Submission to the Sustainable Health Review

Summary

WA GP Education and Training (WAGPET) delivers the Australian GP training (AGPT) program funded by the Federal Department of Health. The AGPT program is the dominant training pathway in WA for a doctor seeking to become a AHPRA recognised specialist general practitioner. The AGPT in WA

- Promotes and provides a general practice career to underpin the State health system
- Helps build the primary - secondary - tertiary interface, as doctors training to be GPs (GP registrars) work across all of these
- Provides 30% of vocational doctors in training with a job and a supported position
- Ensures full and increasing scope of practice to reduce ED and potentially preventable hospitalisations (PPH)
- Increases the proportion of health services in WA funded by MBS PBS and thus
- In the long term, ensures only those needing a State facility will access such facilities.

Saving Opportunities from a Strong General Practice Service

The State Health System is currently deprived of $400m p.a. in nationally averaged Medicare Benefits that would be paid for community based services, if we had the doctors and their support facilities to provide them.

The State Health System funds a similar $400m p.a. for potentially preventable hospital admissions (PPHs) not to mention emergency department presentations. PPHs are admissions are for conditions that could be prevented or diagnosed and treated early outside an emergency or in-patient setting.

Across Australia there are 46m outpatient visits, and so WA could expect 10% or 4.6m appointments that are potentially manageable in the community and thus MBS and PBS eligible.

Federal – State Agreement Changes

A robust Federal State Agreement is required if we are to address these State-based inequities. Areas for the funding and service agreement will need to address

- Clinical governance across the acute, sub-acute and chronic, preventive sectors
- Sufficient numbers, distribution and quality of community based doctors
- Community based MBS remuneration for full scope of practice e.g. Medicare Review
- A shared electronic health record e.g. My Health record
- Cultural changes that recognise there can be better and more effective continuity care and quality of care if a hospital setting does not try to do everything

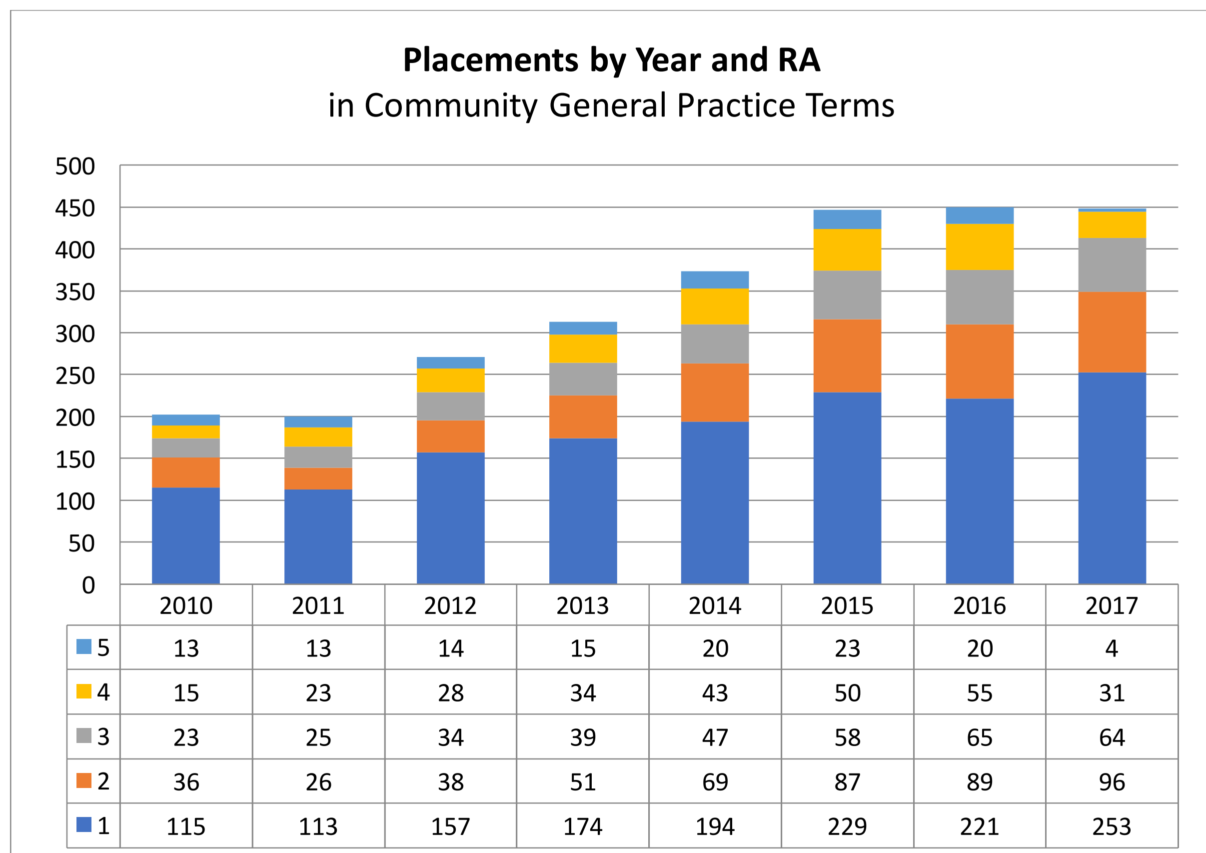
Sufficient numbers, distribution and quality of Community-based Doctors

While vocationally training doctors are on the AGPT, the Medicare Benefits Scheme effectively pays the salary of the doctors when they are training in the community through a dedicated AGPT 3GA MBS provider number. The AGPT is free for the doctor in training who in return must work some or all of their time in a rural, remote or outer urban area. The Federal Health Department funds WAGPET to recruit, accredit, assess and support training facilities as well as trainees.

There are 600 doctors on the 3 – 4-year AGPT program each year in WA (with an annual intake of 178 including the rural pathway). While training towards a GP fellowship of the college their choice – FRACGP or FACRRM – the doctors work in areas where WA communities need them most. This includes State Health facilities where special skills are acquired and provided, or where the State Health System provides primary care services e.g. much of the north of WA.

Numbers and Distribution

WAGPET has a contractual KPI to distribute the total number of FTE weeks delivered by GP registrars in ratio of 60: 30: 10 across urban, rural and remote areas. All doctors on the program must spend at least 12 months in an outer urban area or 6 months in a rural or remote area. All doctors on the special rural pathway must spend all of their training time in a rural or remote area.



	2010	2011	2012	2013	2014	2015	2016	2017
5	13	13	14	15	20	23	20	4
4	15	23	28	34	43	50	55	31
3	23	25	34	39	47	58	65	64
2	36	26	38	51	69	87	89	96
1	115	113	157	174	194	229	221	253

Figure 1: Distribution of Doctors Training to be General Practitioners (Registrars) in WA

This distribution of GP registrars is very different to the overall distribution of general practitioners as can be seen with the graph below for WA.

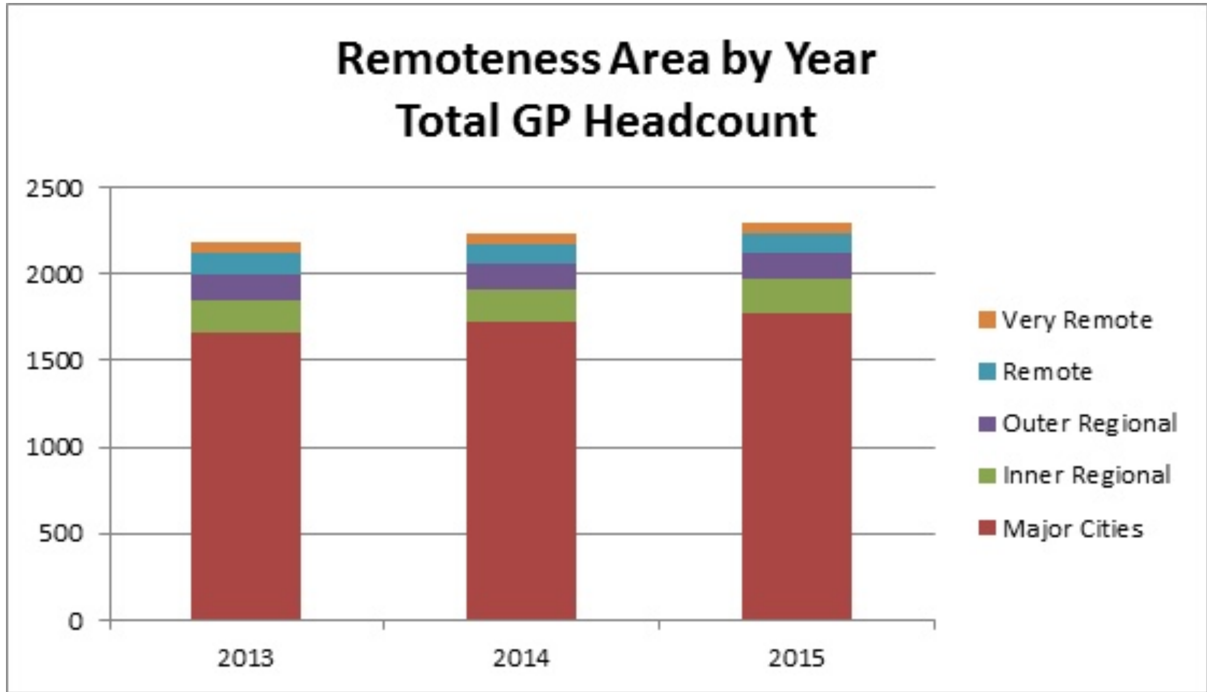


Figure 2: Distribution of All General Practitioners in WA for Comparison

This more rural remote distribution is upheld after fellowship, with specific reference to remote and very remote areas when we compare the cohort of doctors still in training (registrars) with those who have fellowed with WAGPET (thus controlling for changes in the population distribution in WA over the past decade).

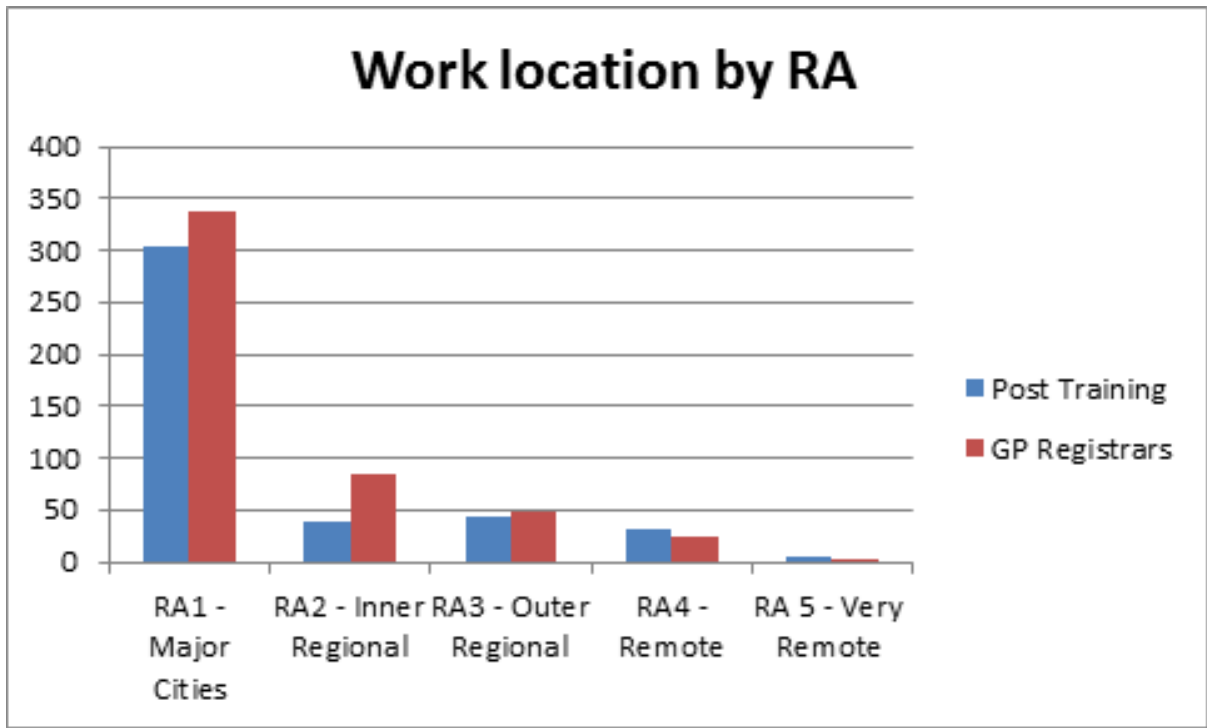


Figure 3: Comparison of General Practice Registrars and WAGPET Recent Fellows

Maximum Scope of Practice

Prevocational Medical Training. The State Health System is responsible for funding and delivering the training doctors will need to be accepted onto the AGPT. To be eligible for the AGPT, doctors must have completed their intern year and acquired basic competency across many medical and surgical domains e.g. paediatrics, emergency, obstetrics, gynaecology, general medicine, general surgery, psychiatry and geriatrics. Some will have further experience in dermatology, palliative care and Aboriginal and Torres Strait Islander and multicultural health.

WAGPET has contributed to the impressive work of METARC and the State Medical and Dental Workforce Committee around integrating all medical training, including general practice training. This work underpins a comprehensive, affordable and efficient mechanism for ensuring all generalist medical practitioners acquire these basic competencies, without which they may not be accepted onto the program, may not pass the assessments and may not deliver the full scope of practice in their subsequent career. Only with GPs working to their full scope of practice can we expect referrals, retrievals and avoidable hospitalisations to decrease over time. Numbers and distribution is not sufficient.

Vocational GP Training. While undertaking the AGPT program, all these capabilities are further developed, but based on and applied to the community context and health needs. Doctors who are well prepared before entering the AGPT are able to adapt and grow their expertise to the new setting and in doing so prevent or mange early those conditions they have seen at the acute stage during their hospital based training.

During training, the doctors undergo a very comprehensive, continuous and contextually relevant learning and assessment program. They then must complete 2 – 3 rounds of college examinations, all of which test the full scope of practice expected of any GP practising anywhere in Australia.

Post-vocational GP Training. Through independent research, WAGPET tracked the 500 general practitioners who completed their college fellowship 2010 – 2016 in WA with WAGPET firstly by comparing training data with AHPRA data.

Results showed rural fellows were 8x more likely to have been on our rural pathway (all or most training done rurally) and 3x more likely to have been Australian born.

They were 3x as likely to have done additional skills while in the AGPT suited to rural practice e.g. anaesthetics, obstetrics, emergency, mental health, palliative care, renal medicine (dialysis) or Aboriginal health care. For every ten-weeks of rural training any AGPT doctor undertook, they were 21% more likely to still be working rurally now. Further, the fellows were much more likely to be working in remote and very remote areas than all other rural doctors in WA.

We interviewed over 75% of all the fellows and discovered 45% were in the same practice they trained in last, demonstrating the impact of training location on career location. For

80% of fellows their scope of practice had either stayed the same or increased. Many said they referred less frequently and managed more patients locally as their experience increased post-training. 70% had acquired a special interest of skill relevant to their location.

91% of the fellows were still working in WA – which shows the stickiness effect of the AGPT in WA as less than 60% of the doctors completed their medical degree in WA. 70% were working 0.6 FTE or more, and more than half of those were working full-time. There are no 'black holes' post-vocational training, no loss of continuity to change the distribution and scope of practice requirements established in the AGPT program experience.

<u>Integrating Rural Medical Training</u>
There are a lot of beneficiaries, advocates and deliverers of rural medical training programs applicable to the different stages of a medical career, and under different priorities, focus and governance.

In WA, we have aligned these in a single CEOs reference group across those responsible for identifying community needs, delivering appropriate and affordable services, supporting those services and supplying those services with a full scope of practice local workforce. These agencies are WA Country Health Service, Rural Clinical School of WA, Rural Health West, WAPHA and WAGPET. The support of the State Health System, along with agreed KPIs, would create a transparent accountability for this important group and for the co-designed deliverables – including funding and resources – from each partner organisation.

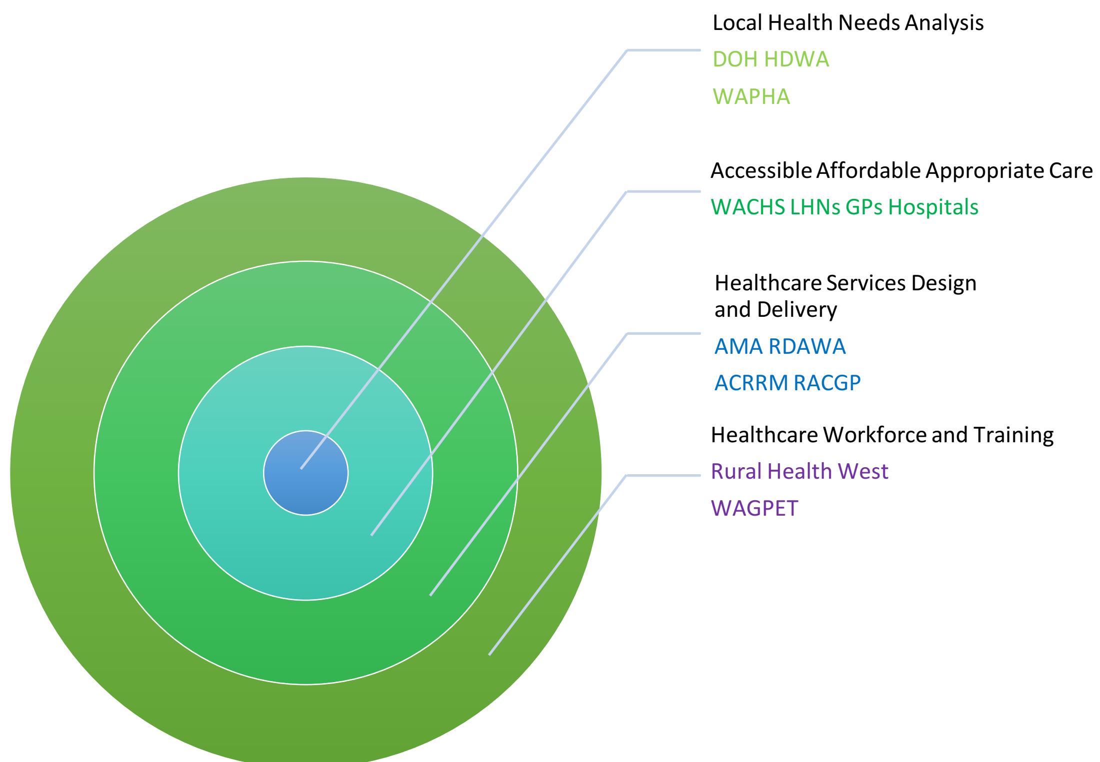


Fig 4: Co-designing the Delivery of Rural Health Services

From 2007 – 2015 WAGPET delivered prevocational community based training under contact to the Federal and State Health Departments. The program had the support of the two general practice colleges (ACRRM and the RACGP), AMA, WACHS, Rural Health West, Silver Chain, Rural Clinical School of WA, the Junior Medical Officers, the Aboriginal Health Council of WA and the Kimberley Aboriginal Medical Services, and the Rural Doctors Association of WA.

With Medicare provider numbers for the doctors and support for the facilities that employed and supervised them, we were able to place doctors in general practice, Aboriginal community controlled health services, Silver Chain, and other offered settings like family planning, alcohol and drug services, prisons, community mental health and aged care facilities. The State health department funded – as usual – blended rotations in peripheral, regional and rural hospitals so the doctors worked across the full spectrum of care, often following their patients as their care required a different context e.g. ante-natal care, assisting at delivery, six-week baby check-up, post-natal care e.g. mental health. This program bridged the 'black hole' between the rural clinical school experience and rural vocational training, especially in general practice.

The program – known as the community residencies program – was further enhanced when WACHS developed whole year contracts that embedded this concept of cross-context acute – subacute – chronic – preventative care. When the Federal government withdrew both the provider numbers (that essentially paid the salary of the doctor) and its financial support, WAGPET and then WACHS carried on with a greatly reduced program.

Unfortunately, the program was effectively hobbled just as the large increase in prevocational doctors started to hit our tertiary hospitals and just when it was poised to train up to 30% of all doctors each year in the non-tertiary sector.

The return of the access to Medicare provider numbers for prevocational doctors, with or without the Federal support, would give this program a sound business case for the State government. The State Health Department has to pay the prevocational doctors' salaries anyway, train them anyway. This program has the added benefit of training and supplying a workforce able to reduce potentially preventable presentations and admissions in the short, medium and long term.

The work done by METARC under the direction of the chief medical officer (CMO) on building a structured training pathway and a competency based learning and assessment program would dovetail nicely into a reinvigorated community residency program.

Australian Trained Medical Practitioners

WA has one of the highest ratios of imported medical (IMG) practitioners across all specialty groups, including general practice. While IMGs provide a stop-gap short-term local or specific need, this acute solution has become a chronic one to the detriment of a local, sustainable, affordable medical workforce. The trend data is clear – IMGs do not stay as long where they are needed, and not as long as AMGs. The medium to long-term effect is a

burgeoning net inflow of IMGs to urban areas and a much lesser contribution to remote and very remote areas where the community need is greatest. The remote areas need continual short term topping up, expensive replenishment of the IMG workforce, increasing FIFO and DIDO (again expensive) as there is one-way tracking for IMGs to the city once their compulsory obligations are met.

The community investment in Western Australian university educated and State Health system trained doctors is lost when IMGs take the jobs that could be done by an AMG under supervision, i.e. a GP registrar. Most IMGs are ineligible to supervise doctors in college training programs, either because they do not have the college fellowship, or because they are working in unaccredited facilities deemed unlikely to offer the full scope of practice needed to attain fellowship and to thus serve a community fully. This further limits supported GP training opportunities so necessary before a GP registrar moves to more challenging locations.

Once in those locations, our recent research has confirmed that GP registrars stay on. More than 90% of the WAGPET fellows since 2010 have stayed in WA, 45% in the same facility. 80% have the same or increased scope of practice.

We know that if doctors trained mostly in remote and very remote areas they are most likely still there. This all adds up to the AGPT dramatically influencing the volume, distribution and scope of practice of general practitioners. This contrasts with the importation of IMGs. The following graph show the net inflow of AMGs and IMGs in the time WAGPET has been operational, though the trend was apparent even 30 years ago.

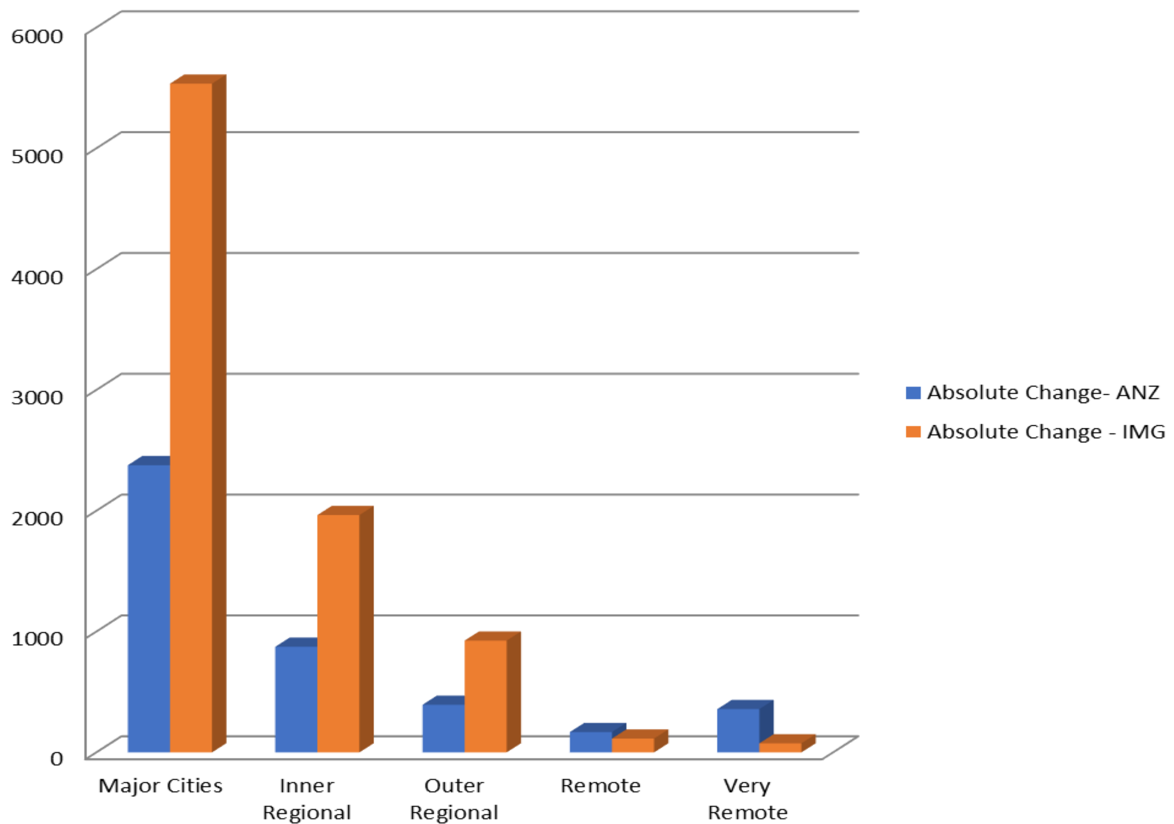


Figure 5: National Net Inflow of AMGs and IMGs by RA

While IMGs were an important adjunct to a dwindled medical workforce – and remain so in some areas still – their numbers and call on the MBS (reflected in the FSE) demonstrate that we have reached a point where there is a policy clash, short term versus medium and long term. This is an expensive waste of resources.

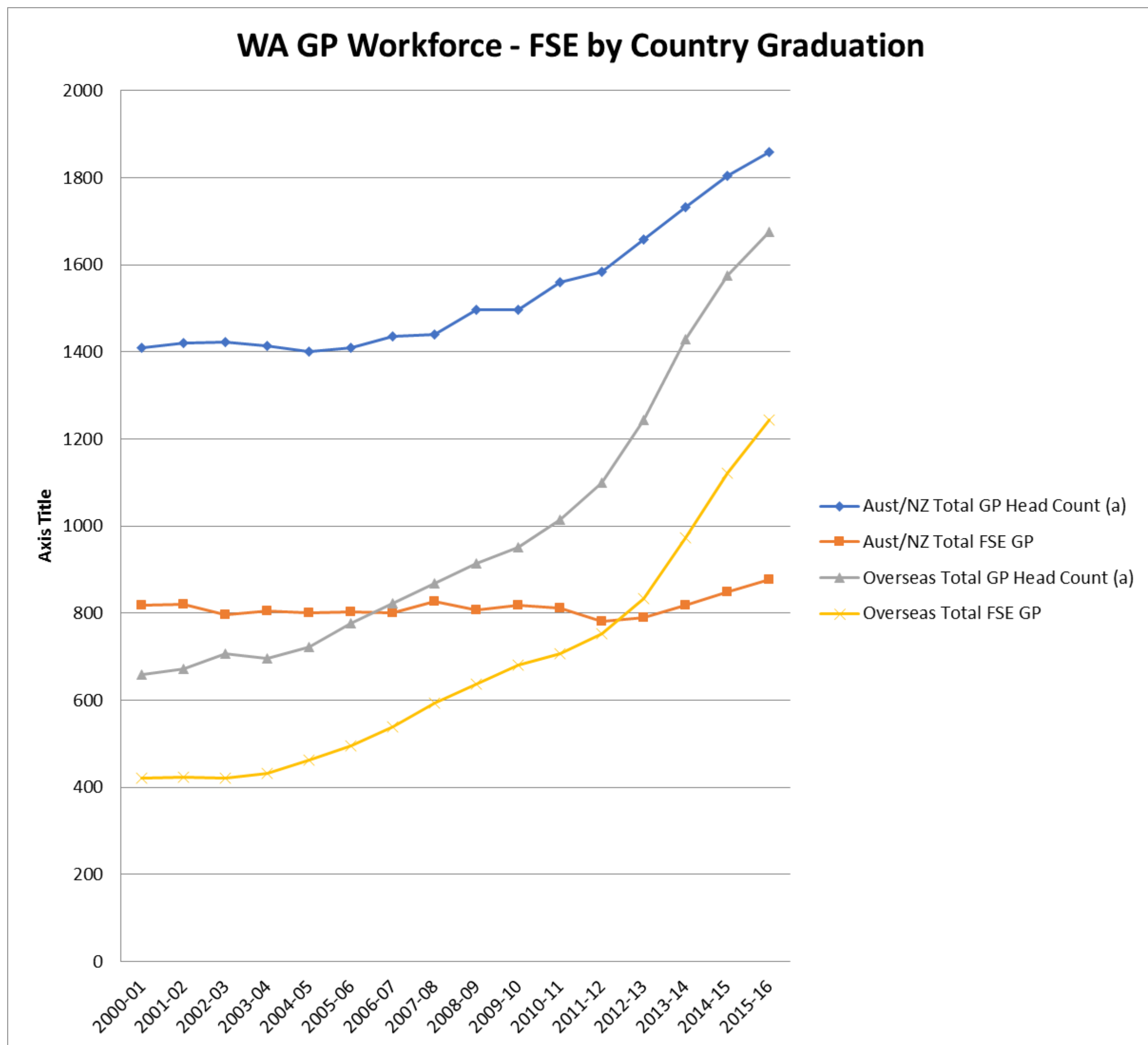


Figure 6: IMGs and AMGs by Head Count and FSE 2001 – 2016

State Return on Investment Analysis

The AGPT in WA relies on the State Health System to select and train interns and prevocational doctors for a total of three years in those areas of medical practice most relevant in providing a number of "rights" the community can expect from their general practitioner – the right care, to the right patient in the right place, in the right time, at the right price, and with right outcomes. The State Health System also provides special skills training for rural-bound doctors in areas such as anaesthetics, obstetrics, emergency and surgery.

In return the AGPT delivers a redistributed and sufficient general practice and general practice procedural workforce across WA that, by virtue of its hospital-based and contextual training, will help to reduce hospital admissions and ensure Medicare – instead of the State government – pays for services that, by rights (above), should be delivered in the community.

The community residencies program would expand the breadth of the ROI by applying to 25% of prevocational doctors in any year. This could apply to interns but the business case is not as strong. Interns generally need more support, don't have access anywhere in Australia on any program to Medicare provider numbers, and the key stakeholders generally do not support interns in the less supervised community setting (for their safety and for the safety of their patients).

Summary

A systems approach to a sustainable healthcare system in WA will reveal the quiet achievers and pockets of potential, like the AGPT program. Work has already commenced to better integrate the AGPT program with prevocational medical training (with proof of concept in the community residencies program) and with this alignment WA can expect

- More general practitioners working where they are needed most
- More of the national MBS and PBS funding coming to WA
- Sufficient training places for all students including those from Curtin University
- Cost savings from retrievals, IMG locums, FIFO and DIDO, emergency department presentations and potentially preventable hospitalisations
- Improved quality, access, acceptability, equity, efficiency (technical, dynamic and allocative) and outcomes for Western Australians, wherever they live and work.

Adj Prof Janice Bell

Chief Executive Officer WAGPET
Chair Curtin Medical School Advisory Board
Chair RACGP Expert Committee Post Fellowship Education

18 September 2017