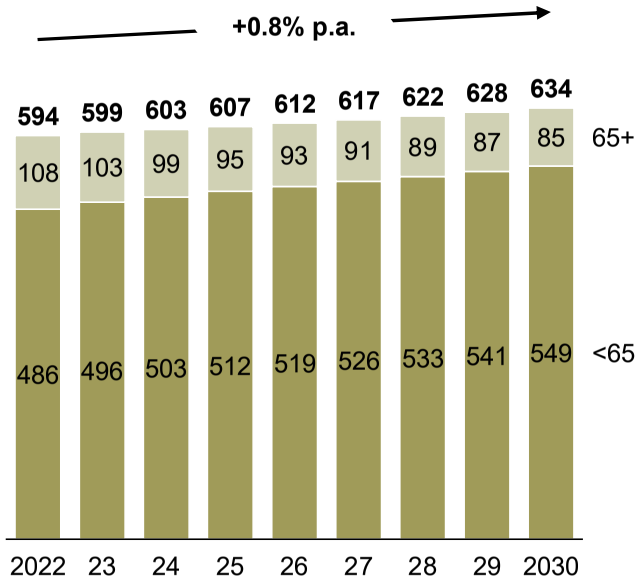
WA RURAL GP SUMMIT

Continued population growth is likely to be a key driver of increased demand for GP services in rural WA

PRELIMINARY

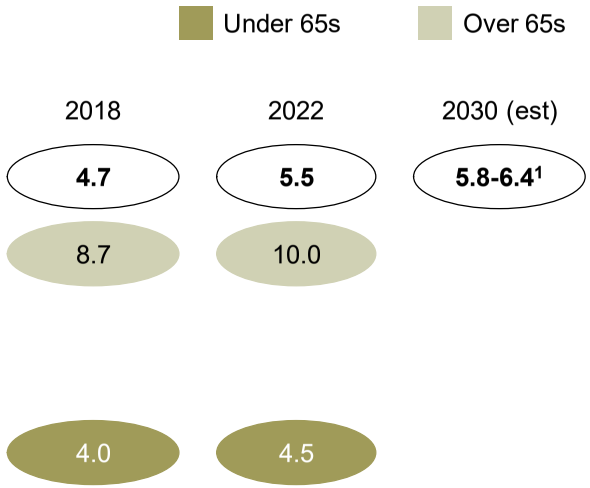
The rural WA population is projected to grow through to 2030…

Regional and remote WA population, thousands



…together with average GP attendances per capita

GP attendances per person, n. per year



Key takeaways

- Rural WA population estimated to grow from **590k to 630k by 2030**
  - Decline in 65+ population estimated to be more than offset by increases in other groups
- **GP attendances per person increased** overall between 2018 to 2022, and may continue to grow

1. Directional estimates based on application of 2018 to 2022 growth in GP attendances per capita (~3.7% p.a.) to regional WA GP attendance utilisation (limited growth in remote attendances per capita); low case demand projection assumes half the growth rate in upper bound case (~1.9%)

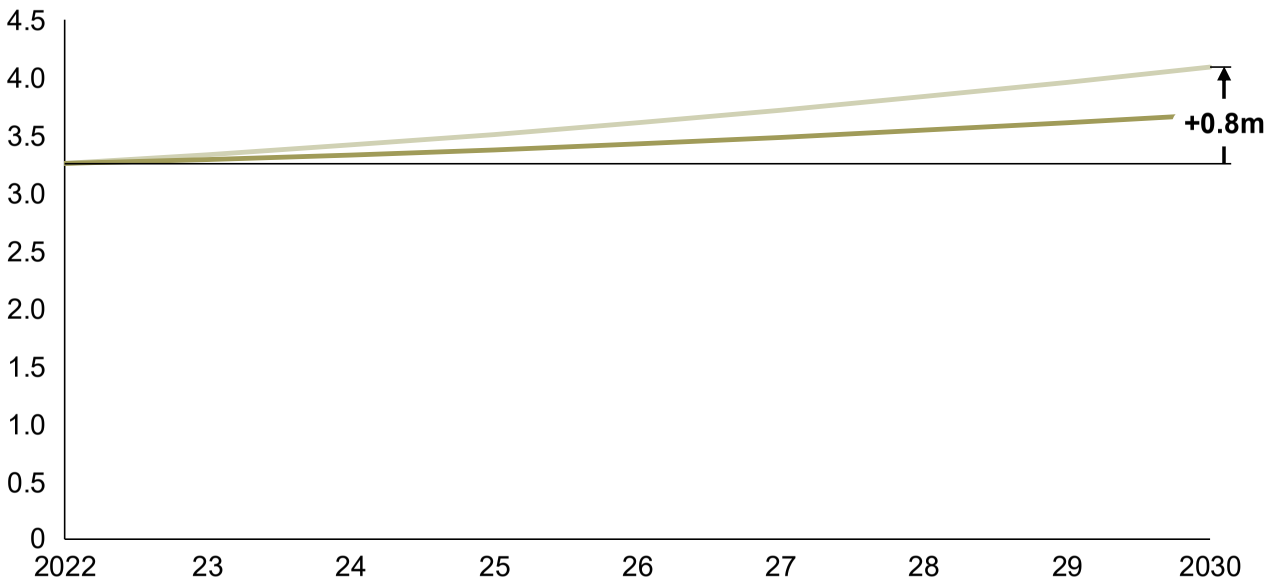
Source: ABS regional population data; ABS Rest of WA population projections; AIHW MBS services data on GP Attendances

Rural GP attendance demand may grow by ~400-800k consults p.a based on projected population and GP utilisation growth

PRELIMINARY

~10-30% increase in GP consult demand is estimated by 2030, which would equate to ~400-800k additional attendances p.a.

Estimated GP attendances in regional and remote WA, millions



1. Rural WA utilisation growth used to remain conservative on estimates, as regional WA experienced high utilisation growth between 2018 to 2022. Application of historic rates would result in higher demand than currently forecast

Source: AIHW MBS services data on GP Attendances; ABS regional population data; ABS Rest of WA population projections

Key assumptions

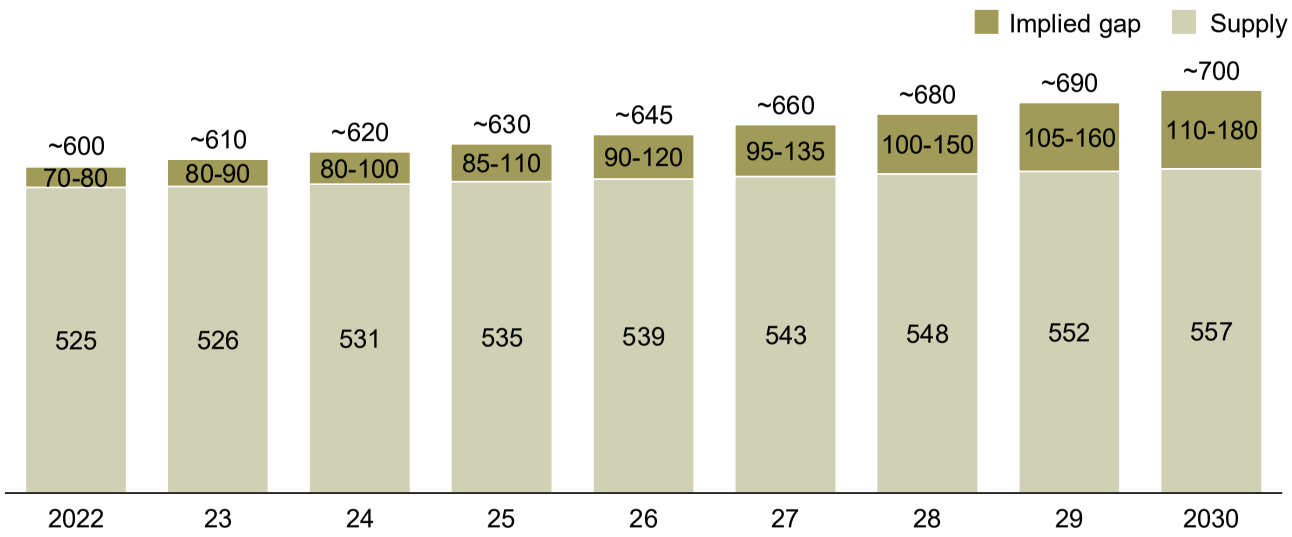
Projected GP attendances estimated by multiplying projected population by per capita GP attendance utilisation

- **Current and projected population assumption**
  - ABS population projections for regional and remote WA, split by those <65 and 65+
- **Projected utilisation assumptions**
  - AIHW MBS data on GP attendances in regional and remote areas by age, divided by ABS population estimate by region and age, projected forward
  - High case: Regional utilisation to grow at historic rural WA utilisation growth rate (~3.7% p.a.) to 2030[1]; remote areas kept stable at 2022 rate as limited growth seen between 2018-22
  - Low case: Regional utilisation growth rate halved (~1.9% p.a.); remote areas kept stable at 2022 rate

To meet this estimated 2030 demand, it is estimated that up to ~110-180 additional GP FTE from 2022 will be needed

PRELIMINARY

Implied widening WA GP FTE supply gap, n.



2022 regional and remote WA GP FTE and FTE per capita sourced from Productivity Commission analysis of MBS data – does not include GP registrars or other groups not captured through MBS (included in RHW GP headcount estimate)

1. GP FTE shortage in 2022 estimated by triangulation of best practice rural GP FTE per capita (1:1,000), historical average Australian rural GP FTE per capita, and 2024 priority GP vacancies in rural WA
2. High case demand projections calculated using 2018 to 2022 growth in GP attendances per capita (~3.7% p.a.) across regional WA (limited growth in remote attendances per capita); low case demand projection assumes half the growth rate in upper bound case (~1.9%)
3. Net rural GP growth of ~0.8% per year applied to estimate supply growth, based on average 2018 to 2022 growth; no change in GP productivity from 2022 assumed

Source: Rural Health West Annual Workforce Update survey data; Productivity Commission, Report on Government Services 2024; AIHW MBS services data on GP Attendances; ABS regional population data; ABS Rest of WA population projections

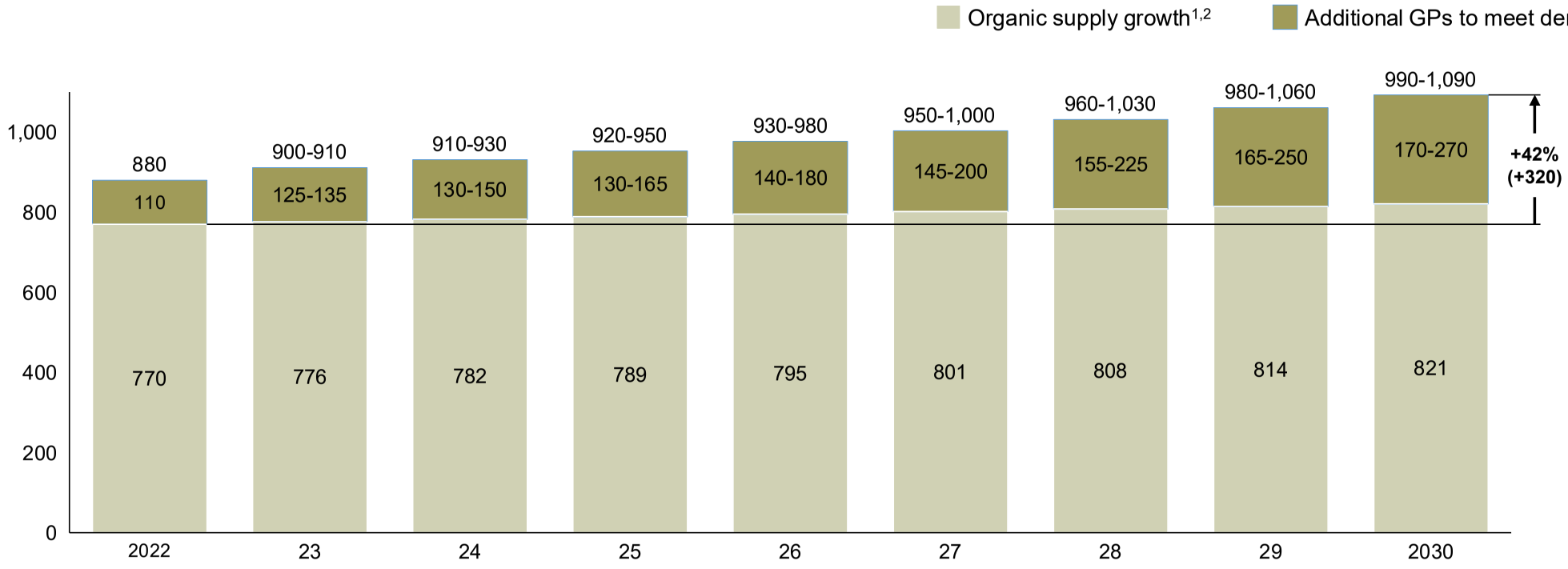
Key takeaways

- **It is estimated that there is a current shortage of ~70-80 GP FTE in rural WA** based on available 2022 data[1]
- Historical growth in GP supply of 1.2% p.a. is lower than projected demand growth **resulting in a widening gap**
- **An additional ~40-100 GP FTE may be needed by 2030** based on estimated projections[2,3]
- **Resulting total of ~110-180 additional GP FTE** needed between now and 2030
  - This is in addition to replacing attrition/retirement, and attracting 32 new GPs in line with historical trends
- These projections do not factor in changes to **burden of disease, social determinants of health, etc.**

Assuming no changes to workforce trends, this translates into a need for ~320 additional net GP headcount by 2030

PRELIMINARY

Estimated GP headcount required in regional and remote WA to meet projected demand,

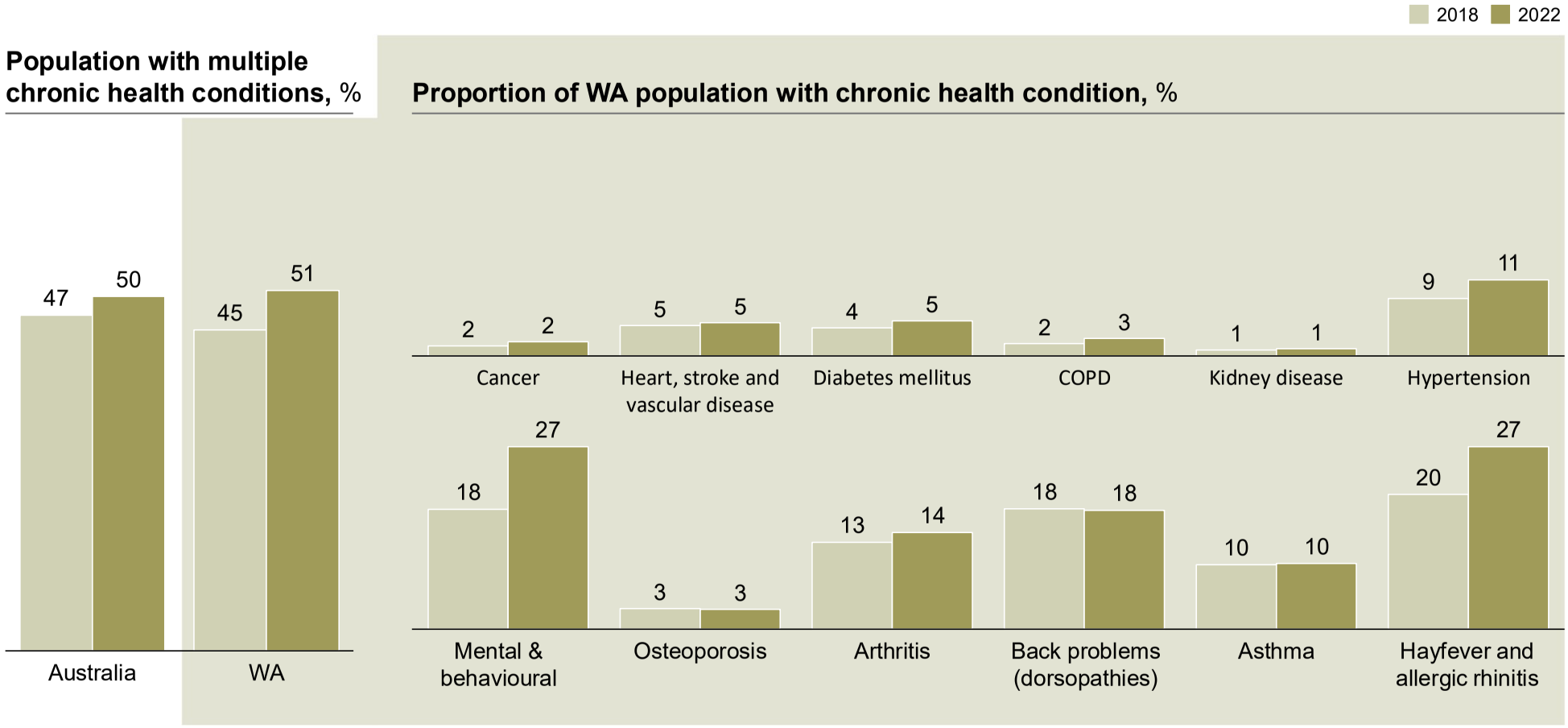


1. Based on projected GP FTE required to meet demand scenarios, adjusted by a scale factor of 0.68 GP FTE per GP based on 2022 data
2. Current GP headcount of 770 reflects the current RHW-reported rural GP headcount (911) less GP registrars (141)

Source: Rural Health West Annual Workforce Update survey data; Productivity Commission, Report on Government Services 2024; AIHW MBS services data on GP Attendances; ABS regional population data; ABS Rest of WA population projections

Growing prevalence of chronic health conditions across WA may contribute to further demand for GP attendances

PRELIMINARY

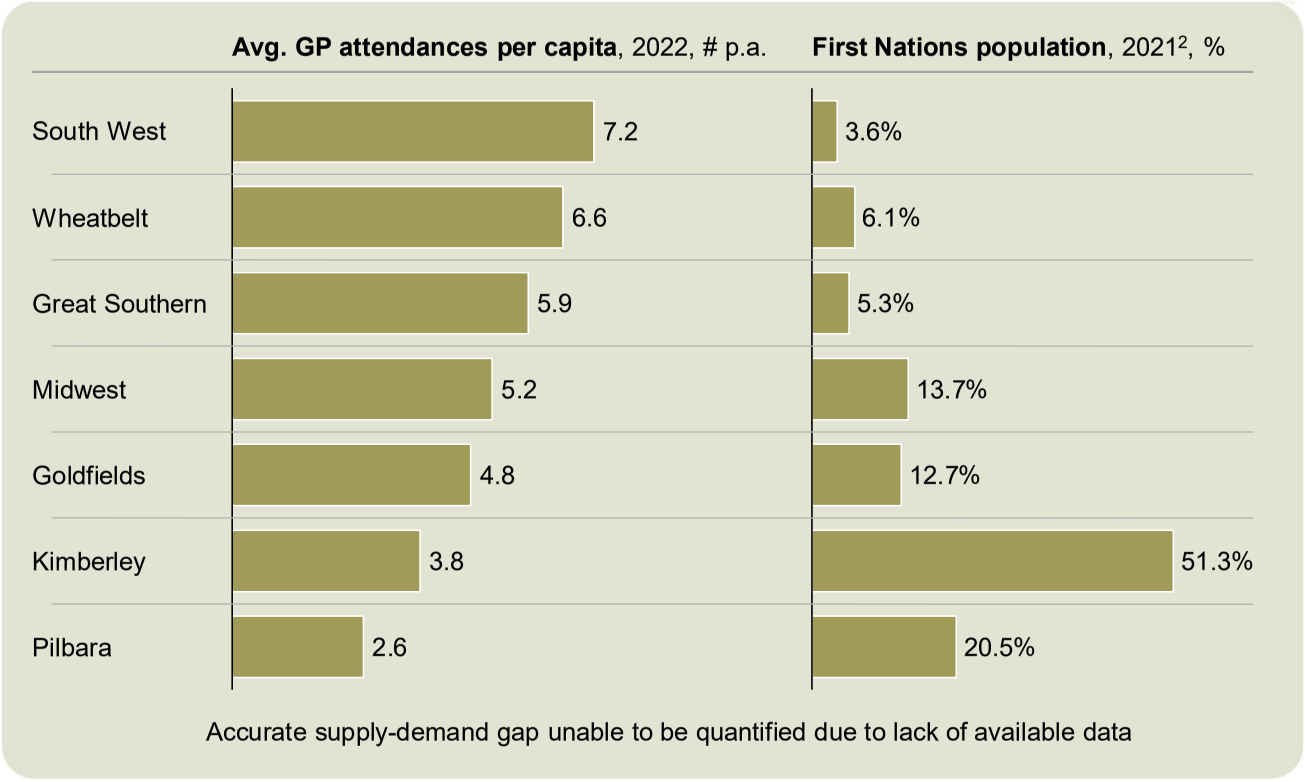


Source: ABS National Health Survey

Estimated GP attendances per capita may not fully reflect Aboriginal and Torres Strait Islander peoples' need for GP services

PRELIMINARY

- GP attendances per capita are generally **inversely correlated** with proportion of First Nations population across regions
- This is despite **high chronic disease prevalence** for First Nations peoples, with **~40% of population in 2019** estimated to have one or more chronic conditions
- Gaps may be driven by reduced access to care, evidenced by a **4.1x difference** in WA for potentially preventable hospitalisations between First Nations and non-First Nations populations[1]



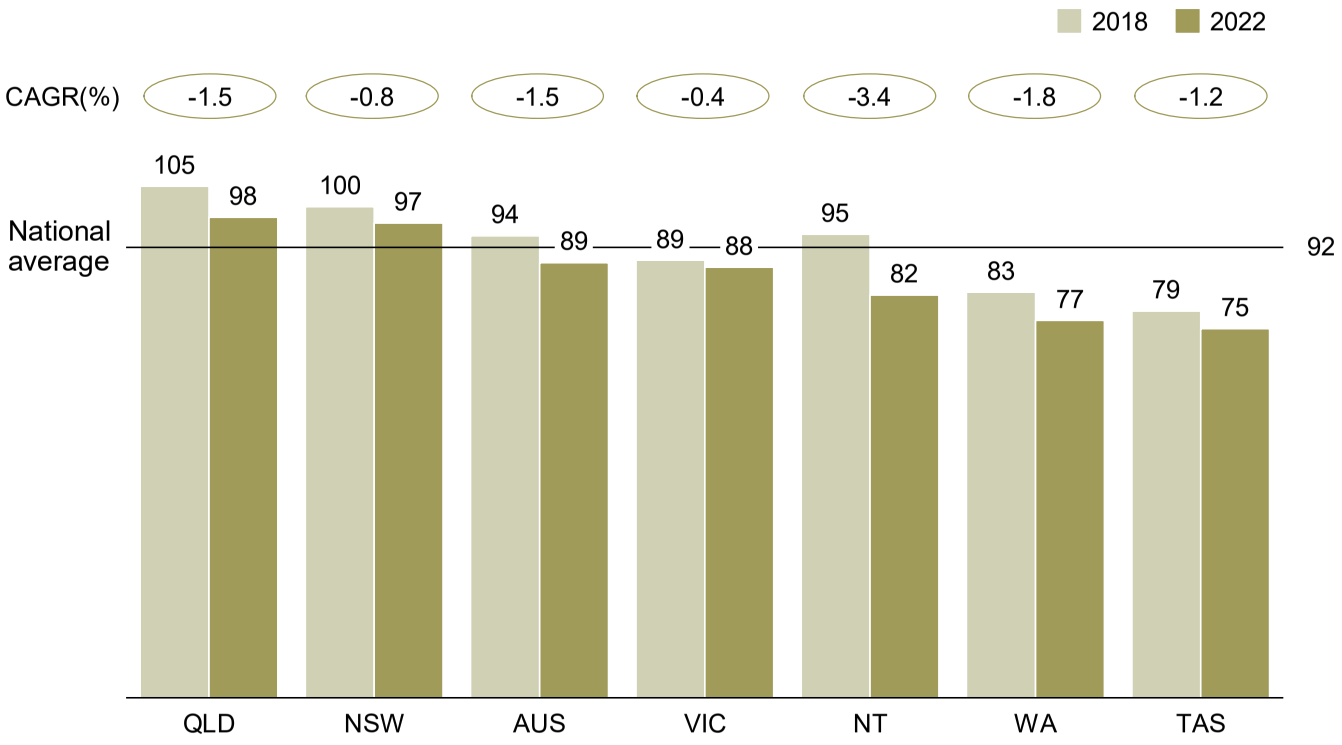
1. Potentially preventable hospitalisations used by the AIHW as a proxy for access to primary care. WA has the second highest incidence of potentially preventable hospitalisations in First Nations peoples behind NT. Other states have 1.4x to 3.7x differences in total potentially preventable hospitalisations between First Nations vs. other Australians, with an ~3.0x difference gap nationally
2. 2022 data from AIHW not yet released

Source: ABS regional population estimates; ABS estimates on Indigenous population, 2021; AIHW MBS services data on GP Attendances; AIHW Cultural safety in health care for Indigenous Australians

The 2024 Productivity Commission Report found that rural WA has consistently had lower GP FTE per capita vs other states

PRELIMINARY

GP FTE per 100,000 people in outer regional and remote areas,



Comments

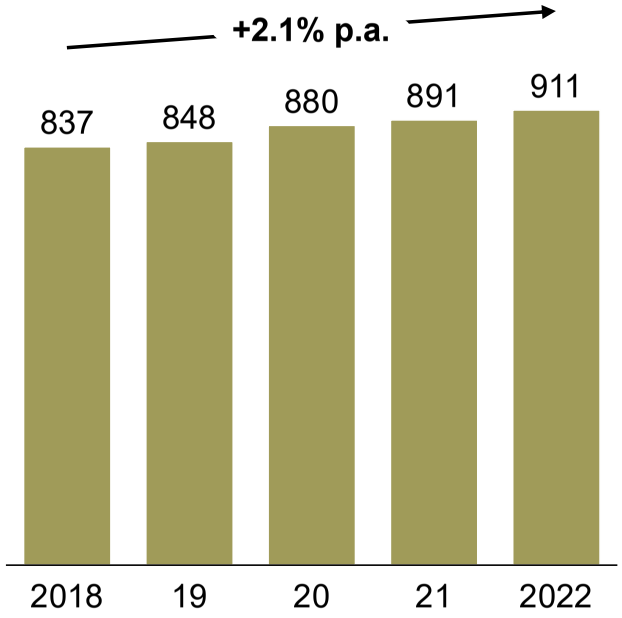
- **WA has one of the lowest GP FTE per capita** rates in outer regional and remote areas (second only to Tasmania) and below the national average
- **Rural GP FTE per capita declined in all states** relative to 2018
- **WA was among the fastest rate of decline** (1.8% p.a.), second only to the NT (-3.4%), this is despite growth in absolute GP FTE and headcount over the same period (details follow)

Source: Productivity Commission, Report on Government Services 2024

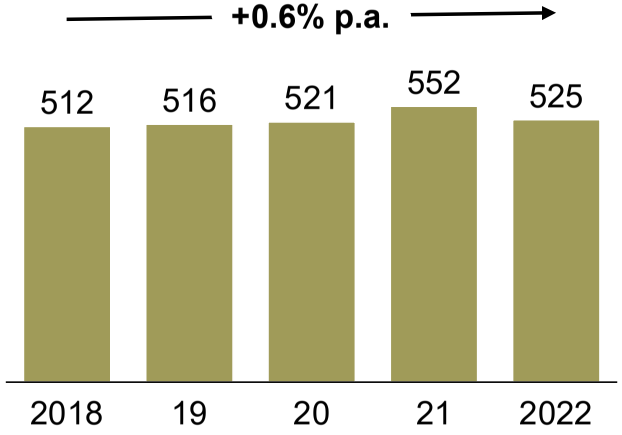
Rural WA secured ~70 additional GPs over the past 5 years, this translated to ~10 more FTE and a decline per capita

PRELIMINARY

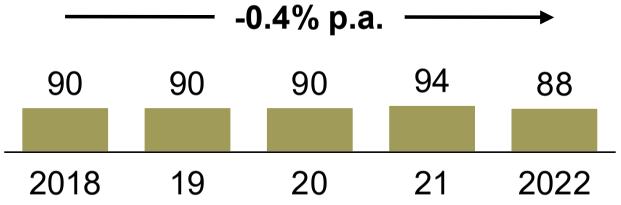
WA regional and remote GP headcount, #



WA regional and remote GP FTE[1], #



WA regional and remote GP FTE per capita, FTE per 100k

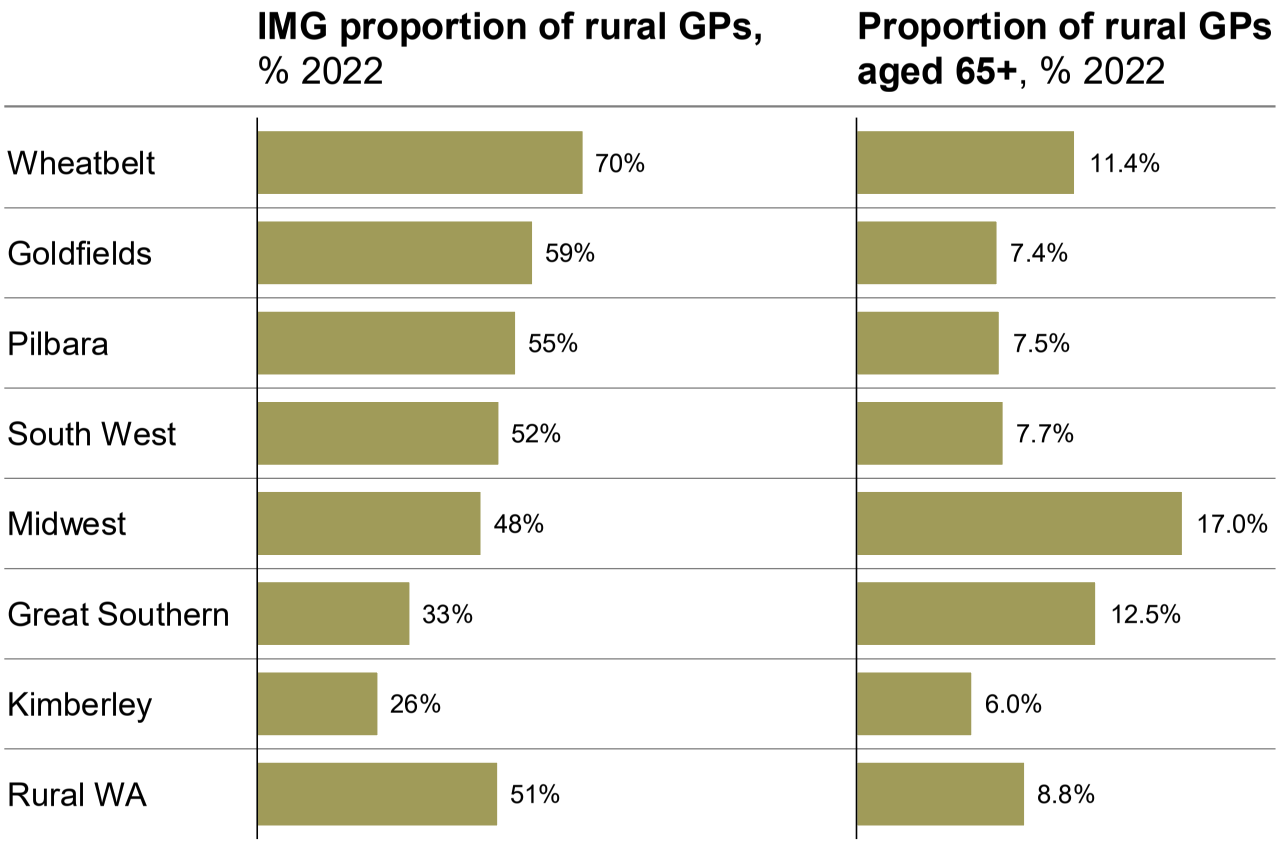


1. 2022 regional and remote WA GP FTE and FTE per capita sourced from Productivity Commission analysis of MBS data – does not include GP Registrars or other groups not captured through MBS (included in RHW GP headcount estimate)

Source: Rural Health West Annual Workforce Update survey data; Productivity Commission, Report on Government Services 2024

Rural WA is reliant on IMGs and an increasingly ageing group of established GPs

PRELIMINARY



Comments

- **IMGs make up half of WA's rural general practice workforce**
- The rural general practice workforce is ageing, with **8.8% of the workforce aged 65+**, and **26.6% aged 55+**, with average age increasing with MMM[1] remoteness
  - **The Midwest, Great Southern and Wheatbelt** regions have the highest proportions of GPs aged 65+ (17.0%, 12.5% and 11.4% respectively)
- **~10% of rural GPs** are projected to reach retirement age[2] in the next 3 years

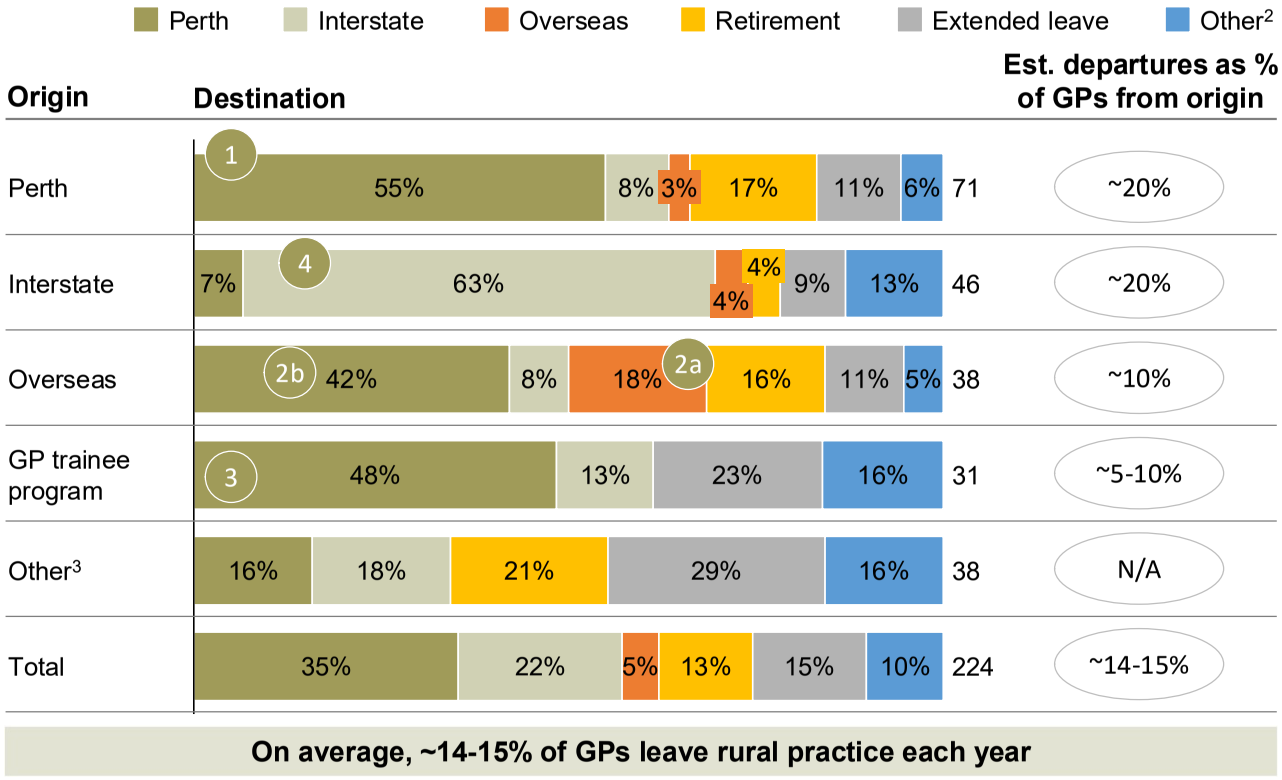
1. Modified Monash Model
2. 67 assumed as retirement age, with surveyed age in 2022 taken as baseline

Source: Rural Health West Annual Workforce Update survey data

Retention remains a challenge, ~50% of rural GPs, IMGs and trainees who leave rural WA go to Perth

PRELIMINARY

Destination of WA's rural GPs upon leaving rural practice, by origin, 2021 and 2022



On average, ~14-15% of GPs leave rural practice each year

Comments

West Australian origin clinicians

1. **~55%** of rural GPs that **moved from Perth as GPs return to metro Perth**
3. **~50%** of departing **rural GPs that started as trainees relocate to metro Perth**

Overseas origin clinicians[1]

2a. **~80% remain in Australia**

2b. **~40% moved to Perth (in line with WA origin GPs)** suggesting potential similar response to retention factors

Interstate origin clinicians

4. **~60%** return home, potentially reflecting greater challenges retaining social connections vs Perth origin GPs

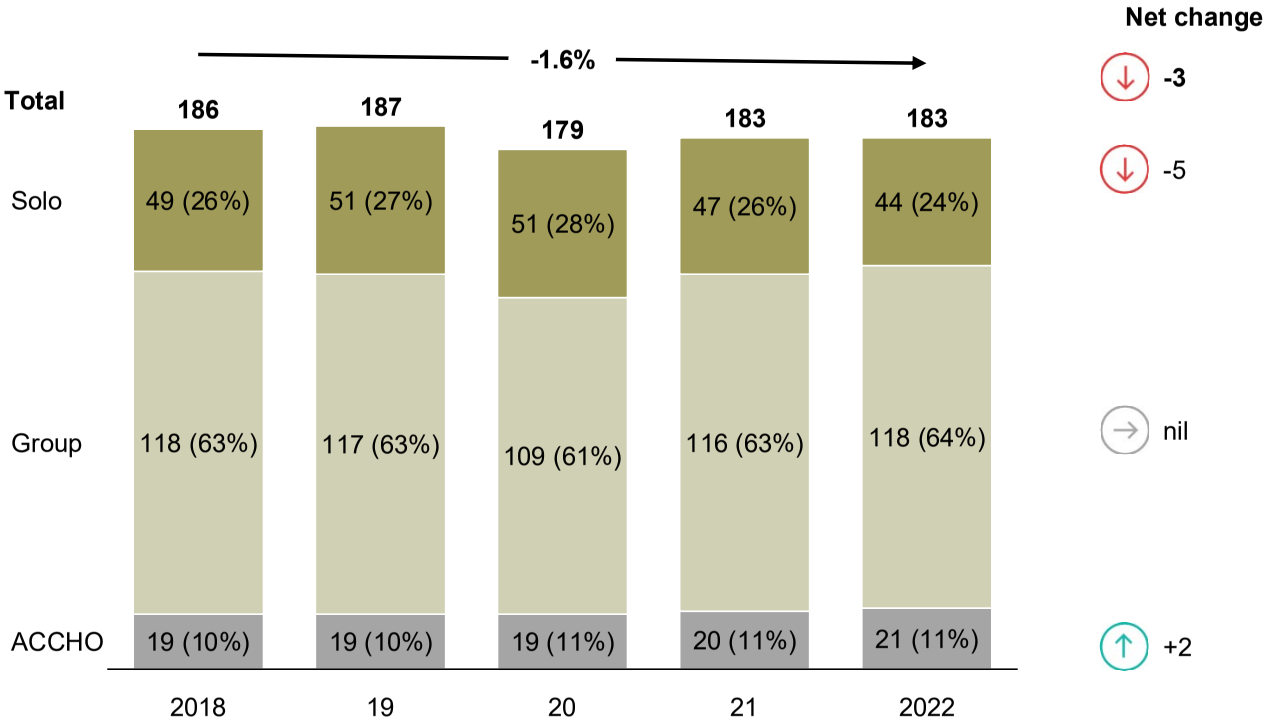
1. Includes any doctor from overseas
2. Includes those leaving rural practice as locums, have deceased or for other destinations
3. Includes those commencing rural practice as locums, returning to rural practice from extended leave, or joining rural practice from other sources

Source: Rural Health West Annual Workforce Update data

General practice numbers have reduced slightly with retirements and closures, potentially reflecting challenges to practice viability

PRELIMINARY

Rural general practices by type, n.



Comments

Composition of general practices has shifted towards group practices since the pandemic, with key drivers including:

- Challenges to **solo practice economic viability** – practices in <5,000 person, regionally isolated towns received the most government support to attract and retain GPs (~96% of local government GP service spend)
- **Retirements** in solo practices, leaving other practices to absorb unmet demand
- **Extended closures** between locum support periods, and patients choosing not to be seen by locums

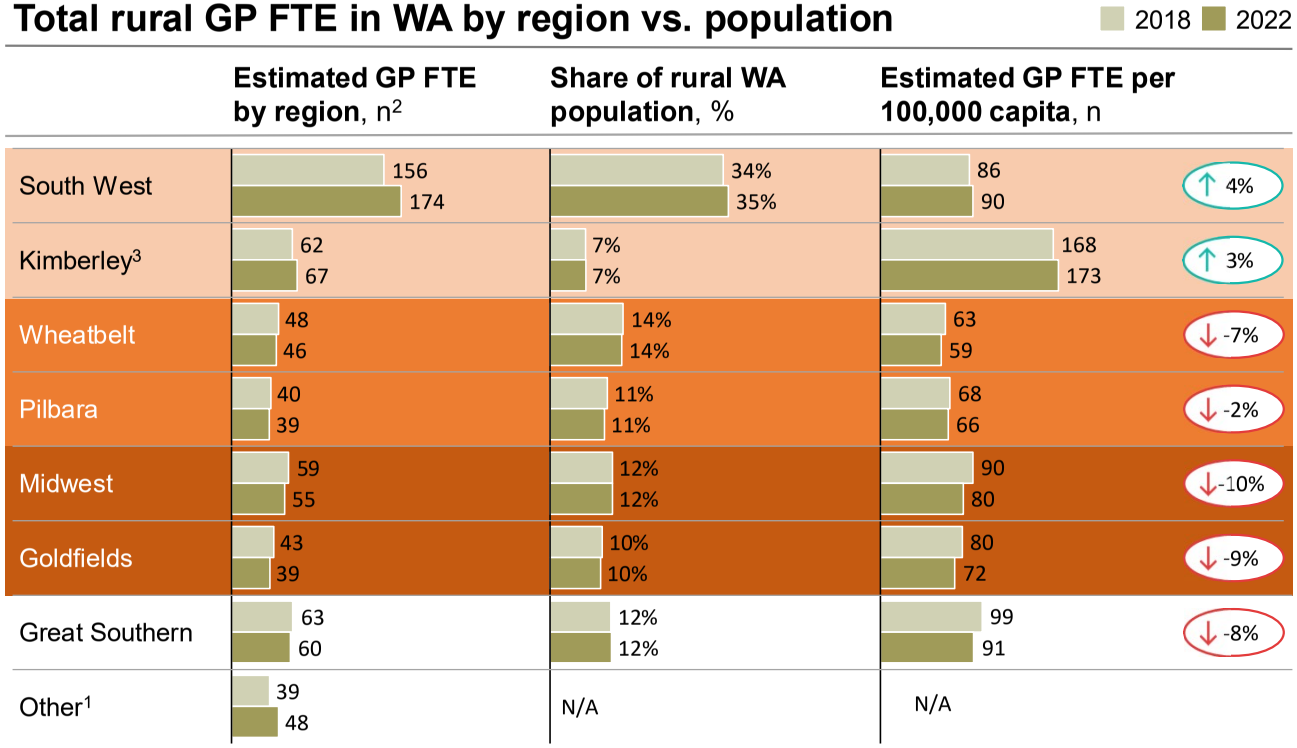
Reduction in solo practices may have **access implications** for rural communities, where required to travel further to reach group practices

Source: RHW Annual Workforce Update survey data; RHW research

The Wheatbelt and Pilbara have lowest GP supply per capita, while Midwest and Goldfields saw the greatest declines

PRELIMINARY

Total rural GP FTE in WA by region vs. population



Comments

Kimberley and South West saw absolute and per capita supply improvements between 2018-22

The Wheatbelt and Pilbara have proportionately fewer rural GPs per capita relative to other parts of WA, and are below Australia-wide GP per capita averages (~90 per capita)

Midwest and Goldfields saw the greatest decline, driven by retirements and reduction in IMGs

1. Includes GPs based in metro areas (RFDS Western Operation, Jandakot Base), Inner Regional and Indian Ocean Regions
2. GP headcount converted to FTE by applying a factor of 0.61 to 2018 and 0.58 to headcounts in 2018 and 2022 respectively, calculated using MBS FTE data against Rural Health West headcount data
3. While the Kimberley appears to have high GPs per capita, demographic-driven health needs are higher and data does not reflect population seasonality

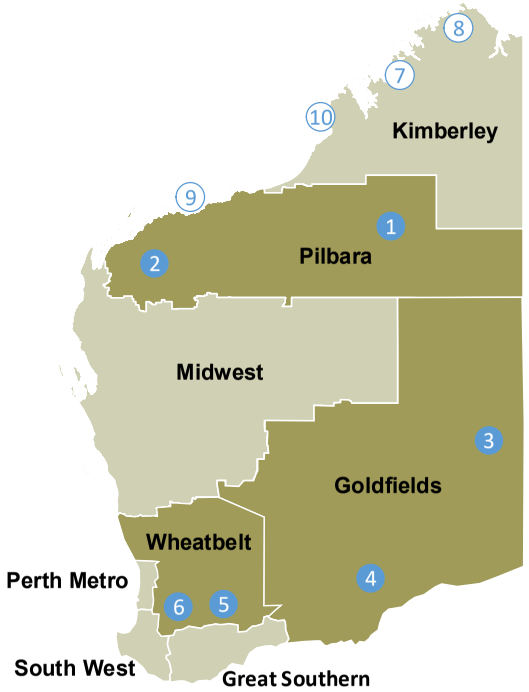
Source: Rural Health West Annual Workforce Update survey data

The most at-risk regions face attraction and retention barriers, with workforce ageing and inability to secure resident GPs

PRELIMINARY

Ⓧ Most at-risk communities ⓧ Other at-risk communities[3]

Sample of high-risk regions



Region	Sub-region	GP FTE[1]	Vacancies[1]	Long-term vacancy?[2]	Key challenges
Pilbara	1 East Pilbara	1.3	-	⊗	• **Attraction:** All GPs are FIFO-based; largest geographic coverage region across WA • **Retention:** Service continuity risk with 1.3 FTE in case of retirement or relocation; 1 GP per ~5k people (worst coverage ratio in rural WA)
	2 Ashburton	2.5	2	⊗	• **Attraction:** High vacancy to position ratio; 3rd lowest GP to First Nations population ratio (1:470 vs. some or most falling between 1:91 and 1:350), potentially more complex needs in this populations
Goldfields	3 Kambalda – Coolgardie – Norseman	2.3	-	⊗	• **Attraction:** No GP coverage in some towns; previous locum requests not filled; service continuity risk at 2.3 FTE
	4 Leinster – Leonora	5.5	1	✓	• **Attraction:** All GPs are FIFO-based; large First Nations population to be served; at least 1-2 vacancies per year continuously from 2020 to 2023
Great Southern	5 Kojonup & Katanning	6.6	2	✓	• **Attraction:** Large vulnerable population in Kojonup covered by 1 resident GP FTE; 2-3+ vacancies per year between 2020 to 2023
Wheatbelt	6 Wagin	1.1	1	⊗	• **Retention:** Service continuity risk with 1.1 FTE in case of retirement or relocation; 1 GP per ~4,900 people

1. As at 2023
2. Determined by regions with vacancies in 2023 and over multiple previous years
3. At-risk communities are: 7) Derby - West Kimberley; 8) Kununurra; 9) Port and South Hedland; and 10) Broome

Source: Rural Health West data

8.4 Workshop Milestone Action Plans

Workshopped Milestone Action Plans

Appendix 8.4

WA RURAL GP SUMMIT

Ensure generalism is strongly embedded into medical school and post-graduate training curricula, pedagogy and assessment

What does success look like for the initiative in the next 1-2 years?

- Majority of clinical placements in GP/community health, compared to specialist tertiary hospital wards
- Address 'hidden curriculum'
- Enhanced relationship between GPs, universities – research, CPD, funding, grant support, payments for GPs
- Recognition and acknowledgement of GPs as specialists – role modelling

Who is the natural owner(s) of this initiative overall?

- Universities, Royal Australian College of General Practice (RACGP), Australian College of Rural and Remote Medicine (ACRRM), Post-graduate Medical Education units (PGME) in tertiary hospitals, Postgraduate Medical Council of WA (PMCWA)

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Document time (longitudinal) of placements across GP, tertiary, community, urban, rural smaller hospital service	Universities, PGME units, Colleges
2 Come to an agreement over payments	Universities
3 Purposeful teaching – longitudinal care, reduce "acute" focus	PGME units, Universities
4 Teaching for JMOs (by GPs) to enhance profile of GP and rural	RACGP, ACRRM, PMCWA, PGME units
5 Training post saturation is an issue in rural areas – needs consideration	Universities

What is the biggest risk or challenge to implementing this initiative?

Funding, red tape, competing demands – balancing GP trainee vs med student supervision

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Provide IMGs with financial, social and professional supports as well as programs that support IMGs to effectively train and work within the Australian health care system

What does success look like for the initiative in the next 1-2 years?

- IMGs enter a less complex system eg. Timeframes, PESCI
- Australia is a destination of choice eg. Lifestyle, less complex process, removing barriers
- IMGs feel valued – breaking down IMG/AMG divide, siloed thinking
- Removing some of the financial imposts imposed on IMGs
- Active support from entry into workforce until College/s take over support role

Who is the natural owner(s) of this initiative overall?

- Rural Health West

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Create a concierge service via health professional networks	Rural Health West – Regional Health Professional Networks
2 Create a comprehensive orientation/induction program, including cultural training, Medicare, understanding the Australian health system	Rural Health West and Colleges
3 Develop an IMG GP Network (IGPBN model) which provides support from entry to Fellowship and beyond to address professional isolation	TBA
4 Investigate other countries who induct IMGs well into their health systems	Rural Health West

What is the biggest risk or challenge to implementing this initiative?

- How to access funding parcel which is geared towards increasing Australian trained rural workforce
- Lack of interest in investing in this significant cohort and investing in the building blocks of support systems
- Challenge the high costs for visas, Royal Australian College of General Practice Fellowship Support Program, Australian College of Rural and Remote Medicine Independent Pathway, how can we remove these financial imposts?

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Increase support for rural practices to host medical students

What does success look like for the initiative in the next 1-2 years?

- Empowered GPs and practice teams – leading to better supported students
- Standardised curriculum for rural practice rotations
- Standardised student placement agreements
- Practices, supervisors and students have clear expectations about placements

Who is the natural owner(s) of this initiative overall?

- GP Supervisors Australia, Royal Australian College of General Practice, Australian College of Rural and Remote Medicine, universities *(consult with Federation of Rural Australian Medical Educators (FRAME) and Leaders in Indigenous Medical Education (LIME))*
- WA Universities
- The Rural Clinical School of WA (RCSWA) and WA Universities

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

		Potential owner
1	Establish project team to produce a paper to go to University of Notre Dame, Curtin, University of Western Australia	GP Supervisors Australia
2	Conduct audit of existing resources available to support rural practices	GP Supervisors Australia
3	Develop a suite of resources for rural practices, supervisors and students – to include CPD accredited training modules, handbooks, training resources	GP Supervisors Australia with Colleges
4	Seek agreement from stakeholders on standard curriculum and placement expectations - , including adjunct status for participating GPs	RCSWA
5	Standardised remuneration for practices. Practices could be accredited (noting existing accreditation for registrar placements). Supervisors with extra training could be remunerated at a higher rate.	RCSWA
6	*Out of scope but discussed*: consideration for the establishment of a training practice designed and built to enable student placements, which would be connect to a hub (could also utilise telehealth).	

What is the biggest risk or challenge to implementing this initiative?

Universities wanting individual ownership which complicates matters for practices
Developing a unified curriculum
RCSWA not resourced to support relevant milestones

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Ensure that GP registrars have meaningful access to leave, including parental, personal, annual, study and cultural leave

What does success look like for the initiative in the next 1-2 years?

- Base rate and entitlement parity with public system registrars
- Portability of leave enabled
- GP Registrars taking leave:
  - While confident their practice is safe/ no guilt
  - Before burnout, when needed, when planned
  - Funded at same rate of earnings, not at base rate of pay

Who is the natural owner(s) of this initiative overall?

- General Practice Registrars Australia, with support of private practice

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Advocacy for National Terms and Conditions for the Employment of Registrars (NTCER) increase, including supplement to support entitlements for duration. Est. $90M over 10 years (TBC)	Commonwealth
2 Research to demonstrate benefits/impact of having meaningful access to leave on retention rates	GP Registrars Australia, GP Supervisors Australia
3 Develop model of portable leave entitlements – cost, system eg. construction industry LSL fund, KPMG report 2023 found not possible (TBC)	Colleges
4 Incentives available for Fellows to also be available to GP Registrars (increase earning capacity)	All representative bodies
5 Relief/rotating GP Registrar and GP pool to cover leave – especially within the ACCHOs	

What is the biggest risk or challenge to implementing this initiative?

Tradition style of employment contract does not always work – need to modernise employment relationship
State based issues/concern, NTCER funded by Commonwealth
Supporting portfolio careers eg. Working across community, clinic, public system, outreach clinics etc may be what the community requires, however this increases the complexity of solutions

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Target financial incentives more carefully according to a town's population size, geographical remoteness and local need

What does success look like for the initiative in the next 1-2 years?

- Better patient access to healthcare
- Better continuity of care due to better medical officer support and sustainability/retention of their positions
- Recognition of GPs as specialists under EBA by WA Health

Who is the natural owner(s) of this initiative overall?

- Australian Government Department of Health and Aged Care, Rural Health West, Australian Medical Association of WA (AMA WA), WA Primary Health Alliance (WAPHA)

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Develop comprehensive dynamic needs assessment tool	Rural Health West, WA Country Health Service (WACHS), WAPHA
2 Review/revise current WIP rates and guidelines so that it allows for inflation, recognises clinical governance and supervision roles, etc	WACHS, AMA WA, WA Department of Health
3 Consider what should be included in and who should receive incentive payments eg. Sick leave, airfares to return home to family annually,	Commonwealth – with Rural Health West, WAPHA and AMA WA advocacy to support
4 Review incentives in other jurisdiction, as well as application processes/tools	
5 Develop an overlay of the combination of incentives and assessing these in the context of a specific town	
6 Revise WIP payments so that they incentivise more complex patient care items, eg incentivising good patient care	

What is the biggest risk or challenge to implementing this initiative?

Potential adverse impact should incentives be decreased once better doctor to patient ratio achieved – will lead to decreased attractiveness of area and create cyclical change to incentives
Multiagency interactions needing to work on this
Timeline for decisions, implementation

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Market general practice as the 'go to' career option for medical students and pre-vocational doctors, including highlighting the variety that general practice careers offer

What does success look like for the initiative in the next 1-2 years?

- Increased survey results among medical students and vocational doctors choosing general practice pathways, but specifically rural general practice
- Greater collaboration among Colleges etc in an agreed approach to changing perception of general practice

Who is the natural owner(s) of this initiative overall?

- Collective – Australian Medical Association WA (AMA WA), Rural Health West, Colleges and Universities

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Write to all medical advocacy organisations and ask they stop the negative narrative around general practice	AMA WA
2 Review of existing research among organisations into career aspirations and expectations etc of medical students and graduates	Rural Health West
3 Conduct qualitative and quantitative research into WA medical students career aspirations and expectations	Universities
4 Conduct a 'myth busting' campaign about life as a GP and its inherent advantages	Colleges and general practice associations
	State and Federal governments

What is the biggest risk or challenge to implementing this initiative?

Perception around remuneration, ongoing negativity around GP (media coverage), GPs talking themselves down as undervalued. GPs complain more than any other discipline. Fear/ lack of clarity about context of making career decisions, silos between organisations

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Scale up intern and junior doctor posts in primary care settings and rural locations

What does success look like for the initiative in the next 1-2 years?

- Scale up current arrangements available through John Flynn Prevocational Doctor Program from 4 regions to additional regions, as well as increased number of positions available
- Better support systems in place – accommodation, logistics, contracts, supervision
- Current limitations addressed – expanded pool of RMOs, expanded pool of practices and supervisors

Who is the natural owner(s) of this initiative overall?

- Operations – WA Country Health Service (WACHS), general practice, Rural Health West, The Rural Clinical School of WA Regional Training Hubs
- Policy – Office of Chief Medical Officer, Post , Commonwealth
- Funding - Commonwealth

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Extend current placements to include placements in the Goldfields region	WACHS and general practice
2 Establish new community placement positions in Silver Chain, Royal Flying Doctor Service Goldfields, urgent care clinics eg. Broome (utilise existing capital infrastructure)	WACHS and general practice
3 Consider establishing a teaching practice	Universities – training, adjuncts, information technology
4 Consider CPD recognition for GPs eg. bundling of points	Colleges
	Government - support

What is the biggest risk or challenge to implementing this initiative?

Accreditation – Postgraduate Medical Council of WA, not Australian Medical Council
Funding
Recognition – trainees into vocational training

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Establish a pathway to allow GPs to upgrade and maintain their advanced/ procedural skills for rural general practice

What does success look like for the initiative in the next 1-2 years?

- Procedural GPs have sufficient lists for skills maintenance
- Sufficient Supervised Clinical Attachments for rural GPs in tertiary hospitals
- WACHS working with procedural GPs to ensure their skills are maintained

Who is the natural owner(s) of this initiative overall?

- WA Country Health Service (WACHS), Colleges, Office of the Chief Medical Officer (OCMO), Rural Health West

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 OCMO to prioritise supervised clinical attachment (SCA) places for procedural GPs in tertiary hospitals	WACHS
2 Review QLD model for scalability to rural WA (employers role to arrange and ensure SCA/professional development to all doctors contracted to their services)	Colleges – Australian College of Rural and Remote Medicine and Royal Australian College of General Practitioners
3 Secure funding to support locum back fill, cost of training, travel for GPs seeking additional upskilling	Rural Health West
4 Host planning meetings with rural GPs/visiting medical practitioners and WACHS (regional sites) to meet requirements of the community	
5 Arrange visiting specialists to support local proceduralists onsite at rural hospitals	
6 Education piece by WA Country Health Service to visiting medical practitioners: what services can be delivered at specific sites	

What is the biggest risk or challenge to implementing this initiative?

Credentialing – would benefit from being statewide, not site specific
Medical indemnity insurance – should be fully covered, automatic, with “no paperwork”
Location – volume and type of practice in rural locations is variable for maintaining skills and/or working to full scope of practice

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Simplify communication pathways between GPs and the hospital sector, particularly processes for escalating GP queries and concerns

What does success look like for the initiative in the next 1-2 years?

- Communication systems and processes are consumer focused – information follows the consumer throughout the health system, and is timely and relevant
- Respectful, constructive relationships between hospitals and GPs

Who is the natural owner(s) of this initiative overall?

- WACHS has greatest opportunity to influence (facilitate) improvement across stakeholder groups and partners

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

Milestone	Potential owner
1 Improve quality and consistency of information systems across the community/hospital interface, by engaging clinicians (including GPs) in the design of systems and business solutions at all levels	WACHS/ Department of Health
2 Re-establish effective Medical Advisory Committees and GP liaison roles in all settings (accountable, genuine) with a focus on relationship building across hospitals and community settings	WACHS
3 Strengthen rural generalist/GP roles in hospital settings through joint appointments and in decision making/leadership roles (working across community and hospital settings)	WACHS with private providers and partners

What is the biggest risk or challenge to implementing this initiative?

Continuity of leadership in driving improvement and relationship building (turnover of leadership roles effecting progress)

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

Initiative: Explore FIFO/DIDO-based GP servicing models for persistently hard-to-serve locations

What does success look like for the initiative in the next 1-2 years?

- Universal access for rural communities to some form of GP care, irrespective of geography and demographics
- Equity of entitlements for FIFO/DIDO doctors
- Same doctors servicing same communities for longer than two years/ clinicians embedded/embraced by community
- Decreased used of secondary care services

Who is the natural owner(s) of this initiative overall?

- Rural Health West, with National Rural Health Alliance
- Office of the Chief Medical Officer
- Commonwealth in longer term

What are the 4-5 major milestones needed to deliver this initiative, and who are the natural owners?

1. Identification of at-risk communities eg. Failed markets, using an assessment tool to allow early intervention
2. Improve in-house telehealth services to allow continuity of care (PHS/ITS) *(requires resourcing)* and delivery of true primary health care
3. Build stable pool of clinicians (potentially rotating between metro/regional centres) *(requires resourcing)*
4. Develop induction process, introductions, enculturation to the community
5. Develop structure of clinical governance for FIFO vs regular GPs eg. Clinical handover
6. Education/awareness program for community to understand/accept the utility of FIFO/DIDO models
7. Explore FIFO models from elsewhere that work
8. Inform regional services of system arrangements

Potential owner

Rural Health West

Commonwealth

Individual health services

WA Local Government Association

Local community/local government

What is the biggest risk or challenge to implementing this initiative?

Lack of continuity of care, locums, patient safety
Ownership (State vs Commonwealth) and accountability (transparency)

When can we get started on the initiative?

(X) Immediately ( ) 6 months ( ) 1 year+

8.5 Individual Commitments Captured via Poll

Individual Commitments captured via Poll

Appendix 8.5

WA RURAL GP SUMMIT

Poll responses: What is one thing that you can commit to actioning over the next 3 months to progress the initiatives discussed today? 1/2

- Develop best practice supervision resources in collaboration with WA universities / RCSWA to enable high quality placements for med students and postgraduate doctors in rural general practice.
- Promote the benefits of Telehealth in community, lead discussions in rural community about realistic levels of service and acceptance of changed service models to meet community need.
- Advocacy of agreed priorities to governments.
- Work with final year medical students to improve their GP placement experience.
- Continuing the promotion of Rural Generalist and rural GP careers to prospective trainees.
- Work with the junior docs to help them find possibilities in a rural career.
- Look into the John Flynn program in more depth to see how we might support those JMOs more effectively in rural areas while on placement.
- Advocacy for junior doctor rural training positions JFPDP and Internships.
- Introduce CPD incentives for medical student placements in GP.
- Engage with GP on research support.
- Help sort out PIP arrangements with practices.
- Talk with the universities if they want rural GP to give talk to the medical students about future career.
- Discuss further, follow up and act on commitments.
- Scoping increase in JMOs in WACHS sites.
- I am working very hard to make general practice both rural & metro more viable and better supported.
- To provide the reality for the future to support our marketing and other
- support.
- Promote satisfaction of Rural GP.
- I can continue to worry about a continued rural shortage for the foreseeable future.
- How we can better support the medical students?
- Continue consulting with general practices to hear what is occurring to inform our reporting deliverables.
- Bringing a project team together to work on initiatives to drive increased support for rural practices to host med students.
- Being more positive in promoting GP.
- Discuss with my own clinical and P&C team about how we can contribute.
- Get the data, tell the story and advocate.
- Spend more time with students to give them an inspiring experience that they don't forget.

Poll responses: What is one thing that you can commit to actioning over the next 3 months to progress the initiatives discussed today? 2/2

- Communicate the initiatives to others in my sphere of influence.
- Advocacy.
- I will spread the positive message about rural general practice.
- Building on connections made today.
- Make sure our practice has up to date listing with RACGP and ACRRM for registrars for semester 2.
- Tweet more.
- Work with stakeholders to progress change.
- Update my organisation on some key points.
- Utilise my reach over my organisation to support and promote the right message and opportunities in the diverse world of GP.
- Write a letter to everyone telling them not to deride GP.
- Follow up on connections from today.
- Maintain the whinging.
- Get out of the weeds to focus on the key issues.
- Advocating for interprofessional respect and civility.
- Champion the cause…
- Share my positive experiences of being a rural GP trainee.
- Research!
- Strengthen rural focus of current GP programs.
- Continuing to plead for funding to be able to employ the IMGs in my community who are not working and are being wasted.
- Work to increase John Flynn placements.
- Marketing the lifestyle of the rural lifestyle.
- Advocate.
- Medical student, pre vocational and registrar mentorship.
- Improve direct GP communication.
- Starting conversations.
- Being joined up and champion the cause.
- Not give up.