Foreword

In late 2010, the Rural Doctors Workforce Agency (RDWA) was commissioned by Country Health SA to develop a pathway to rural general practice that described how to create an assured and increased supply of Australian trained GPs to live and practise in rural South Australia.

I am pleased to report that the project has been successful in producing not one but two significant outcomes for rural health workforce in South Australia.

Firstly, this report shows that South Australia has the components to attract, educate and train rural general practitioners and GP proceduralists. The Road to Rural General Practice Report describes the additional structures and processes required to attract a new cohort of practitioners who want to work in the highly valued and recognised role of general practitioners with specialised rural practice skills.

Secondly, the project process was comprehensive, inclusive and provided the consistency necessary to guide the success of the project. I am confident that the process used to achieve this outcome provides a blueprint for further collaboration around rural workforce in South Australia.

Through the project it became clear that one of the most important ingredients of success was the public and declared recognition of rural general practice as a highly valued specialist vocation and career.

This recognition enables the doctors practising in rural SA to remain proud of their work and demonstrate to younger generations of practitioners the unique place rural medicine has in the health of our population.

I would like to recognise the contributions of the Expert Panel, workshop and focus group participants, stakeholders and the project team. As a result of their efforts, I am confident we will have the workforce to provide healthcare for our rural communities now and in the decades before us.

I commend this rural pathway project report, the Road to Rural General Practice.

Lyn Poole
Chief Executive Officer RDWA
Chair Rural Pathway Expert Panel
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>i</td>
</tr>
<tr>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>The Rural Pathway project</td>
<td>5</td>
</tr>
<tr>
<td>Findings of the study</td>
<td>7</td>
</tr>
<tr>
<td>Rural SA health service context</td>
<td>10</td>
</tr>
<tr>
<td>Demand analysis</td>
<td>14</td>
</tr>
<tr>
<td>Supply issues</td>
<td>16</td>
</tr>
<tr>
<td>The model</td>
<td>27</td>
</tr>
<tr>
<td>Appendix 1 Expert Panel</td>
<td>33</td>
</tr>
<tr>
<td>Appendix 2 Expert Panel meetings</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 3 Summary of issues and concerns</td>
<td>36</td>
</tr>
<tr>
<td>Appendix 4 Summary of Issues from focus groups</td>
<td>38</td>
</tr>
<tr>
<td>Appendix 5 Workshops</td>
<td>49</td>
</tr>
<tr>
<td>Appendix 6 Workshop presentations</td>
<td>52</td>
</tr>
</tbody>
</table>
Executive summary

This report provides a description of the process that has been undertaken to arrive at the findings presented. Strong collaboration has been the cornerstone of the project methodology.

It provides a service context from a Country Health SA perspective and from the general practice perspective. It analyses the supply and demand related to rural doctor workforce and demonstrates the shortfall in supply. And finally it offers a solution in the creation of a program Road to Rural General Practice (R2RGP).

The State Government of South Australia is publicly committed to not only retaining the existing level of health service provided in rural South Australia, but to enhancing it. In addition Country Health SA is required to provide 24 hour, seven day a week emergency services in each of its hospital locations.

The population distribution of rural South Australia is such that it cannot sustain a resident specialist workforce able to undertake all of these roles and functions.

Rural South Australia is very reliant on its resident general practitioners to provide their primary health care services and to provide inpatient care emergency services, surgery, obstetrics and anaesthetic services in the Country Health SA owned and operated hospitals and health services.

This has been the case for decades and given the rural infrastructure and population distribution and projections, will not change in the foreseeable future.

The analysis undertaken through this project has affirmed the capability and appropriateness of some of the components required. This is evident in the areas of education and the programs that support the promotion and attraction of rural South Australian students considering a career in medicine. Equally there is a demonstrated capability in the two regional training providers who manage the training of doctors through their registrar years.

There is a clearly described need for there to be fundamental change to the crucial decision making period as students graduate from university and undertake their post graduate year one and year two training (PGY1 and PGY2).

This is the period when young doctors make decisions about what specialty they will undertake. Currently there are six positions based in rural South Australia for medical graduates in PGY1. There were 246 places available in the metropolitan area in 2011.

Demand modelling demonstrates a need for up to 53 recruits each year. If it is accepted that there will continue to be a blend of Australian-trained and internationally-trained doctors residing and working in rural SA, there is a need to create at least 20 PGY1 and PGY2 training positions each year.

It is recommended that the six PGY1 positions continue in Mt Gambier and a minimum of 14 and up to 24 new positions are created in rural SA. This will allow graduates to be based in rural locations during these formative decision-making years.

It is very important that these young doctors have the opportunity to be immersed in rural health and receive training from our existing rural GPs and specialists. There are no GP role models or champions in metropolitan hospitals.

Country Health SA Hospital Inc will become a Local Health Network on 1 July 2011. It needs to gain formal recognition as a single teaching and education facility, with the same status,
functionality and access to funding as a metropolitan teaching hospital. This will allow R2RGP trainees to complete their hospital training, including procedural training, in an environment most relevant to rural general practice.

There is an enormous reliance on the GP resident workforce to have procedural capabilities. With the exception of some 35 resident specialists, GPs provide the majority of obstetric and anaesthetic services across rural South Australia.

There is no accommodation in any consistent way to provide current GP registrars with training opportunities in these specialist areas in metropolitan-based facilities. The Road to Rural General Practice Program proposes that there are dedicated procedural training posts available in both rural and metropolitan locations. It also proposed that at least half of the annual cohort of registrars have procedural capability.

Coupled with rural training, there is a need to describe and promote rural general practice as a prestigious and highly valued specialty career.

Historically all general practitioners who reside in rural South Australia and provide services for Country Health SA were engaged under a fee-for-service model with the responsibility for the recruitment and retention of suitably skilled GPs and GP proceduralists resting with each individual general practice.

In recent years alternate models of engagement have through necessity, found their way into the construct of service delivery contracted and funded by Country Health SA. There are now salaried doctors and specialists, GPs operating on sessional payments and newly created organisations managing emergency services.

For rural general practice to be experienced as a viable career option there is a need to ensure that there are a variety of engagement models available to attract the current generation of students. These new engagement models need to demonstrate competitive remuneration and conditions of engagement similar to those offered to the more traditional specialist positions.

For this model to work there needs to be the same option available to the existing resident rural doctors to ensure that they have a capacity to participate not only as treating practitioners but as teachers and educators.

Of equal importance is the need for Country Health SA, to overtly describe the mix and blend of procedural activities it requires at each of its locations. This will allow participants in the program to know where their chosen career path may take them.

This report was commissioned to provide advice to Country Health SA, to clarify the concerns that there is an over reliance on internationally trained doctors who for many years have provided a full range of services to rural communities and an inadequate number of Australian trained rural general practitioners prepared to live and work in rural South Australia.

The RDWA with the support of an expert panel who have overseen this project can confirm that there is an increasing under-representation of Australian trained GPs in rural SA and there is an opportunity to redress this problem.

The solutions proposed through the creation of the Road to Rural General Practice Program create the opportunity for Country Health SA to remedy the situation.

This remedy will be successful if the providers who have participated in this process and who have a responsibility to educate and train the workforce collaborate with Country Health SA to design the implementation strategy.
The Rural Pathway Project

In late 2010, Country Health SA commissioned RDWA to work with key stakeholders to determine the feasibility and the issues related to creating a rural pathway for general practitioners in South Australia. The Minister for Health, John Hill, MP, launched the project to a group of key stakeholders in September 2010.

Specifically, the project aimed to identify:
- potential gaps or barriers to the existing pathway that might jeopardise workforce numbers needed to support the implementation of the SA Health Service Plan or place rural communities at risk in terms of access to quality health care services
- key critical success factors essential to the effective operation of a rural general practice pathway
- system or component changes (including add-ons) to be introduced to improve the existing rural general practice pathway.

Country Health SA’s CEO sponsored the project. An Expert Panel (see Appendices 1 and 2) was formed to provide guidance to the RDWA’s Project Team. RDWA CEO, Ms Lyn Poole chaired the Panel and directed the project. Project team members, Mr George Beltchev, Ms Rita Brewerton, Ms Helen O’Malley, Ms Mandy McCulloch and Ms Lesley Johns, designed and undertook consultations and analysis of information collected throughout the project.

Expert Panel members represented the Aboriginal Health Council of South Australia, Adelaide to Outback GP Training Program, Australian College of Rural and Remote Medicine, Australian Medical Association (SA), Country Health SA, Department of Health SA, Department of Health and Ageing, Flinders University of South Australia, General Practice SA, Rural Doctors Workforce Agency, Royal Australian College of General Practitioners, Rural Doctors Association SA, South Australian Institute of Medical Education and Training, Sturt Fleurieu GP Education and Training and the University of Adelaide.

Strong collaboration is the cornerstone of the project methodology. The project recognises the key organisations involved in attracting, training, employing and supporting rural GPs and GP proceduralists, as well as the students, interns and registrars currently considering rural practice.

While each organisation can demonstrate a positive contribution to the supply of rural GPs and GP proceduralists, all stakeholders indicated that they face systemic impediments in the current supply chain and recognise the value in collaborating to consider the rural pathway from a holistic perspective.
Project methodology

The project had five connected phases:

Phase 1:
**Discovery.** During the first phase, the project team documented the rural pathway models in other jurisdictions and identified policies and programs which aim to contribute to attraction, recruitment and retention.

Phase 2:
**Analysis.** The project team examined the current activities to assess efficacy and identify gaps. This enabled the production of detailed mapping – commonly referred throughout the project as the ‘spaghetti diagram’. The ‘spaghetti diagram’ represented the complexity of the current systems and processes (See page 17).

Phase 3:
**Key stakeholder consultations.** This phase was directly informed by the Discovery and Analysis phases. Project team members met with key stakeholders individually in the first instance to discuss the findings to date and ascertain the level of interest that the stakeholders might have in becoming a Rural Pathway partner. This included identifying the needs of the partner in order that they could participate and what part the partner could play in the outcome (the model).

Phase 4:
**Develop potential models.** Workshops (Appendices 3, 5 and 6) and focus groups (Appendix 4) were convened to work with the Project Team and Expert Panel to contribute to model design specifically for the characteristics and factors of rural South Australia.

Phase 5:
**Project Report.** This phase involved the drafting of a final project report for presentation to Country Health SA.
Findings of the study

The challenges of providing the appropriate level and mix of health care services to rural populations are evident throughout rural Australia. In South Australia, the population of around 450,000 rural residents is dispersed in small communities, and SA does not have the infrastructure associated with the large regional cities of the eastern states. It does, however, have significant distance factors, particularly for half the rural population who live 200 kilometres or more from the capital, Adelaide.

The dispersed and relatively small nature of SA’s rural communities does not have the concentration of population to support the full range of resident specialists. In the main, these services are provided by resident general practitioners, a small number of resident specialists and by visiting specialists.

General practitioners working in SA are highly skilled practitioners working across a very broad scope of practice, providing community based, inpatient and highly skilled emergency services to their communities, and for many, specialist type services using their advanced skills in GP proceduralist areas such as obstetrics, anaesthetics and surgery.

For some time now, the number of Australian trained GPs and GP proceduralists choosing rural general practice has not been able to meet the demand for practitioners to provide the healthcare needs for rural SA communities. This supply gap has largely been met by recruitment of international doctors, who have contributed to ensuring that workforce is in place to maintain healthcare service provision.

It is anticipated that SA will continue to have a supply gap if a strategy to redress the situation in not enacted.

Factors currently impacting on the existing GP workforce include an ageing population which has a greater need for healthcare services, the long-term care needs of people with chronic disease, a large cohort of ‘Baby Boomer’ GPs who will commence retiring this decade, and desire for work and life balance by both current and future generations of GPs.
Australia has recently adopted a health workforce goal that would see it achieve workforce self-sufficiency by 2025 for doctors, nurses and midwives. It is within this context that South Australia recognises that more must be done to improve the rate of Australian medical graduates seeking to work in rural SA.

The current components of new workforce education and training are generic in nature, provide opportunities for rural exposure as part of general medical training, are complex to navigate and do not lead to any clearly defined long-term career path in rural medicine.

The education and training offers students and graduates the opportunity to experience rural environments, rural practice and in the case of registrars, long-term rural placement.

These activities of the universities through the rural clinical schools, the rural placements of students, the Parallel Rural Community Curriculum (PRCC) program at Flinders University, the John Flynn Scholarships, the RDWA and rural club initiatives, allow medical students to have some rural exposure. The evidence demonstrates that students who participate in these activities, particularly through the PRCC, benefit academically.

The benefit that arises from students gaining a broader understanding of rural issues and rural health must be acknowledged.

However, the initiatives and programs that are classed as ‘rural activity’ in the undergraduate years are activities that relate to rural exposure and must be seen in the context of students gaining a well-rounded education, not as a pathway to rural practice.

Focus groups with undergraduates and graduates conducted during this project confirm that rural placements are chosen, not because students have an intention to have a rural career, but because they believe they will get superior clinical training and a breadth of activity than would not be afforded in metropolitan general practice.

Regional training providers (RTPs) manage registrar cohorts that are based in rural areas and these registrars are a significant contributor to rural workforce during the time that they are there. It is understood that a small number of rural pathway registrars remain in rural South Australia once they have gained their Fellowship.

It is striking to note that procedural training for country GPs is not embedded in any of the major metropolitan hospital training programs, despite the fact that these are essential services in rural communities, particularly in the areas of obstetrics and anaesthetics.

An analysis of the supply components demonstrates that the effort and enthusiasm to include rural activity does not translate into Australian graduates taking up careers as rural general practitioners in South Australia.

Training and education sectors demonstrate knowledge and understanding within their own areas of expertise, and those sectors are well placed to trade on their high levels of service within their spheres of responsibility.

However, the complexity of navigating the system is, in itself, offputting.

The social dislocation and family considerations in undertaking long-term rural places are challenging. There is little support, and there is no continuous pastoral care provided to these people once they graduate from university.

1 2011, Health Workforce Australia: National Training Plan - Overview
When accepted into the training program, RTPs provide significant support to their rural registrars throughout their registrar years. The same cannot be said during the post graduate years (PGY) 1 and 2 when young graduates are making decisions about their future and assessing their career options.

The critical period in PGY 1 provides a stark contrast for graduates as they select their chosen craft group. Being based in a metropolitan hospital, they are exposed to the dominant traditional specialist roles which are constantly on display.

There are no GP role models in metropolitan teaching hospitals. It is extremely difficult for general practice, and more particularly rural general practice, to have any sustained influence during this period beyond a 10-week placement through Prevocational General Practice Placements Program (PGPPP).

Currently, rural registrars completing Fellowship and choosing to remain in rural South Australia are required to find themselves a position in rural private practice. If they have gained procedural skills, their employment options would suggest that they look to employment with a practice that has a responsibility for the provision of procedural activity with Country Health SA.

The non-proceduralists have a freedom to work in smaller communities and smaller size practices. The standard of general practice business ownership in rural SA is high, and by and large the rural GPs are good employers who work hard to attract and retain fellow GPs.

The current system, however, does not allow for the flexibility required to engage the next generation of rural GPs who wish to work in a more structured environment with a greater degree of certainty and who have no intention of becoming business owners or of remaining in one location for an indefinite period of time.

For rural SA to be competitive in offering a career as a rural general practitioner or as a rural general practitioner with procedural skills requires a commitment not only from general practice but also from Country Health SA to establish a career path that affirms the choices and the sacrifices that these doctors make in choosing to educate, train and work in SA rural communities.

The education and training offers students and graduates the opportunity to experience rural environments, rural practice and in the case of registrars, long-term rural placement.
The project examined the rural SA health service context to assist in understanding current and future workforce demand.

The following issues in the context were considered:

- population demographics and influence on service demand
- the service models, number, mix and distribution of GPs and GP proceduralists in rural SA
- Country Health SA service responsibilities
- the impact of technology on service provision
- the changing expectations of communities in access to healthcare.

Population characteristics

South Australia has the highest proportion of older people in the nation, and the demand for primary and secondary health care by older people is greater than other age groups. The prevalence of chronic disease is increasing and the impact upon country communities is a higher than average number of years of life lost prematurely per 1,000 head of population compared to metropolitan residents.

The ageing population and increase in chronic disease account for significant portions of increased demand on rural health service provision. These factors largely influence the growing demand for service in rural communities across Australia. In SA, however, the ability to manage that demand is influenced by the smaller, more dispersed population than those in the eastern states. SA’s population is not concentrated around large regional centres boasting populations of 90,000-100,000 as seen in Victoria, New South Wales and Queensland. The largest regional centres have populations around 20,000 people. This has led to SA having a rural hospital infrastructure of a different scale. The average available beds at regional hospitals in rural SA range from 42 to 82 beds. In Victoria, major regional hospitals range from 105 to 519 beds.

The lack of sizable hospital infrastructure and smaller populations mean that SA does not have the capacity or the need to have large numbers of resident specialists, and that rural communities in SA are serviced by a small contingent of resident rural specialists, a strong visiting specialist workforce and a significant reliance on rural general practitioners to provide inpatient and emergency care.

GPs in rural South Australia are expected to run emergency departments, admit patients to hospital, manage patients within the hospital and, for those GPs with extended scope of practice in areas such as anaesthetics, obstetrics, gynaecology, surgery, paediatrics and psychiatry, to treat and undertake procedures on patients within the hospital setting.
Rural general practice profile

While the focus of this report rests with increasing the supply of Australian trained general practitioners, it is equally important to recognise the important contribution to SA’s rural medical workforce that internationally trained doctors make.

Rural SA is an attractive place to live and work as a general practitioner, and SA will continue to attract suitably qualified and experienced doctors.

SA, like the rest of Australia has a strong and growing cohort of internationally trained doctors working in rural locations. Internationally trained doctors and their families have been and will continue to be a part of the rich fabric of general practice in rural SA.

Many international doctors practising in rural SA have completed the requirements of Fellowship and have been granted permanent residence. A large number of internationally trained GPs contribute their teaching and supervision time to supporting the next generations of medical practitioners.

The RDWA holds extensive SA general practice workforce data, built over more than a decade of providing services for SA rural GPs. As at June 2011, there were 423 GPs and 82 GP registrars in 116 rural practices in the Australian Standard Geographical Classification – Remoteness Areas 2-5 in South Australia. There are 11 practices with more than 10 GPs; 24 practices with 6-10 GPs; 26 practices with 3-5 GPs; and 55 practices comprising two or fewer GPs. There are 123 GP Procedurists practising in obstetrics, anaesthetics and/or surgery (including one registrar).

In terms of replacement, the workforce data show that 19 doctors are aged 65 or more, and 86 in the 55-64 age bracket. Forty of these GPs are GP proceduralists. It is reasonable to predict that the major proportion of these GPs will retire from or significantly reduce their practice hours in the next five to 10 years.

The gender profile is 69% male and 31% female, with male rural GPs working an average 45.4 hours per week compared to female rural GPs who work an average 37.7 hours. The lower number of hours worked by female GPs reflects the part-time work and a balancing of work and life demands. It is important to note the implication for workforce supply when this hourly average is applied to the future workforce: the incoming GP registrars. Currently, female registrars outnumber males around two to one. This eight-hour-per-week gap will be magnified in a restructured male:female workforce profile.

Thirty eight per cent of GPs have been practising in their current environment for fewer than five years, and 90% are involved in on-call and after-hours work.

In the last triennial survey of rural general practitioners by RDWA, 23% of the respondents indicated they intended to leave general practice in rural SA in the next two to five years.2

2 RDWA Rural General Practice Workforce Survey 2009.
General practice structure in rural SA

The structure of general practice is an important factor when examining demand for future workforce.

In Australia, general practice is encouraged and rewarded to be constructed as small business. Like all small business, general practice must be many things all of the time.

In rural SA, these 116 small businesses need to ensure they have a workforce that is capable of delivering a range of services in primary health care settings. They need to be contemporary employers to ensure they attract a workforce in an area of international shortage. They need to manage all of the day-to-day responsibilities of owning and operating a business, while facing an ever increasing demand for providing health services.

Added to this is that in SA most GPs have at least two jobs – they provide the full range of community based practice services, and the inpatient and emergency services for the local hospital. They work fulltime in their own practices and are contracted to provide services into Country Health SA hospitals.

The relationship between the need of Country Health SA for hospital services is often inversely proportional to the need of the GP to provide those services from an income supplementation point of view. Larger practices in the larger communities are less reliant on Country Health SA contracted hospital services as an income stream, with some practices earning more than 70% of their revenue from Medicare Australia in fee-for-service and related incentive payments.

Conversely, Country Health SA is heavily reliant on those practices to provide sufficient GPs to operate the accident and emergency services 24 hours, seven days a week and to provide procedural services. In the smaller one to two doctor towns the opposite is often the case with the practices struggling to be viable (or competitive as an employer) without the activity that is generated from the emergency services and inpatient care funded by Country Health SA.

To date, there appears to be an implied expectation that rural practices will recruit additional workforce to meet not only their community based primary health care demands but also to ensure that there is an adequate volume of skilled GPs to service accident and emergency and the procedural on-call activity. GPs report that there is an urgent need for specific service planning to aid these decisions.

GPs’ commitment to training and education has been a long-established tradition in rural SA.

Unlike other small businesses, rural general practices commit a significant amount of their time and resources into training the next generations of health professionals. This is clearly shown in the number of rural GPs who participate in the training of medical students and the supervision of registrars. In fact, many students and registrars opt for rural placement because they know that they will experience high quality, broad exposure in the rural clinical setting that they would not get in metropolitan settings.

A major barrier to the continuation of training and education is the physical space constraint being experienced in general practices. Tensions are emerging as GPs are required to choose between more GPs or registrars or students or visiting specialists or nurses or allied health practitioners because of the finite physical space in their practice.
Country Health SA

Country Health SA has a responsibility to ensure that all of their public hospital sites provide a 24-hour, seven-day-a-week accident and emergency service. Country Health SA has committed to increasing the range of services that are delivered as close as possible to where people live, and to reduce the need for people to travel to Adelaide for services that can be delivered in rural settings.

Country Health SA funds more than $50 million annually in fee-for-service and associated incentive payments for medical service purchased activity.

Having established a contractual agreement with the majority of resident GPs, Country Health SA continues to seek sufficient workforce to fulfil their obligations in the provision of 24-hour, seven-day-a-week essential services to rural communities.

In more recent times, a range of alternative models of accident and emergency service have been required; for example, using after-hours clinics, sessional payments for providers, local practices operating the emergency roster for three weeks out of four with hospital-based locums fulfilling the fourth week, or sub-contracting the service to alternative providers.

Aboriginal community controlled health services

There are a number of Aboriginal community controlled health services (ACCHS) operating in rural SA. In the main, the ACCHS struggle to maintain a resident GP workforce. The ACCHS should be given special consideration in the development of the pathway program to ensure there is a capability to participate in the training and education of pathway participants.

This is important to ensure that all pathway participants have the opportunity to work within Aboriginal health services and increase their cultural and clinical competence. It also creates an opportunity for Aboriginal health services to attract a stable resident doctor workforce.
Demand analysis

Demand modelling is a fraught occupation. The variables and their impact are highly difficult to predict over time and the education and training timeline for GPs is considerable. Scenario modelling is accepted currently as the most useful tool for answering questions of demand. Scenarios can be designed to be sensitive to interventions such as the impact of increased retention of early career practitioners.

The following general points have been used to guide the development of understanding demand:

- the increased numbers of women in GP registrar training
- the greater impact on reduction of provided hours when older generations leave general practice and cease providing emergency services
- the impact of community education and expectation and technology
- increased service demand.

Conservative scenario

For the purposes of the project, a conservative prediction of need has been used, and the rationale has been described.

The RDWA survey of Rural GPs provides comprehensive and credible source data on the cohort in question. Based upon the survey responses of 2009, the average working week is 40 hours. Multiplying 40 hours per week by the number of GPs produces an annual quantum of workforce of around 970,000 hours.

The following factors are then applied at the following rates to produce a formula that can serve as a basis for further discussion and debate. It is not an absolute indication of demand; rather, an equation that can be sensitive to differing emphasis on the various factors.

There is consistent evidence that there is a steady growth in the number of female general practitioners entering the workforce.

By applying average hours worked by rural GPs in South Australia to an increased female participation profile, it would be reasonable to suggest that the replacement for a GP who exits current rural practice with one GP headcount would be inadequate to provide the same level of hours.

In the conservative scenario, a factor of 1.2 FTE has been used as an ‘average’ FTE (irrespective of gender) to replace each GP leaving rural practice as of today. The first goal is to achieve the same level of workforce hours available as today.

---


If the large cohort of ‘retirement ready’ GPs who are around 60 years of age was to exit as of today, then the replacement would be higher than 1.2 FTE due to the higher number of hours worked by this particular cohort. It has been estimated that an additional 0.1 FTE per FTE would be necessary to retain the existing level of hours based on their work week pattern.

The significant decline in interest to provide both full-time general practice services and emergency services could further impact the reduction in hours worked per week.

The subtotal for replacement factoring gender and generation is that for 20 GPs who leave rural practice, 24 will be needed to replace them – up to 28 if the 20 leaving are 55 years or more who work around 48-hour weeks.

Technology, community education and expectation around being able to access high levels of health services locally, and an ageing population which will be less able to travel, will all drive demand, as will the State’s policy of delivering more services closer to where people live.

For the purposes of the conservative scenario, a factor of 5% growth per annum has been used. If demand for general practitioner and hospital services grows at the rate of 5% per annum, this will translate into the need for at least an additional 850 to 1000 hours per week – or up to an additional 25 GPs per annum.

In summary, a conservative workforce demand scenario would require 28 doctors to replace each group of 20 doctors who leave. To deal with service growth, a further 25 doctors are likely to be needed for each 5% in service growth.

Technology, community education and expectation around being able to access high levels of health services locally, and an ageing population which will be less able to travel, will all drive demand, as will the State’s policy of delivering more services closer to where people live.

Currently around 20 to 25 international medical graduates are recruited annually to fill declared vacancies in rural practice. Equally, there are on average, 20 to 25 vacancies listed in any one year. This represents a workforce turnover of around four to five percent per annum which would be considered low in any industry or professional group.

Assuming that this same quantity of international doctors continue to be recruited, an additional eight full time equivalent doctors for each 20 who are replaced will be required. This is in addition to the 25 recruits needed to meet service growth. This is a total annual recruitment of around 53 doctors.
Supply issues

Nationally, increasing the numbers of training places has been seen as a key strategy to deal with what is recognised as a serious undersupply of new generations of doctors.

While there has been relatively small numbers of new Australian trained medical graduates commencing practice in rural SA, there has been a significant and constant supply of internationally trained doctors, predominantly recruited by the RDWA. This workforce is and will remain integral to the delivery of services now and in the future.

In considering Australian graduate supply in the SA context, the basic outline of the current training pathway and the stages involved in medical training in Australia are captured in Figure 1, with reference to the South Australian providers.

The figure illustrates the numerous stakeholders involved in the teaching and training pathway, many of which interface with the metropolitan public hospitals which have been the traditional clinical training setting for medical practitioners in South Australia. This diagram demonstrates the complexity that surrounds the teaching and training functions and shows medical education as a continuing process spanning many years.

Medical School - the entry component

The major providers of services in South Australia in this component of the pathway are the medical schools at the University of Adelaide and Flinders University, as well as the Rural Doctors Workforce Agency (RDWA).

The RDWA runs a program targeting secondary schools in rural South Australia to support students in years 10, 11 and 12 who are living or have lived in rural South Australia to prepare themselves for the requirements of gaining entry into medical education.

This program aims to provide an opportunity to have a positive experience to assist in countering the evidence that has shown a lower participation rate at universities of children who received their secondary education in rural and remote communities.

The RDWA’s MedSPACE Ready program targets students in years 10 and 11 introducing them to the possibilities of attending university and brings the students into Adelaide mid-year for a residential workshop. During this workshop RDWA hosts the students and organises tours of the respective universities.

Based on research commissioned by the RDWA and conducted by the University of Adelaide which shows that students who receive training in UMAT achieve better scores and greater success in this stage of the selection process, RDWA’s MedSPACE Set program targets students in year 12 with a rural background and provides them with extensive UMAT training. Training is offered in three locations, Whyalla, Mt Gambier and Adelaide.
Figure 1: The current medical training pathway in South Australia

1. An Oral Assessment is not required for entry to Flinders University’s undergraduate Bachelor Clinical Science.
The universities have identified a rural cohort intake in their medical placement numbers and although this is not exclusive to South Australian entrants, the RDWA has sought to maximise the number of applicants through sheer volume of numbers participating in the MedSPACE programs. In 2010 over 120 students participated in the program.

RDWA’s MedSPACE Go also provides support services to university students. This support is provided through the university Rural Clubs which are not restricted to medical students but embrace all rural students pursuing health science related degrees (e.g., nursing, allied health, dentistry, etc.). Through these Rural Clubs more than 27 different activities are organised with the sole aim of furthering the students’ rural experience in a supported and positive fashion.

Assessment for entry to medical school

In South Australia applicants have three choices to apply to enter medical school:

- Undergraduate Medical Admissions Test (UMAT), Oral Assessment and Australian Tertiary Admissions Rank (ATAR) or Special Tertiary Admissions Test (STAT) for University of Adelaide’s undergraduate entry Bachelor of Medicine, Bachelor of Surgery (MBBS);
- UMAT and ATAR or STAT for Flinders University’s Bachelor of Clinical Science, which is a two-year undergraduate degree from which students transfer across to Flinders University’s four-year graduate entry Bachelor of Medicine Bachelor of Surgery provided they have achieved the required Grade Point Average (GPA);
- Graduate Australian Medical School Admission Test (GAMSAT), Oral Assessment and GPA for Flinders University graduates.

The GAMSAT is usually undertaken by graduates in March each year, and year 12 school students sit the UMAT in July each year. Scores in both these tests determine whether an applicant is offered an oral assessment, the second assessment process. Based on performance during the oral assessment, candidates are ranked pending the final results of year 12 or GPA from the undergraduate degree.

Offers are made by the two universities once these results are advised. Student places in South Australian medical schools are not quarantined for South Australian students. Once South Australian and interstate first round offers have been accepted, further rounds are offered until all places are filled.

Research completed by the University of Adelaide\(^5\) indicates that:

- Female applicants are less likely to be invited for an Oral Assessment (0.88) but if they are, they are more likely to place (1.33)
- Older applicants are less likely to place (0.78)
- Non-school leavers are more likely to receive an Oral Assessment (9.54)
- Higher socioeconomic applicants are more likely to place 1 vs 4 (0.55).

‘Rural Background Entry’ at University of Adelaide

For the 2011 academic year, the University of Adelaide introduced a defined entry pathway to the undergraduate MBBS for students with a rural background. This program is referred to as ‘Rural Background Entry’ (RBE). The University of Adelaide Health Sciences faculty has targeted 25% of commencing Commonwealth Supported Places (CSP) each year being made available for the RBE places (bonded, unbonded and tertiary transfer)\(^6\).

---


\(^6\) Prof Newbury, J., Presentation MBBS at University of Adelaide, December 2010, Spencer Gulf Rural Health School, University of SA and University of Adelaide, December 2010.
RBE candidates are subject to the same process in their application as other medical candidates, namely: UMAT, an Oral Assessment and an ATAR above 90 (or equivalent), or STAT score of 180 or higher, or GPA of 5.0 or higher in their first year of full-time study in an undergraduate program at the University of Adelaide.

The candidates make an application for a RBE place when submitting their South Australian Tertiary Admissions Centre (SATAC) preferences. The University requests that SATAC includes additional data fields in order to collect enough information to establish if an applicant fits the Department of Health and Ageing ‘rural’ definition. If candidates are not made an offer for a RBE place, they are returned to the overall list for consideration in subsequent offer rounds.

For the first time, the 2011 intake, the University of Adelaide quarantined 25 RBE places. These are open to RBE nationally, not SA specific. The data presented by Professor Jonathan Newbury highlight the competitive nature for these places and evidence of the traction being gained by the RDWA program medSPACE Ready and medSPACE Set:
• of 3000+ applicants sat the UMAT
• 300+ RBE applicants
• 75 were offered Oral Assessment (cut off equivalent to general medical program cut off);
• 25 RBE places are available annually.

The Fairway Scheme

Introduced in 1990, the Fairway Scheme provides students from under-represented schools with a greater opportunity to be selected into undergraduate programs at the University of Adelaide. The scheme aims to ‘even the playing field’ by providing bonus points to students’ ATARs to aid their selection. Rural schools are automatically included in the scheme, and therefore rural students wishing to gain entry into the undergraduate MBBS at the University of Adelaide receive the benefit of the additional points.

Flinders University Medical School intake

Traditionally, Flinders University has offered a four-year graduate entry Bachelor of Medicine Bachelor of Surgery program. In 2010 the university introduced an undergraduate entry point. The first two years of the undergraduate course comprise the Bachelor of Clinical Science curriculum followed by the four-year graduate entry medicine program. Selection criteria for entry into this undergraduate double degree comprise high ATAR and UMAT scores.

Flinders University weights the UMAT score at 10% of the selection with the remaining 90% based on the ATAR. Rural school-based students gain a 10% loading on their ATAR8.

Data provided by Flinders University9 indicate that 38% of the double degree undergraduate cohort of 2010 had a rural background. This is significantly higher than the profile of students participating in the graduate entry program which has averaged 25% rural background over the past five years:

2006 - 26% of the cohort is of rural origin
2007 - 22%
2008 - 29%
2009 - 30%
2010 - 20%.

7 Ibid.
8 A/Prof Walters, L., Presentation December 2010, Flinders University.
9 Ibid.
During 2011, Flinders University introduced a new Indigenous Pathway Scheme for the 2011 intake. In 2011, Flinders University medical school has enrolled 130 students and 19 full-fee paying students (overseas students). The balance between full-fee paying students and domestic students has shifted over the past five years as demonstrated in the table below.

Table 1: Number of Bachelor of Medicine Bachelor of Surgery students at Flinders University of SA origin

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Australian and New Zealand students</td>
<td>80</td>
<td>103</td>
<td>115</td>
<td>121</td>
<td>117</td>
<td>111</td>
</tr>
<tr>
<td>SA Origin (number, whole of SA, not solely SA rural)</td>
<td>44</td>
<td>49</td>
<td>67</td>
<td>67</td>
<td>63</td>
<td>57</td>
</tr>
<tr>
<td>SA Origin (% whole of SA, not solely SA rural)</td>
<td>55</td>
<td>48</td>
<td>58</td>
<td>57</td>
<td>54</td>
<td>51</td>
</tr>
</tbody>
</table>

*Figures provided are an estimate pending final figures once the class is established. The final number should be within 1-2% of that provided.

Specifically over last five years the number of domestic students has increased by 15 due to:
- the slight decrease in full-fee paying students
- bonded students replacing full-fee paying students.

The University reports a dropout rate of 1% per annum.

Scholarship programs and other entrance schemes

The Bonded Medical Places (BMP) scheme offers students a greater chance of entry into medical school by providing funding to the universities for additional commencing Commonwealth supported medical school places each year. These extra places are intended to provide more doctors for areas experiencing doctor shortages.

In addition to the BMP scheme, there are a number of scholarship programs and student support schemes aimed at assisting the medical workforce shortage in rural and remote Australia and/or providing financial support to rural background students, including:
- Medical Rural Bonded Scholarship Scheme (MRBS)
- Rural Australia Medical Undergraduate Scholarship (RAMUS)
- John Flynn Placement Program (JFPP)
- HECS Reimbursement Scheme,
- Puggy Hunter Memorial Scholarship (PHMS).

The South Australian Bonded Medical Scholarship Scheme (SABMSS) was established to increase the number of rural SA students accessing medicine, and has provided places for 30 medical students since the program’s inception. These bonded students will work in rural SA or in area of need as determined by the Department of Health.

This strategy is funded by Country Health SA, and the first scholarship holders have graduated and are part way through their PGY1 year.
Exposure to rural practice during medical school

Research has shown that exposure in pre-registration years to general practice strengthens the overall training and knowledge gained by students. This includes improved communication and people management skills and a greater awareness of the construct of the overall health system.

Throughout their medical programs, both Flinders University and the University of Adelaide utilise the teaching and training skills of general practitioners. Rural GPs in South Australia play a significant role in providing formal teaching of students.

Each university incorporates rural placements in their medical program. At Adelaide all students undertake a minimum of four weeks in a rural setting.

In the fifth year an integrated curriculum is offered. Participation in rural placements through the University of Adelaide is summarised in Table 2.

Table 2: Participation in rural placements: University of Adelaide

<table>
<thead>
<tr>
<th>Year</th>
<th>Placement numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>10</td>
</tr>
<tr>
<td>2004</td>
<td>15</td>
</tr>
<tr>
<td>2005</td>
<td>17</td>
</tr>
<tr>
<td>2006</td>
<td>12</td>
</tr>
<tr>
<td>2007</td>
<td>12</td>
</tr>
<tr>
<td>2008</td>
<td>16</td>
</tr>
<tr>
<td>2009</td>
<td>25</td>
</tr>
<tr>
<td>2010</td>
<td>22</td>
</tr>
</tbody>
</table>

Students in the Flinders University MBBS program spend at least seven weeks in a rural setting.

The University’s Parallel Rural Community Curriculum (PRCC) is also offered to students in the third year of study, giving the students the opportunity to spend the entire third year in a rural location. Offered in three regions (Riverland, South East of South Australia and the Hills Mallee Fleurieu) the PRCC is fully subscribed.

Approximately 30% of the graduate program cohort has a rural experience through participation in this program. The University has advised that PRCC graduates were more likely to choose a rural career than graduates from Flinders Medical Centre.10

---

10 Worley P et al Vocational career paths of graduate entry medical students at Flinders University: a comparison of rural, remote and tertiary tracks, MJA, 2008 188 (3) pp 177-178
Internship and Postgraduate Year 2 Components

Medical graduates who undertake their internship in South Australia become employees of SA Health. With the exception of six places created by Country Health SA, all intern placements are based in metropolitan teaching hospitals.

Successful completion of the internship year (PGY1) results in general registration, a prerequisite for entrance to general practice and other specialty training.

The objective of internship is to provide junior doctors with ‘quality, sustained workplace experience and training to enable them to translate the core competencies into clinical practice as a sound platform on which to build their specialist careers’.11

The core components of the PGY1 year are general surgery, general medicine and emergency medicine with acute medical exposure.

In South Australia, the South Australian Institute of Medical Education and Training (SA IMET) coordinates the postgraduate medical training. It has responsibility for accrediting PGY1 and PGY2 positions and allocating junior medical staff to hospital positions.

Figure 2 demonstrates the increasing number of permanent resident medical graduates in South Australia.

Figure 2: SA medical graduate numbers

*Permanent Resident

Interns apply nationally for a placement in a hospital. National figures indicate that there were 2,697 acceptances reported Australia-wide during 2010 for the 2011 clinical year. Each year approximately 30% of medical graduates from SA universities go interstate to do their PGY1.

The number of positions available by specialty area for PGY1 placements for 2011 is depicted in Table 3.

Table 3: Number of SA IMET positions available aligned with first preferences, 2011

<table>
<thead>
<tr>
<th>Hospital Program</th>
<th>No. of Positions</th>
<th>No. of 1st Pref Applications</th>
<th>No. of 1st Pref Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Training</td>
<td>188</td>
<td>239</td>
<td>121</td>
</tr>
<tr>
<td>DRANZCOG</td>
<td>6</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>General Practice Training</td>
<td>34</td>
<td>36</td>
<td>21</td>
</tr>
<tr>
<td>Basic Physician Training</td>
<td>67</td>
<td>97</td>
<td>43</td>
</tr>
<tr>
<td>Surgical RMO</td>
<td>45</td>
<td>92</td>
<td>28</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>19</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>16</td>
<td>55</td>
<td>10</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>10</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Dip Anaesthetics</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>386</strong></td>
<td><strong>575</strong></td>
<td><strong>247</strong></td>
</tr>
</tbody>
</table>

*Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology

Prevocational General Practice Placements Program

The Prevocational General Practice Placements Program (PGPPP) provides graduates with the opportunity to undertake a general practice placement during their pre-vocational training year. Each of the teaching hospitals in South Australia offers PGPPP in at least one site. There are currently 11 PGPPP sites in rural South Australia. The PGPPP is funded by the Federal Government and delivered through General Practice Education and Training Limited (GPET) and the two RTPs.
Registrar training

Training for Fellowship of either ACCRM or RACGP can commence once the junior doctor has completed their intern year. There are three choices for general practice training open to registrars, and each is managed independently:

- Vocational Preparation Pathway (via Australian General Practice Training, or AGPT)
- Remote Vocational Training Scheme (RVTS)
- ACRRM Independent Pathway (IP).

The GP training programs are three or four years full-time (or part-time equivalent). Training is conducted within accredited medical practices, and supervised and assessed by medical educators. During training, registrars gain experience in teaching hospitals, rural and urban practices and specialised medical centres.

The largest training program, Australian General Practice Training (AGPT), is managed by GPET, an independent company created in 2001 by the Australian Government to establish a regionalised approach to training. The program is delivered by the 17 regional training providers across Australia. The two SA RTPs cover both urban and rural general practice training requirements.

There is an annual application process for the AGPT program, where applicants nominate their preferred RTP(s) and whether they wish to participate in the general (urban) or rural pathway.

Table 4 indicates the number of capped training places in 2011. There are a greater number of applications than places provided by Sturt Fleurieu GP Education and Training (SFGPET) and Adelaide to Outback GP Training Program (AOGP) RTPs.

A GP registrar undertaking a rural pathway can choose to pursue the Fellowship of ACRRM, the Fellowship of the RACGP or the optional Advanced Rural Fellowship offered through the RACGP, or Fellowship of both colleges.

Table 4: GP Registrar positions, 2011 – South Australia

<table>
<thead>
<tr>
<th>GP Registrar 2011</th>
<th>General Pathway</th>
<th>Rural Pathway</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SF</td>
<td>AOGP</td>
<td>Subtotal</td>
</tr>
<tr>
<td>GPET Allocation</td>
<td>15</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Applicants</td>
<td>20</td>
<td>38</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: Dr Mugford, B, Black, L, Presentation RTP Presentation, Sturt Fleurieu GP Education and Training, Adelaide to Outback GP Training Program, December 2010.
Figure 3: Steps for achieving Fellowship: FRACGP (including FARGP) and FACRRM

| Year One | Core Clinical Training Time | 12 months |
| Year Two | Primary Rural & Remote Training | 2 x 6 months |
| Year Three | Primary Rural & Remote Training | 2 x 6 months |
| Year Four | Advanced Specialised Training | 12 months |

**FACRRM qualifications (ACRRM)**

**FRACGP qualifications (RACGP)**

**Hospital Training Time**
12 months

**GP Terms**
- GPT 1 - 6 Months
- GPT 2 - 6 Months

**GPT 3**
6 Months

**Extended Skills**
6 Months

**FRACGP (VR)**

**Advanced Skills Training**
12 months for FARGP

* Credit given for AGPT training already undertaken towards one fellowship prior to undertaking a second or third fellowship. * Can be achieved in dual accredited practices or posts.


A GP registrar undertaking a rural pathway can choose to pursue the Fellowship of ACRRM, Fellowship of the RACGP or the optional Advanced Rural Fellowship offered through the RACGP, or Fellowship of both colleges.

### Table 5: Registrar numbers on the General Practice Pathway – South Australia

<table>
<thead>
<tr>
<th>GP Registrar 2011</th>
<th>General Pathway</th>
<th>Rural Pathway</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SF</td>
<td>AOGP</td>
<td>Subtotal</td>
</tr>
<tr>
<td>Core Hospital Registrars</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Junior Community Registrars</td>
<td>31</td>
<td>29</td>
<td>60</td>
</tr>
<tr>
<td>Senior Community Registrars</td>
<td>24</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>Procedural Training Registrars</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Awaiting Fellowship</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: Dr Mugford, B, Black, L, Presentation RTP Presentation, Sturt Fleurieu GP Education and Training, Adelaide to Outback GP Training Program, December 2010.
Advanced skills training

Advanced skills training is not compulsory to gain Fellowship.

Those registrars who chose to undertake the advanced skills training are allocated to an approved training post in order to acquire the skills necessary for competent independent practice in the specified discipline. Table 6 shows the distribution of advanced skills training as identified by AOGP.

Table 6: Numbers undertaking procedural training – Adelaide to Outback GP Training Program

<table>
<thead>
<tr>
<th>Advanced Skills Training</th>
<th>Number Completed</th>
<th>Returned to AOGP Region</th>
<th>Currently in AOGP Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>P - Anaesthetics</td>
<td>14</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>P - Obs &amp; Gyne</td>
<td>10</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>P - Surgery</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>P – Emerg (G)</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>P – Emerg (P)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>NP – Aboriginal Health</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>NP – M/skeletal Medicine</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NP - Paeds</td>
<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>NP – Pall Care</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>NP – Small Town (variety)</td>
<td>9</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>57</strong></td>
<td><strong>35 (61%)</strong></td>
<td><strong>22 (39%)</strong></td>
</tr>
</tbody>
</table>

Source: Dr Mugford, B, Black, L, Presentation RTP Presentation, Sturt Fleurieu GP Education and Training, Adelaide to Outback GP Training Program, December 2010.

This shows that 29 of the 57 who completed procedural training undertook anaesthetics, obstetrics or surgery. Eleven of those 29 returned to the AOGP region, of which seven remain in the AOGP region. The AOGP region includes metropolitan locations.

Currently GP registrars wishing to undertake advanced skills training in obstetrics, anaesthetics or surgery are competing with registrars who are undertaking those disciplines as their speciality training.

There are no structured or identified positions offered with any consistency to allow GP registrars to plan and choose their procedural activity.

The RTPs have no systemic control over the access to these positions, and are reliant on their ability to negotiate with each of the teaching hospitals which may have an occasional vacancy in those specialist training areas.
The model

This Rural Pathway Project has identified a low-risk, high-gain and sustainable solution to the issue of insufficient supply of new Australian trained GPs wanting to reside and practise in rural SA. Importantly, the solution recognises the resident GPs and GP proceduralists currently practising in rural SA.

The investigative work that has occurred through this project confirms the need for improvement and change to ensure that there are is a flow Australian trained general practitioners available and keen to work in rural South Australia.

It is clear that there is a need to create a program or a pathway that leads medical students through a series of well-defined rurally based training experiences that culminate in them being engaged as rural general practitioners.

It is crucial that this program has clearly defined objectives, simple to navigate processes and culminates in a career that has status and the recognition of being an essential specialist profession.

With the creation of this program, it is crucial that there is a commitment to the complete program. Each identified component is dependent on the other for each to succeed. A declared time frame that tracks the milestones will need to be adhered to ensure that the program is negotiated and implemented to support the flow of participants.

The other key ingredient to success will be the design, confirmation and promotion of the specialist role including the remuneration and conditions of engagement that will be available. Without this there will be a continued struggle to have medical graduates choose rural general practice over other high status specialties.

The model aims to ensure that there are no disincentives inadvertently created for the current workforce. On the contrary, the Road to Rural General Practice (R2RGP) model declares that rural general practice is a highly valued specialist career and vocation.

As prerequisites to the model, the cooperation and collaboration by all stakeholders who have engaged in the project, provide the basis for the delivery of a sustainable model, and augurs well in constructing a model that utilises existing organisations and providers.
Ideally, the additional resources that are made available to support this model will be targeted at supporting the individual participants and the required infrastructure, rather than being used to procure additional places in the education and training sectors.

The R2RGP model has a modest commencement that can build directly from the existing programs including the rural scholarship and intern programs. The model is scaled to increase from 10 places in the first year to 20 in the second and subsequent years. Half of these places would be quarantined for proceduralist training. As a result of this scaling, the model is not high cost to commence, and provides the time necessary to build the next component.

The R2RGP Program provides a rural-based four or five-year training program that reaches into metropolitan teaching hospitals when necessary. It has a clearly defined and highly valued career at the completion of training.

Implementation will be successful if all stakeholders maintain their current level of service, and will be enhanced if they maintain the energy and enthusiasm they have demonstrated in the project.

This project found that an essential factor for success in attracting future generations and retaining the existing workforce was the recognition of rural general practice as a valued career with the status of other specialist roles.

A defined career pathway, with agreed and understood roles between GPs and GP proceduralists and Country Health SA, will support recognition of the status and value of rural general practice as a career and support junior doctors making career decisions to select rural practice in SA as their destination of choice.

The Road to Rural GP (R2RGP) Program will provide a supportive, incentive-based career pathway in South Australia for doctors to pursue a vocationally registered career in rural general practice. The program will be rural-based and may reach into metropolitan facilities for particular training periods.

**Internship (PGY1) and PGY2**

The R2RGP Program will open in the final year of medical school with interested students applying to Country Health SA for acceptance onto the Program. In its first year, the R2RGP Program will accept 10 trainees. For each year thereafter, capacity will be built to accept 20 new trainees each year.

R2RGP applicants will nominate the program as part of their internship application. The intern year and PGY2 will be completed by R2RGP trainees in a rural general hospital or larger community hospitals. During this period, R2RGP trainees will be case managed by representatives selected by Country Health SA. Trainees will also be provided with mentors, who will continue in this role for the remainder of their general practice training.

Mid-way through PGY2, R2RGP trainees will apply to the Australian General Practice Training (AGPT) program, indicating their preference for rural pathway training and that they are a R2RGP trainee (similar to the process used to identify Queensland Rural Generalist trainees). R2RGP trainees will participate in the normal selection AGPT process nominating either South Australian RTP.
Figure 4 Road to Rural GP pathway

<table>
<thead>
<tr>
<th>PGY1</th>
<th>Intern year completed in rural general hospitals or larger community hospitals; apply to GP Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY2</td>
<td>PGY 2-5 enter and complete rural general practice training (FACRRM, FRACGP or FARGP)</td>
</tr>
<tr>
<td>PGY3</td>
<td>Road to Rural GP (R2RGP)</td>
</tr>
<tr>
<td>PGY4</td>
<td>Pathway owned and governed by CHSA</td>
</tr>
<tr>
<td>PGY5</td>
<td>R2RGP places reserves for procedural training in obstetrics, anaesthetics and/or surgery.</td>
</tr>
</tbody>
</table>

- High School
  - UMAT Interview + Year 12 results or STAT
  - Accepted
    - Flinders University
      - Commence Bachelor Clinical Science
      - After 2yrs + GPA req
      - University of Adelaide
      - PGY1
        - University Medical School

- University Other Degree
  - (at Uni of Adelaide) Inter Course Transfer <2yrs; UMAT + Oral + GPA
  - Accepted
    - GAMSAT > Oral + GPA from 1st Degree

- University Medical School
  - Not accepted
  - Accepted
    - Employment by CHSA
    - Rural Private Practice
    - Two Employers
    - Hybrid Employment

The model
Rural general practice training

On being selected into the AGPT Program, the relevant regional training provider will be made aware of their participation in the R2RGP Program. The R2RGP trainee will commence rural general practice training as per the existing rural curriculum incorporating the requirements of ACRRM and/or the RACGP.

Training will take place in Country Health SA facilities and designated R2RGP training locations, which will meet the necessary training accreditations. Additional curriculum relevant to rural practice in areas such as enhanced emergency medicine and Indigenous health can be negotiated with the training providers.

The Program will take four or five years from PGY 1 to complete, depending on the inclusion of procedural training.

Procedural training

Each entry year, half the positions will be quarantined for procedural training (five positions in Year 1, moving to 10 positions for each year thereafter). Procedural training will be available in anaesthetics, obstetrics and surgery. Additional procedural posts could be added as required.

Rural generalist training

For those doctors who chose not to take up proceduralist roles, they can choose to take up advanced skills training in key areas of core service including but not limited to mental health, paediatrics, oncology, sexual health, Indigenous health or palliative care.

Emergency medicine skills

All participants in R2RGP will gain enhanced emergency medicine skills to the standard to be credentialed by Country Health SA. This is a fundamental, core competency for all GP generalists and GP proceduralists engaged in inpatient and outpatient emergency care with Country Health SA and as such will form part of the standard R2RGP Program.

The role of Country Health SA

It is proposed that Country Health SA will be the leader and the owner of the R2RGP Program. The R2RGP will be most successful if Country Health SA commissions an advisory body of existing stakeholders including members of the resident rural workforce to assist in the governing and coordination of this program.

The process undertaken in the development of this report which has engaged and gained the support of all the key stakeholders is a solid foundation from which to begin.

Country Health SA Hospital Inc will become a Local Health Network on 1 July 2011. It needs to gain formal recognition as a single teaching and education facility, with the same status, functionality and access to funding as a metropolitan teaching hospital. This will allow R2RGP trainees to complete their hospital training, including procedural training, in an environment most relevant to rural general practice.

As an essential part of the R2RGP Program, Country Health SA will need to build capacity to provide postgraduate training in its rural facilities.
To accommodate the first year’s intake, the six intern positions at Mount Gambier can be utilised and it is proposed that four additional intern positions be established at Whyalla. The number of intern positions will need to be further expanded in Year 2 as the R2RGP intake reaches 20 positions, with possible expansion into other rural general hospitals and larger community (sub-regional) hospitals.

Country Health SA will need to develop 10 PGY2 positions in Year 2, and 20 each year thereafter.

Country Health SA needs to engage a teaching and training workforce, incorporating the existing resident rural GP workforce.

Metropolitan hospitals must provide for R2RGP training positions in areas that are required to complete the R2RGP Program. It is important that the majority of training be provided in rural locations; however, participants also need to have the flexibility to choose to take up periods of their training in metropolitan facilities if they so desire.

Country Health SA’s service planning needs to identify the rural locations where GP procedural training will occur. Country Health SA will also need to identify in advance which locations will provide procedural services.

The career of the R2RGP graduate

Traditionally GPs have been independent, autonomous and self-employed or engaged in a small business. The R2RGP Program will provide a defined career pathway for medical students and junior doctors.

Through case management in the early years of the Program, and mentorship for the duration of the Program, R2RGP graduates will understand the clearly identified employment options before completing their training.

Employment and engagement options

It is proposed that R2RGP graduates can enter into employment as a rural specialist with Country Health SA, and have access to rights of private practice allowing them to reach back into general practice for part of their activity.

Equally, they can operate from general practice working into Country Health run facilities using the existing fee-for-service model or by engaging in a visiting specialist/sessional payment arrangement with minimum guarantee of level of activity per annum.

These engagement options must also be made available to the existing rurally based GP workforce to ensure there is maximum flexibility and recognition of the role of the GPs who are today’s and tomorrow’s teachers and educators.
### Sample Model Implementation Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Program Phase</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Launch Road to Rural GP Program</td>
<td>Graduating medical students apply for Road to Rural GP Program and internship May/June</td>
</tr>
<tr>
<td>2013</td>
<td>Road to Rural GP Program Year 1</td>
<td>10 interns accepted for Road to Rural GP, five of which are training as proceduralist</td>
</tr>
<tr>
<td>2014</td>
<td>Road to Rural GP Program Year 2</td>
<td>20 interns accepted for Road to Rural GP, ten of which are training as proceduralist</td>
</tr>
<tr>
<td>2015</td>
<td>Road to Rural GP Program Year 3</td>
<td>Intern year in rural location Apply for GP training May/June</td>
</tr>
<tr>
<td>2016</td>
<td>Road to Rural GP Program Year 4</td>
<td>Commence GP training in rural location &amp; reach in to metro location as needed</td>
</tr>
<tr>
<td>2017</td>
<td>Road to Rural GP Program Year 5</td>
<td>Commence GP training in rural location &amp; reach in to metro location as needed</td>
</tr>
<tr>
<td>2018</td>
<td>Road to Rural GP Program Year 6</td>
<td>Commence GP training in rural location &amp; reach in to metro location as needed</td>
</tr>
</tbody>
</table>

**PGY1**
- Intern year in rural location
- Apply for GP training May/June

**PGY2**
- Commence GP training in rural location & reach in to metro location as needed

**PGY3**
- GP Training Year Two
- GP Training Year Two

**PGY4**
- GP Training Year Three
- GP Training Year Three
- GP Training Year Three

**PGY5**
- GP Training Year Four
- GP Training Year Four

**Exit**
- 5 GPs
- 10 GPs
- 10 GPs

---

* Road to Rural GP trainees electing to complete the FRACGP will complete 3 years of GP Training, or part time equivalent. Those electing to train in a procedural skill and/or complete the FACRRM or FARGP (RACGP’s Advanced Rural Fellowship) will take 4 years GP training, or part time equivalent. A procedural skill for the purpose of this report is defined as obstetrics, anaesthetics or surgery. Training program may be extended where a Road to Rural GP trainee wishes to train in more than one procedural skill.
Expert Panel

The Expert Panel brought together key stakeholders involved in training, representing, supporting or engaging rural GPs and GP Proceduralists to develop a model to increase the number of GPs and GP Proceduralists working in rural South Australia.

Membership

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Doctors Workforce Agency</td>
<td>Ms Lyn Poole, Chair</td>
</tr>
<tr>
<td>Aboriginal Health Council SA</td>
<td>Dr David Scrimgeour</td>
</tr>
<tr>
<td>Adelaide to Outback GP Training Program</td>
<td>Ms Linda Black</td>
</tr>
<tr>
<td>Australian College of Rural and Remote Medicine</td>
<td>Dr Tim Kelly</td>
</tr>
<tr>
<td>Australian Medical Association (SA)</td>
<td>Dr Peter Sharley</td>
</tr>
<tr>
<td>Country Health SA</td>
<td>Dr Peter Chapman</td>
</tr>
<tr>
<td>Department of Health SA</td>
<td>Prof Paddy Phillips</td>
</tr>
<tr>
<td>Department of Health and Ageing</td>
<td>Ms Fran Lovell</td>
</tr>
<tr>
<td>Flinders University of South Australia, Faculty of Health Sciences</td>
<td>A/Prof Lucie Walters</td>
</tr>
<tr>
<td>General Practice SA</td>
<td>Dr Tim Wood</td>
</tr>
<tr>
<td>Rural Doctors Workforce Agency</td>
<td>Dr Richard Mackinnon</td>
</tr>
<tr>
<td>Royal Australian College of General Practitioners</td>
<td>Prof Nigel Stocks</td>
</tr>
<tr>
<td>Rural Doctors Association (SA)</td>
<td>Dr Peter Rischbieth</td>
</tr>
<tr>
<td>South Australian Institute of Medical Education and Training</td>
<td>Mr Brendan Peek</td>
</tr>
<tr>
<td>Sturt Fleurieu GP Education and Training</td>
<td>Dr Bruce Mugford</td>
</tr>
<tr>
<td>University of Adelaide, Faculty of Health Sciences</td>
<td>Dr Tim Wood (also GPSA)</td>
</tr>
</tbody>
</table>

Functions

The Expert Panel’s functions were to:

- Establish key points of collaboration between stakeholders to encourage students to elect to become rural doctors;
- Identify current barriers to students completing training in rural South Australia;
- Identify training initiatives critical to support the development of skills for rural practice;
- Identify and establish a complete path for training that is substantially rurally based;
- Consider the optimum governance arrangements necessary to create and maintain a rural pathway.

Process

To achieve these functions, the Expert Panel undertook the following process:

- The Panel designed a series of workshops to explore the issues relating to the project;
- The Panel evaluated the findings of the workshops;
- Members of the panel were responsible for nominating and briefing a proxy, as appropriate, in advance of meetings;
- Members of the Panel invited up to four representatives from their organisations to attend the workshops;
- Practising non-salaried doctors were entitled to claim a sitting fee for attending the Panel meetings and workshops as per the General Practice SA GP Claims Policy.
Expert Panel meetings

The Expert Panel met on four occasions:

Meeting 1

The first meeting of the Expert Panel was held on Thursday 14 October 2010. The Chair opened and welcomed everyone to the meeting at 1.00pm. Agenda items included:

- Terms of Reference – a draft copy of the Terms of Reference was provided for the Panel to endorse;
- Project Development strategy – a copy the Project Development Strategy was provided for the Panel to endorse;
- Workshop 1 Planning Session.

Ms Rita Brewerton, Consultant member of the Project Team was invited to observe the meeting in the role of facilitator of the upcoming workshops.

Key outcomes from the meeting were:

- The draft Terms of Reference were amended to include:
  - a process section outlining workshop design and evaluation, nomination and briefing of proxies, numbers of representatives to attend workshops and payment for non-salaried doctors to attend the Panel meetings and workshops;
  - a list of definitions and acronyms
- Following the discussion on the Project Development Strategy, it was agreed that the Expert Panel would design the three workshops.
  - RDWA distributed a survey to Panel members by 16 October 2010 requesting key issues faced by communities and organisations in the provision of GPs and GP Proceduralists to rural South Australia which formed part of the discussion at Workshop 1.
  - All background papers were distributed to the Expert Panel members on 22 October 2010 prior to Workshop 1.

Meeting 2

The second meeting of the Expert Panel was held on Thursday 18 November 2010. The Chair opened and welcomed everyone to the meeting at 1.00pm. Agenda items included:

- Minutes from the previous Expert Panel meeting and Workshop 1 – copies of the minutes taken were provided to the Panel to endorse;
- Workshop 2 Planning Session.

Key outcomes from the meeting were:

- A matrix summarising the critical components identified at Workshop 1 was amended to include additional items. The amended matrix was sent by RDWA to Panel members on 30 November 2010.
- To assist with the information to be gathered from Workshop 2, RDWA was asked to distribute a list of questions outlining the information required to determine the demographics of the doctors being produced by the existing training pathway and the future workforce required. This list was distributed 30 November 2010.
Meeting 3

The third meeting of the Expert Panel was held on Thursday 24 February 2011. The Chair opened and welcomed everyone to the meeting at 1.30pm. Agenda items included:

- Minutes from the previous Expert Panel meeting and Workshop 2 – copies of the minutes taken were provided to the Panel to endorse;
- A presentation reviewing the process so far and the next steps for the Project.

**Key outcomes from the meeting were:**

- Following the viewing of the presentation and the discussion of the next steps, the Panel determined that there were three questions to be answered by Workshop 3:
  1. What are the principles that should guide the model?
  2. Can all stakeholders declare what they can do/contribute to the whole to inform the design of the model?
  3. What can be constructed to build on what already exists OR do we construct something to which everyone contributes?
- RDWA sent these questions to all Panel members on 25 February 2011, and also invited Panel members to submit suggested draft principles (Question 1) to RDWA to be collated prior to Workshop 3.

Meeting 4

The fourth meeting considered the draft R2RGP model and report.
# Summary of issues and concerns

These tables represent the issues of interest or concern identified by the participants of the workshops and the focus groups that have informed the development of the Road to Rural General Practice Model.

## Focus: Education

<table>
<thead>
<tr>
<th>Critical Success Factors</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive recruitment to study medicine</td>
<td>Secondary students</td>
</tr>
<tr>
<td>Selection of rural students to study medicine</td>
<td>Secondary students</td>
</tr>
<tr>
<td>Affirmation that rural GP is a good career choice</td>
<td>Secondary students and medical undergraduates</td>
</tr>
<tr>
<td>Strong rural exposure. Requires:</td>
<td>Undergraduates</td>
</tr>
<tr>
<td>• Sound stable infrastructure</td>
<td></td>
</tr>
<tr>
<td>• Appropriate numbers of supervisors</td>
<td></td>
</tr>
<tr>
<td>• Appropriate numbers of teachers</td>
<td></td>
</tr>
<tr>
<td>• Strong rural culture/ethos of teaching departments</td>
<td></td>
</tr>
<tr>
<td>• Recognition of GP consultant status</td>
<td></td>
</tr>
</tbody>
</table>

## Focus: Training

<table>
<thead>
<tr>
<th>Critical Success Factors</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change of intern year curriculum</td>
<td>Intern</td>
</tr>
<tr>
<td>Quarantined training positions or priority access for procedural training</td>
<td>PGY1 and beyond</td>
</tr>
<tr>
<td>First access to specialised/procedural training</td>
<td>Post graduate</td>
</tr>
<tr>
<td>Identify/streaming rural focussed cohort</td>
<td>Undergraduate and post graduate</td>
</tr>
<tr>
<td>Creation of regional hospital training positions</td>
<td>Post graduate</td>
</tr>
<tr>
<td>Rural Procedural posts</td>
<td>Post graduate</td>
</tr>
<tr>
<td>GP’s direct ownership/placement decision in “general service” or GP training in hospital positions</td>
<td>Post graduate</td>
</tr>
<tr>
<td>Increased specialist college dialogue</td>
<td>SA Health/SAIMET and RTPs</td>
</tr>
<tr>
<td>Need for a dedicated rural hospital in Adelaide and/or change of regional status of LMHS and Modbury to Mt Gambier, Riverland, Whyalla, Port Pirie, Port Lincoln</td>
<td>Post graduate</td>
</tr>
<tr>
<td>Revised rotations - frequency, location and GP control</td>
<td>Post graduate</td>
</tr>
<tr>
<td>Promotion of rural GP career pathway</td>
<td>Undergraduate and post graduate</td>
</tr>
<tr>
<td>Increase number of GP registrars</td>
<td>SA Health/SAIMET/GPET</td>
</tr>
<tr>
<td>SAIMET/SA Health seek to control/quarantine 30% (in line with rural population representation) of training positions</td>
<td>SA Health/SAIMET/GPET</td>
</tr>
</tbody>
</table>
### Focus: Career

<table>
<thead>
<tr>
<th>Critical Success Factors</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of GP specialist consultant status – easing relationships with other Colleges. Facilitate supervision including procedural training by GP specialist consultant</td>
<td>Colleges</td>
</tr>
<tr>
<td>Clinical trainers/GPs – teacher development, supervisor capacity and appropriate recognition. Need to align this component of the workforce to be able to meet the projected trainee throughputs</td>
<td></td>
</tr>
<tr>
<td>“Rural Finishing School” for procedural training</td>
<td></td>
</tr>
<tr>
<td>Clear alignment of career pathway strategy with SA Health Country Health Service Plan and community needs</td>
<td>SA Health</td>
</tr>
</tbody>
</table>

### Focus: Systemic

<table>
<thead>
<tr>
<th>Critical Success Factors</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of GP specialist consultant status</td>
<td>Colleges</td>
</tr>
<tr>
<td>Competency based PGY1 and PGY2 not weeks of placement</td>
<td>Colleges</td>
</tr>
<tr>
<td>Develop and define opportunities for procedural general practitioners – where, what, service construct, urban connectivity</td>
<td>SA Health</td>
</tr>
<tr>
<td>Infrastructure capacity at rural general practices geared to meet demand in increased trainees and changes to rural general practice pathway</td>
<td>SA Health, Dept of Health and Ageing</td>
</tr>
<tr>
<td>Reinforcement of Country Health SA Hospital Plan – use 4 General Hospitals as training sites/certainty of role of rural GP</td>
<td>SA Health, SAIMET, GPET, RTPs, Hospitals</td>
</tr>
<tr>
<td>Change in placement allocations recognising:</td>
<td>SA Health, SAIMET, GPET, RTPs</td>
</tr>
<tr>
<td>• eastern state service delivery model not appropriate to SA needs</td>
<td></td>
</tr>
<tr>
<td>• GP as a specialty</td>
<td></td>
</tr>
<tr>
<td>Use of new approaches to teaching and training to extend into rural general practices – eg simulated learning environments, telemedicine and telecommunications</td>
<td>Rural GPs, SA Health, RTPs</td>
</tr>
<tr>
<td>Relevant supports in place throughout training journey and into career</td>
<td>All organisations and stakeholders</td>
</tr>
<tr>
<td>Reinforcement that rural general practice is a “great career choice”:</td>
<td>All organisations and stakeholders</td>
</tr>
<tr>
<td>• not required for a lifetime but a good career for a short time</td>
<td></td>
</tr>
<tr>
<td>• GPRA etc promotion</td>
<td></td>
</tr>
<tr>
<td>• Lifestyle indicators published</td>
<td></td>
</tr>
</tbody>
</table>
Summary of issues from focus groups

Groups of medical students and rural GP Registrars were invited into the RDWA for two separate focus group discussions.

During the session with the students, the following topics were discussed:

- Perceptions of rural practice, both positive and negative
- What would be required for students to consider rural practice as a career path
- The impact of family on choosing a career in the city or country
- Whether practice ownership is a barrier
- Is rural practice a long term career
- Value of rural exposure during medical school
- Information on career paths – where do students go to get information
- People or events that encouraged the choice of rural general practice as a career
- What is critical to ensure that a rural practice career is considered

With the rural GP Registrars, the following topics were discussed:

- Value of rural exposure during medical school
- Issues that influenced choice of a rural GP pathway
- People or events that encouraged the choice of rural general practice as a career
- Perceived barriers encountered in choosing rural general practice, during GP training and beyond
- How access to procedural training can be improved
- Positive and negative experiences in rural practice

The Project Team also wished to hold a focus group session with interns, however acknowledged that it would be difficult to bring together a suitably sized group for discussion. Instead the decision was made to attend and run a monthly tutorial at the Flinders Medical Centre where Dr Stephen Napoli, GP Proceduralist at Mannum, led the tutorial on GP Obstetrics in a rural area. The discussion was then opened up to the group on the following topics:

- Significance of exposure to rural practice during medical school
- People or events that encouraged the choice of rural general practice as a career
- Perceptions of working in rural South Australia
- What factors and perceptions influence the choice of hospital to complete internship
- The value of exposure to rural general practice
Focus group: Students, 15 September 2010

Demographic Data

<table>
<thead>
<tr>
<th></th>
<th>Number attending: 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td></td>
</tr>
<tr>
<td>20-25 years</td>
<td>6</td>
</tr>
<tr>
<td>26-30 years</td>
<td>3</td>
</tr>
<tr>
<td>31-35 years</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td><strong>University:</strong></td>
<td></td>
</tr>
<tr>
<td>Adelaide</td>
<td>6</td>
</tr>
<tr>
<td>Flinders</td>
<td>4</td>
</tr>
<tr>
<td><strong>Scholarship recipient?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td><strong>Have you lived in rural South Australia?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td><strong>How long have you lived in rural South Australia?</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>4</td>
</tr>
<tr>
<td>5-10 years</td>
<td>0</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>2</td>
</tr>
<tr>
<td><strong>Are you considering working in rural South Australia?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td><strong>How long are you considering working in rural South Australia?</strong></td>
<td></td>
</tr>
<tr>
<td>Short term/locum &lt;5 years</td>
<td>2</td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>2</td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>6</td>
</tr>
</tbody>
</table>

Focus group session

What do you hear about rural practice and what do you think it involves?

- Diversity of practice. General practice is pushed as a lifestyle choice. Living in a town that is very open and willing to have a doctor. Variety and challenge of work would be the strong thing that comes out of discussions.
- Agree with the work aspect. Consider general practice as a career in the country rather than the city because of the potential scope and diversity of practice; whereas city general practice seems quite narrow and more of a referral service. In the country you are managing a lot more complex problems, hospital work as well as your sub-speciality.

Do you hear positive things about rural doctors?

- Generally hearing positive things about rural doctors.
- A lot of respect however they will then go onto say “I could never do that” or “I don’t want to do that”
Why isn’t it for them?

- Hard work
- Quite opposite to the positive lifestyle portrayed. While the work is interesting and varied, you have a lot of responsibility. Would not want the lifestyle of the rural doctors she has worked with because of the expectations and pressure and lack of backup/support; also in terms of being on-call for 24 hours a day 7 days a week.

What about locum support? Not enough peer support?

- Locum support is for 2-3 weeks a year; the rest of the time you are on-call 24 hours a day 7 days a week. If you could have 1-2 days off and a night off each week would make it more attractive.
- Perception that locum support is not available as it should be. Need to book in advance and even then you may not have a locum. Handover needs to be planned. In more remote areas they don’t always turn up. Patients may not visit locum. Can lead to more stress for the rural doctor.
- Challenge of finding a locum is one of the responsibilities you take on in taking up a position as a rural doctor. Can be a barrier.
- A regular contract with a locum for one week support every so many weeks would be attractive

In choosing rural as a career path, what would you want to make that happen?

- Need specialist support/ or phone support to get patients help quickly
- Ability to transport patients to care at no cost to the community (nb. student had worked in an area not serviced by RFDS)
- Knowledge about expectation of doctors (ie. on-call)
- Need to feel safe in the community you are working in (nb. student has heard stories of registrars not feeling safe as everyone in the community knows where they live and calls on them at all hours of the night)
- Money won’t attract people but adequate remuneration is deserved
- Most people doing medicine are going to make enough money no matter what you are doing
- In rural areas there are many things a doctor may do that cannot be billed; therefore there needs to be some sort extra remuneration
- Money would be better spent on professional support/infrastructure
- Non-monetary costs to family when you go out there that are not seen as well

Is lack of support from family or impact on family a concern? Is it different going out alone versus with a family?

- Concern is most forefront – once kids reach high school age probably move back to city. Talked to the GPs in the [rural region] and they send their children to boarding school which has a financial and emotional cost.
- Also need to have something (career) for the partner to do
- Don’t want to work where unable to just pick up and be a support for ageing parents
- Flexibility to move in and out
- Flexibility to be able to take time off if need be
- Cannot move quickly if you own your own practice. An externally owned practice or even a private owned urban practice is easier to leave/sell.
Is practice ownership a barrier?
• Not thought about as too far down the track, but flexibility is the key
• Generation Y don’t want to own the practice anymore. Want the flexibility and freedom to come and go

Is rural practice a long term career for you?
• Yes, but not in the same community for the next 50 years; may change mind
• Much the same. Intend to the 35 years of rural but not in the same location. Want to see more of the country
• Yes, has a [child] and wants to settle down in the right community; long term

What facilities are you looking for when making a long term decision?
• Community activities, playground, swimming centre, social atmosphere of the community

How do you choose the location you go to first in rural practice?
• Plan to locum
• Determine from remoteness indicator as to what interests you
• Aim to work in the [rural region]. Feels cannot move there straight out of training. Thinking about it in a stepped plan – gain the experience.

Have your rural experiences been good and why? Or if not, why not?
• Overall very positive; most negative experiences around on-call. Not enough to turn them off rural
• Most rural experiences have been lifestyle – really enjoyed it. Hasn’t had the experience of working in a rural area. Opportunity is there to get exposure but hasn’t been interested until recently.
• Had a wonderful rural exposure in 5th year, but knows now will not work as a rural GP. Just doesn’t like the wide variety of patients or referring on.
• Acknowledges can be a specialist in the country but limited opportunities. Also will end up being the only specialist so everyone referring to you.
• Planning on commuting. Views this as the perfect balance of both worlds. Specialists in [rural location] do this and it seems to be a nice balance.
• Specialist training is another 7-10 years in the city and by then may be more settled down and less likely to make the choice to move to a rural area
• What specialist opportunities are available in regional SA? Limited
• More opportunities to specialise and knowledge about what you can specialise in in rural areas would be more attractive. A lot more people would go rural than before.
• Visiting specialists – has gained a lot of exposure and one-on-one opportunities from them

Do medical schools give you enough knowledge about what is out there?
• They don’t handle career pathways very well. It’s up to the students to pursue.
Where do you go for information about career paths?

- Mentors at hospitals; junior doctors 2-3 years above you
- If had a direct question would call RDWA but more informal questions directed to peers
- Would not call colleges directly; trouble is you don’t know what you are asking
- Perception that colleges are not supportive of rural doctors; don’t publicise opportunities in country
- Without accredited training sites in rural areas it is difficult to do rural training
- Specialist in [rural location] advised student that if done in the country and something goes wrong then it shouldn’t have been done in the country; but if done in the city and something goes wrong then it was a difficult case. No support for rural specialists.
- Need a culture shift. Twenty years ago rural doctors were considered the scum; so perception has changed but still needs further movement
- “Are you going to specialise or are you going to do general practice?”
- Commonwealth funded places and bonded places can create elitism. However should be nobody’s business.

What other things do you consider in determining what you are going to do?

- Interest; lifestyle; flexibility; ability to travel
- Something to keep you occupied for the next 50 years
- Working environment
- Not certain general practice is for me. Flexibility is a good thing.
- Even if do go rural, want to do more years in the city before move
- A lot of students half interested in rural practice do not want to be locked in. Want flexibility to move in and out.
- More attractive if you know you can get out of it
- Always issue with numbers to go rural in 5th year. Everyone who has expressed interest in going rural is being pursued to apply for a position.
- (Students) are paid to go rural $120 per week
- Some people are not ready to go rural
- Quality of teaching wasn’t as good in 5th year in a rural area as had had in the city in the previous year
- Some things promised through [University rural program] not delivered; quite a negative experience compared to what was told. Has made her think twice about committing to another year of training in the country.
- Contract is with practice not student
- Different forces in play as University required to have 25% go rural. May be treated differently as a doctor rather than student.
- A bad rural experience can make you less likely to take the risk again
- Easy to be turned off and difficult to turn on

When did you first consider rural?

- Early on. Early exposure key.
- Upbringing also an influence
- Rural weekend trips are good. Social focus important as well as the clinical exposure; you get a feel for the community.
- Supportive of RDWA trips – attractive as no commitment; good experience
• Participation on [RDWA clinical skills weekend] increased interest in rural. Good to meet [doctor]; irreplaceable but wouldn’t want to be him (ie. on-call, etc)
• Just want to switch off at the end of the day. Doesn’t seem to be an option in rural areas; also everyone knows who you are in the community. Not sustainable in long term.
• Being a parent, a 5-6 GP town more attractive

Do you realise that workforce agencies can tailor a position for you?
• Most of us don’t know what we want at this stage

Anything that is critical for ensuring that a rural career is considered?
• Early exposure and a clear pathway
• People think that you have to be a GP to go rural. More knowledge about specialty and being able to move across from general practice
• Main barrier that there is a perception of lack of specialist opportunities
• Don’t want to sacrifice future career (of specialist) just to go rural
• Old school negative attitude at [metro hospital]; all about who you know. Perceived disadvantage in going rural that you don’t get to know these key people.
• Going interstate to do intern year. Won’t know anyone in Adelaide to come back to do secondary qualification – a worry.
• Option of some programs that if you go rural you are guaranteed a job later
• PGPPP is seen as a negative thing as you miss out on ED rotation and are forced to go. However when they come back they are really positive about it.
• Thing with that is that at [metro hospital] you choose ED or PGPPP. ED is required to get into some specialist colleges.
• As an RMO it is expected that you know ED
• Either you do both or ED and PGPPP are recognised equally
• Need option of doing both; a lot of people would take it
• At [university] expected to go to [metro hospital] as intern. [rural hospital] intern positions not highly promoted. Pressure to stay in the [metro hospital] system to meet the people you need to know to get into the desired training programs (they hire from their own intern pool). Seen as negative if you go elsewhere for internship.
• At [university] told you can do internship elsewhere and there will always be a spot at [metro hospital].
• [rural hospital] seen positively. Would it make a difference if more country hospitals had intern places?
• [rural location] are keen to have interns. [rural location] would be the last place as the GPs run every specialist out of town. It will be a natural progression towards the proposed CHSA plan.
• Need to find intern spots somewhere.
• Need the population to support these services
• Commonwealth vs State funding issues
• CHSA plan to close and downgrade regional hospitals makes you wonder if a rural practice is sustainable. Can your skills be transferrable to the city?

Final comments
• Scariest part of the whole job would be being alone. Need peer support/buddy system
• Vital to have a supportive allied health team
## Focus group: Registrars 8 December 2010

### Demographic Data

<table>
<thead>
<tr>
<th>Number attending: 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
</tr>
<tr>
<td>25-30 years</td>
</tr>
<tr>
<td>31-35 years</td>
</tr>
<tr>
<td>36-40 years</td>
</tr>
<tr>
<td>&gt;40 years</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>University:</strong></td>
</tr>
<tr>
<td>Adelaide</td>
</tr>
<tr>
<td>Flinders</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Where completed Intern Year:</strong></td>
</tr>
<tr>
<td>FMC</td>
</tr>
<tr>
<td>TQEH</td>
</tr>
<tr>
<td>Modbury</td>
</tr>
<tr>
<td>Mount Gambier</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Regional Training Provider:</strong></td>
</tr>
<tr>
<td>AOGP</td>
</tr>
<tr>
<td>SF</td>
</tr>
<tr>
<td>Southern (GGT)</td>
</tr>
<tr>
<td><strong>Procedural training:</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Which procedural area?</strong></td>
</tr>
<tr>
<td>Anaesthetics</td>
</tr>
<tr>
<td>Obstetrics</td>
</tr>
<tr>
<td>Emergency</td>
</tr>
<tr>
<td>(No one doctor chose 3 areas)</td>
</tr>
<tr>
<td><strong>At time of completing degree, had you lived rurally?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>How long have you lived in rural South Australia?</strong></td>
</tr>
<tr>
<td>&lt;1 year</td>
</tr>
<tr>
<td>6-10 years</td>
</tr>
<tr>
<td>&gt;10 years</td>
</tr>
<tr>
<td><strong>Are you considering working in rural South Australia?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>How long are you considering working in rural South Australia?</strong></td>
</tr>
<tr>
<td>&lt;5 years</td>
</tr>
<tr>
<td>&gt;5 years</td>
</tr>
<tr>
<td>unknown</td>
</tr>
</tbody>
</table>
Focus group session

Did you have enough exposure to rural practice during medical school?

- Plenty through [University] through [Rural School]. 18 months outside city in last 3 years. Whole year in [Rural location] in 5th year. Had interest in rural; not pushed but voluntary.
- IMG – obligatory to do one year in home country post intern year. Provided good understanding that would not have occurred unless obligatory.
- International student at [University]. Conflict of information about whether could participate in rural club; therefore little rural exposure.
- Little rural exposure as a student. One week in first year; no other rural exposure for rest of degree. Was not a member of the rural club. First major exposure PGPPP in intern year.
- Not as much exposure as opportunity to be involved in [Rural School] not available when studying. Involved with rural club. Spent 4 weeks in rural areas in MBBS program.

Summary

- 3 had little rural exposure through medicine school; 1 had significant exposure due to rural health school; 1 had obligatory exposure overseas
- 5 answered this question

What were the issues that made you decide to go rural or not?

- Undecided when started medical school. Decided by final year to be rural GP. Reasons for: lifestyle, diversity of work/broad knowledge. Bound by 10YR moratorium. Prefer rural practice as wider case load. Difficulty as partner is a [specialist registrar].
- Reasons for: lifestyle, continuity of care, hospital work. Bound by 10YR moratorium.
- Rural origin. Chose medicine in high school. During study in Adelaide decided to be a rural doctor. PGPPP placement during intern year convinced her to go into GP training. Reasons for: variety of work, skills required and being part of the community. Little barriers to working in country as partner also rural background and can work in country.

Summary

- 1 chose rural GP prior to entering medicine school
- 1 chose rural GP by end of medicine school
- 2 chose rural GP during intern year
- 1 chose rural GP on being bound by moratorium
- 5 answered this question

Were there any people or events that encouraged you to choose rural general practice?

- Rural club made an effort during medicine school. RDWA involvement during medicine school. Also training providers and GP colleges. The PGPPP was the outstanding event that encouraged her into rural general practice. This was due to actually working during the placement rather than observing as a student.
• Support to have 2x general practice placements in region to see if rural general practice was really what wanted to do.
• As a student, rural rotations were not available and therefore main influence was PGPPP rotation.
• Not one thing really stood out but probably placement in obstetrics as everyone knew everyone and a real feel for community involvement as compared to a city birth. Attended National Rural Health Conference through rural club which reinforced rural pathway choice.
• National health network as a student, as well as ACRRM involvement. Also National Rural Health Conference was encouraging while a student.

Summary
• 3 cited general practice rotations during intern/pre-vocational years as the main influence
• 2 found the National Rural Health Conference reinforced their decision to pursue a rural pathway
• Involvement of rural club, RDWA and curriculum also influence
• 5 answered this question

What were the barriers encountered in choosing rural GP pathway?
• Requirement to move every 6 months during GP training (at least a 12 month placement is now a possibility). No concerns with raising a family in rural as grew up in a rural location. Partner also has a mobile career which helps. Distance from family can be a challenge. Procedural training not easily accessible outside city. Has decided to not pursue procedural training as no desire to stay in city any longer. Will work as a rural GP, which is not as valued according to college pathways OR what lead to believe.
• Education of children – lack of knowledge and confidence to educate children in country. Moved to SA as rural practice can be achieved not far from Adelaide.
• Frowned upon in hospital system to choose rural pathway. Difficulty to find adequate and welcoming training to rural practice. Barrier that on-call work is excluded for time for GP training. Has chosen rural as passionate however acknowledges that an urban training pathway is quicker and easier; end qualification result is the same. Family in rural areas is a barrier when moving around during training. (ie. difficulty moving children from childcare/school to childcare/school all the time). Access to procedural training is difficult when working in rural areas; can leave you feeling exposed in more remote areas without training. Difficult to get back into procedural training programs once out of city.
• Difficulty to move family around during training. Also difficulty for partner to get work in local town; can in nearby centre but still needs to commute. OSHC difficult to obtain; lack of family support.
• Difficulty as husband [specialist registrar]. Travelling every weekend to meet up. Childcare will also be issue away from family.
• Reiterated already stated issues. Partner works away and is quite mobile. Partner looking for a more permanent solution. Found [rural location] during training quite difficult being separated from extended family. Chose current practice as it is close to extended family and to Adelaide.
How can access to procedural training be improved?

• Streamline it. Give priority access in rural pathway to have access to these rotations from the beginning. Have a point of contact in the hospital to map out career and choose best route to becoming the best rural GP. Some of the emergency medicine training required by colleges not as adequate as what you may require in the country.
• If interested in working in more remote areas, lack of procedural skills can make you feel vulnerable.
• Training circle – as soon as you don’t develop the current generation then no one to teach the next generation

Summary

• Personal issues and family support during training/or to support partner’s career
• Requirement to move at least 12 monthly during GP training difficult on family
• Training hospitals not supportive of rural general practice
• On-call not included in GP training time
• Lack of access to procedural training (ie. should be more accessible, able to be better incorporated into GP training, rural access, flexibility)
• Would benefit from a clear career pathway designed around what makes a good rural GP

What are your positive experiences in rural practice?

• Rural origin helps a lot, community feel, continuity of care, variety of work, being involved socially in town, opportunity. No longer interested in living in the city; would be interested in additional training if could be offered rurally OR even 2 days a week. Flexibility in procedural training would make it easier: ie. part time or from supervisor/procedural GPs
• Role models of the GPs you work with
• Community feel, know your patients, opportunities of complete self-reliance are fun (ie. likes the challenge), likes having hospital that is attached to general practice, friendlier feel. Still some great procedural GPs to learn from.
• Ability to get all training in one location and surrounding region.
• Reiterated similar reasons. Feels patients more welcoming in rural regions as well as allied health staff you work with. Everyone knows everyone.
• Reiterated similar reasons. Ability to completely work up a patient before referring them to the specialist (need to before you ask them to travel). Breadth of work – interesting, varied and enjoyable.

Summary

• Variety of work, community feel, continuity of care
• Role models of rural GPs
• Ability to complete all training in one region (eg. intern year, registrar training, procedural training all done in [rural region])

Anything not covered? Gaps?

• Rural opportunities at university were excellent (through Rural Club).
• Need more mentors to encourage rural pathway and expose the challenge or general practice; make it more interesting.
• Big gaps are in the hospitals – people are not encouraged/coached or mentored onto rural pathway
• Disagrees that people are forced into rural pathway; should be encouraged as not a long term solution when forced
• Although chosen rural as under 10YR moratorium it is a wonderful life and should be encouraged
• Agree that hospital years are a problem with lack of encouragement into rural practice. Some people sent on rural PGPPP do not choose it but have no other option for rotation. Needs to be more guided.
• PGPPP is seen as a positive influence on choosing rural general practice
• Rural GP needs better promotion – needs to be seen as a speciality; educating students and the wider medical community
• For rural students going back to a country area not as daunting. PR needs to extend to high school students in rural areas.

Intern tutorial 15 March 2011

Summary
• GAMSAT was perceived as “worse” than the UMAT
• 1 attended RDWA’s 1 day UMAT course and found it really valuable
• Mandated rural exposure (1 day) in first year at [University] not worth it
• Rural research project undertaken in second year at [University] also of little value (as research never taken up)
• Rural Health Clubs are very good + RDWA’s events
• Not worth mandating rural exposure
• Not enough opportunity to do training outside of general practice in rural South Australia; need to change the perspective of the “specialist” colleges
• If you are committed to working in rural South Australia then you are limited to being a general practitioner with/or not with a procedural diploma
• Supervisors are required to create intern places in rural areas
• Country Health SA needs to be seen as putting services out in rural areas not bringing them back in (case example of the decline in specialists in [rural region])
• “Specialist” colleges are full; the competition to get into specialist training is extremely high as it is perceived there are not enough positions for the current number of interns
• Maintaining competitive advantage over other interns is a deterrent for being a rural intern – to see the more complex cases (for your CV) and to develop contacts at the specialist colleges you need to work in a metropolitan hospital
• Registrars recommend that they do not undertake a rural internship as you lose your competitive advantage
• Tertiary education not available outside of Adelaide; existence of tertiary education outside Adelaide would make internship in rural locations more feasible
• An intern year based on competencies rather than core terms would make the possibility of rural interns more feasible
• Interns look for an intense experience
• Exposure to rural medicine is good; it enables you to understand what a rural patient may experience. Conversely, exposure to city medicine is also good. If you are working as a rural practitioner and need to refer someone to the city then it gives you an understanding about what they may experience.
## Workshops

During the Project Design phase, the Expert Panel planned three workshops to help facilitate the design of the model.

### Attendance

At each workshop, stakeholders were represented by members of the Expert Panel, other representatives and invited persons relevant to the topic. The following people took part in the workshops:

<table>
<thead>
<tr>
<th>Dr Ben Abbot</th>
<th>Ms Fran Lovell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr David Adams</td>
<td>Dr Lawrie McArthur</td>
</tr>
<tr>
<td>Dr Martin Altmann</td>
<td>Ms Mandy McCulloch</td>
</tr>
<tr>
<td>Ms Dianne Barrington</td>
<td>Dr Rebecca Morgan</td>
</tr>
<tr>
<td>Dr Michael Beckoff</td>
<td>Ms Belinda Moyes</td>
</tr>
<tr>
<td>Prof Justin Beilby</td>
<td>Dr Bruce Mugford</td>
</tr>
<tr>
<td>Mr George Beltchev</td>
<td>Prof Jonathan Newbury</td>
</tr>
<tr>
<td>Dr Michael Betts</td>
<td>Ms Helen O'Malley</td>
</tr>
<tr>
<td>Ms Linda Black</td>
<td>Mr Brendan Peek</td>
</tr>
<tr>
<td>Dr Peter Chapman</td>
<td>Ms Lyn Poole</td>
</tr>
<tr>
<td>Dr Peter Clements</td>
<td>Dr Cherie Price</td>
</tr>
<tr>
<td>Ms Alison Day</td>
<td>Dr Peter Rischbieth</td>
</tr>
<tr>
<td>Dr Holly Deer</td>
<td>Dr David Rosenthal</td>
</tr>
<tr>
<td>Dr Chris Farmer</td>
<td>Dr David Scrimgeour</td>
</tr>
<tr>
<td>Prof Jennene Greenhill</td>
<td>Dr David Senior</td>
</tr>
<tr>
<td>Ms Jo Hoiles</td>
<td>Dr Peter Sharley</td>
</tr>
<tr>
<td>Dr Steve Holmes</td>
<td>Prof Nigel Stocks</td>
</tr>
<tr>
<td>Dr Peter Joseph</td>
<td>Dr Karen Sumner</td>
</tr>
<tr>
<td>Dr Peter Joyner</td>
<td>Dr Talina Vizard</td>
</tr>
<tr>
<td>Dr Tim Kelly</td>
<td>A/Prof Lucie Walters</td>
</tr>
<tr>
<td>Ms Karen Lancaster</td>
<td>Dr Ken Wanguhu</td>
</tr>
<tr>
<td>Dr Andrew Lavender</td>
<td>Dr Tim Wood</td>
</tr>
</tbody>
</table>

Ms Rita Brewerton facilitated the discussion at each workshop.
Appendix 5

Workshop 1 - Defining the problem

Held on Thursday 28 October 2010, the workshop opened with an introduction to the project and an overview of the work done so far. Everyone in the room was then invited to provide a short presentation on their role and function as it relates to the existing pathway for rural GPs and GP Proceduralists.

The group then identified:
• The key issues in securing an Australian trained GP and GP Proceduralist in rural South Australia, and
• The Critical success factors/components of an optimal rural pathway, summarised in Appendix 2

Workshop 2 - Quantifying the problem

Held on Friday 10 December 2010, Country Health SA, RDWA and stakeholders responsible for training and educating rural GPs and GP Proceduralists in the existing pathway were asked to present information on the future workforce required and the demographics of the doctors currently being produced. Workshop participants heard from:
• RDWA
• Country Health SA
• University of Adelaide
• Flinders University
• South Australian Institute of Medical Education and Training
• Adelaide to Outback GP Training program
• Sturt Fleurieu GP Education and Training

Copies of these presentations can be found in Appendix 6.

The information provided gave a picture of the numbers of people moving through the various stages of the existing pathway for rural GPs and GP Proceduralists, as well as the numbers of doctors required to develop and sustain a safe, reliable, quality health service in rural areas.

Following the workshop, Flinders University provided further information on the number of South Australian students studying medicine as a percentage of the class over the last five years, and further detail on the following was asked of the RTPs:
• Number of doctors who have completed Rural Pathway or General Pathway training in the last 3-4 years;
• Number of doctors who have returned to the RTP’s region (preferably split rural and urban);
• Number of doctors who are continuing to practise in the RTP’s region (again split rural and urban).
Workshop 3

Held Thursday 3 March 2011, the objective of Workshop 3 was to answer the three questions posed at the Expert Panel meeting held 24 February:

1. What are the principles that should guide the model?
2. Can all stakeholders declare what they can do/contribute to the whole to inform the design of the model?
3. What can be constructed to build on what already exists OR do we construct something to which everyone contributes?

Prior to the workshop, Expert Panel representatives were invited to submit draft principles, which were then read and discussed at the workshop. An additional guiding principle was added by the group:

- The Pathway needs to meet community needs, clinician needs and funder (Country Health SA) needs.

The workshop attendees then addressed the other two questions by splitting into two groups and working through the following tasks:

- Identifying what are the key ingredients to success;
- Identifying what are the roadblocks to success and how this can be remedied;
- Identifying what each stakeholder can contribute to the ingredients of success and remedies.

The results from this discussion are included in Appendix 2 and assisted in forming some of the key criteria proposed in the pathway model.
Workshop presentations

CHSA presentation 1

RDWA RURAL PATHWAYS FOR GENERAL PRACTITIONERS IN SA WORKSHOP
10 December 2010
Understanding current and future demand for rural GPs
Adjunct Professor Belinda Moyes
Chief Executive Officer
Country Health SA

Findings from AMWAC Report 2005.2,
The General Practice Workforce in Australia.

- There is:
  > An increasing demand for GP services
  > An overall shortage in the GP workforce especially in remote and rural areas
  > An aging GP workforce
  > Life choices

SA Health

Changes Since This Data Was Prepared

- Increase in publicly funded medical school places by 23%
- 8 new medical schools on line
- Total increase in publicly funded medical students from 1,000 – 1,900 per annum
- From 2004, GP training places have increased by about one third
- More incentives for IMG doctors to practise in Australia, but not necessarily in general practice or rural general practice.

SA Health

Country Health SA

- 11 clusters
- 82 health services
- 4 x Country General Hospitals (Mount Gambier, Bumb, Whyalla, Port Lincoln)

SA Health

CHSA in 2020

- Services rather than hospitals - Primary, Aged Care, Acute, Community & Mental Health services
- The same health services as at present
- Increased flow of services to country (away from Adelaide)
- Emergency cover across country SA
- 4 Country General Hospitals
  > Progress is being made in specialist led services as at Mount Gambier.
  > GP involvement will be more pre-hospital involvement rather than FFS like the Upper Spencer Gulf agreement
- Medium sized hospitals
  > Provide obstetric as well but supported by GP obstetricians and GP anaesthetists
  > Will increasingly have midwives involved with low risk births managed by midwives (collaborative models)

SA Health

Planning

- HAC service plans (33) completed June 2010
- Refining / rolling out early 2011
- Continue current health services
- 4 General Hospitals
- Medium acute hospitals
- Small health services with Aged Care

SA Health
CHSA presentation 1 (continued)

Slide 13

Aged Care
- Support Aged Care residents
- Respite Care
- Palliative Care

Slide 14

Mental Health
- Limited Treatment Centres in the 4 country General Hospitals
  - Supported by specialists
- Acute Care
  - admitted patients

Slide 15

Implications
- Increase % of GP's not involved with the Hospitals
- GP's involved will spend more time working with hospitals rather than occasional involvement
- Hospital rural GP's – extra training
  - Emergency - Diploma
  - Obstetrics – Advanced Diploma
  - Anaesthetics – Diploma

Slide 16

Model Of Engagement
- Rely on GP's?
  - Or
- CHSA to recruit (rural pathways)?
  - Or
- Both?

Slide 17

Any Questions?

Slide 18

Government of South Australia
SA Health
Workshop presentations

RDWA presentation

Slide 1

Slide 2

Population Growth
- Australia’s population will grow by 3m in the next five years
- Growth in Sydney, Melbourne and SE Queensland
- South Australia remains relatively static
- Rural South Australia continues redistribution to coast
- Mobile population in mining areas

Slide 3

Population Characteristics
- Baby Boomers who are 65 years from 2011 and eligible for age pension
- Rapidly increasing chronic disease burden
- Two generations away from preventative intervention impact
- Ageing in community settings

Slide 4

National Workforce Picture
- Rising and acute workforce skills shortage during 2010s
- Largely created by exit of Baby Boomers
- More skills exiting than entering the workforce
- Since 1995, Boomers have underpinned workforce and tax base
- This decade is the start of the ‘Baby Bust’

Slide 5

Medical Workforce Nationally
- 30% increase in numbers of medical practitioners between 2004 – 2008
- 70,600 medical practitioners registered and working
- 24,000 Primary care practitioners
- Primary care practitioners 40% of workforce in 1996
  56% in 2008

Slide 6

Medical Workforce Nationally
- Average weekly hours worked
  46.9 hours in 2004
  42.7 hours in 2006
- Female primary care practitioners
  38.2% in 1996
  38.6% in 2006
- Hours worked:
  Male 44.4 hours per week
  Female 37.7 hours per week
RDWA presentation (continued)

**SA Rural GP Workforce 2002**
- 368 GPs
- Median age 52 years
- 209 Australian Graduates (77%)
- 69 International Graduates
- 12 Permanent Residents
- 116 Practices

**SA Rural GP Workforce 2006**
- 361 GPs
- Median age 50 years
- 255 Australian Graduates (93%)
- 122 International Graduates
- 69 Permanent Residents
- 116 Practices

**SA Rural GP Workforce 2010**
- 368 GPs
- Median age 45 years
- 254 Australian Graduates (61%)
- 89 International Graduates
- 89 PRPs
- 116 practices

**2006-2010**
- Net gain of 17 GPs
- R.G. proportion grew from 32% to 33%
- 70% of GPs are Permanent Residents or Australian Citizen
- Female workforce grew from 27% to 33%

**The factors – private practice**
- Increased number of females
- Females work less hours on average
- Boomers start workforce exit this decade
- Overall decreases in number of hours worked
- Demand for training will increase
- Generation X and Y seek work-life balance

**The factors – public hospitals in SA**
- 80% of workforce works up to 10 hours in accident and emergency after hours on call currently
- Trend is to work less emergency on call
- Service delivery closer to homes, such as changes to Mental Health Act will require greater inpatient care locally.
RDWA presentation (continued)

**International supply**
- Domestic supply has not been able to meet demand in rural areas.
- International supply has provided a steady pipeline of 25-30 experienced GPs per annum for the past 5 years.
- This supply pipeline will continue.

**Key points**
- SA rural population won't grow but its demands for healthcare will increase.
- There are more skills selling than entering the workforce.
- Replacement FTE is greater than current FTE to maintain current service provision.
- Growth in service demand requires an increase in GPs' numbers and new skills.

**Net workforce demand**
FTE requirements can be calculated for both maintaining current hours and growth due to changing services.
Net domestic supply equals:
- Number leaving
- Plus premium associated with trends
- Less the pipeline of International Graduates.

---

Appendix 6
Workshop presentations

Adelaide Uni presentation

Slide 1

Slide 2

Slide 3

Slide 4

Slide 5

Slide 6

Appendix C
Analysis of selection 2004-07

Caroline Laurence et al (3)

Female less likely interview (0.88) but more likely a place (1.33)
Older less likely (0.78)
Non-school leavers more likely interview (9.54)
Higher socioeconomic more likely place 1 vs 4 (0.95)

References

Workshop presentations

Flinders Uni presentation 4

A/Prof Lucie Walters

- 4yr graduate entry degree
- 2010 introduced undergraduate entry into double degree. First 2 years Bachelor Health Science and then 4 years MBBS. Selection criteria high TER and UMAT. UMAT is weighted at 10% for selection; 90% is TER. Loading applied for rural school of 10%.
- 38% of double degree cohort 2010 have a rural background
- 2006 – 26% of cohort rural origin
- 2007 – 22% of cohort rural origin
- 2008 – 29% of cohort rural origin
- 2009 – 30% of cohort rural origin
- 2010 – 20% of cohort rural origin
- New indigenous pathway scheme: 11 NT and 6 SA apply; will know next week how many apply to medicine school
- In 2011, 130 students and 19 FFP
- Over last 5 years domestic students increased by 15; slight decrease in FFP. Bonded students replaced FFP. Bonded places have been withdrawn for 2011.
- 1%pa drop out
- 7 weeks rural over 4 years
- 25% rural in 3rd year (x2 SA and NT)
- PRCC Program leads to 30% cohort having rural exposure
- PRCC 19.1% end up on rural pathway

How many MBBS students at Flinders University are SA origin?

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Australian and New Zealand students</td>
<td>80</td>
<td>103</td>
<td>115</td>
<td>121</td>
<td>117</td>
<td>111</td>
</tr>
<tr>
<td>SA Origin (number, whole of SA, not solely SA rural)</td>
<td>44</td>
<td>49</td>
<td>67</td>
<td>67</td>
<td>63</td>
<td>57</td>
</tr>
<tr>
<td>SA Origin (% of SA not solely SA rural)</td>
<td>55</td>
<td>48</td>
<td>58</td>
<td>57</td>
<td>54</td>
<td>51</td>
</tr>
</tbody>
</table>

* Figures provided are an estimate pending final figures once the class settles down. The final number should be within 1-2% of that given.
Workshop presentations

SAIMET presentation

Slide 1: Better Training Better Doctors Better Healthcare
Slide 2: Brendan Pock, South Australian Institute of Medical Education and Training (SA IMET)
Slide 3: Projected Medical School Graduate Hurricanes 2015 - 2014
Slide 4: SA University Medical Graduates
Slide 5: SA Medical Graduate Numbers
Slide 6: Summary of SA Graduates 2007 to 2011
SAIMET presentation (continued)

SA University Medical Graduates
Summary of non applicants

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Non Res</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Domestic</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>NZM</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Non-Final</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Domestic</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

SA University Medical Graduates
First Preferences for Mt Gambier and District Health Service

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Final</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Domestic</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Pre-vocational positions allocated by SA IMET
Trainee Medical Officers 2010 Positions

<table>
<thead>
<tr>
<th>Program</th>
<th>No. of Positions</th>
<th>No. of Int. Applications</th>
<th>No. of Post Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>49</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Surgery</td>
<td>31</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>18</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

Pre-vocational positions allocated by SA IMET
Trainee Medical Officers 2011 Positions

<table>
<thead>
<tr>
<th>Program</th>
<th>No. of Positions</th>
<th>No. of Int. Applications</th>
<th>No. of Post Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>49</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Surgery</td>
<td>31</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>18</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

National Audit of Intern Acceptances

- 2607 acceptances reported
- 184 acceptance (2%) 154/2607
- 2533 acceptances examined
- 80 (3%) duplicate acceptances
- 44 applicants accepted 2 positions
- 1 applicant examined 3 positions
- Of the 41 applicants with duplicate acceptances
  - 35 (85%) Residency
  - 1 (2.4%) Other (Disability, Project, etc.)
- 7 had not applied in their own jurisdiction
Workshop presentations

RTPs presentation

Key Points

- Rural Pathway in GP Training already exists
- Current numbers seeking rural training are greater than capped GPET allocation of training positions

Key Numbers

<table>
<thead>
<tr>
<th>2017 GP Community Training Places</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>AOGP</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>38</td>
</tr>
</tbody>
</table>

Key Numbers

<table>
<thead>
<tr>
<th>2017 GP Registrar Intake</th>
<th>General Pathway</th>
<th>Rural Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF</td>
<td>AOGP</td>
<td>SF</td>
</tr>
<tr>
<td>GPET Allocation</td>
<td></td>
<td>SF</td>
</tr>
<tr>
<td>Applicant</td>
<td></td>
<td>SF</td>
</tr>
<tr>
<td>Accepted</td>
<td></td>
<td>SF</td>
</tr>
<tr>
<td>Acceptance Rate</td>
<td></td>
<td>SF</td>
</tr>
</tbody>
</table>

Key Numbers - AOGP Procedural

<table>
<thead>
<tr>
<th>Advanced Skills Training</th>
<th>Number Committed</th>
<th>Retained in AOGP Program</th>
<th>Completed in AOGP Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>P - Anaesthesia</td>
<td>14</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>P - Obst &amp; Gynae</td>
<td>16</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>P - Surgery</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>P - Emergency (ER)</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>P - Emergency (P)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MP - Aboriginal Medicine</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MP - Paeds</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>MP - Pall Care</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>MP - Small Town (AOGP)</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>25 (68%)</td>
<td>22 (59%)</td>
</tr>
</tbody>
</table>
RTPs presentation (continued)

Key Points
- A number of different and distinct entities have responsibility for different parts of the pipeline that lead to this training – the linkages have been built but could be further strengthened and better integrated.

Key Points
- Forum would benefit from a comprehensive presentation of RDWA and Country Health SA perspective of demand and supply issues regarding rural GPs for rural communities relative to workforce needs - both now and going forward, say, in 5 years time.

Key Points
- When projecting forward, to include County Health SA and RDWA's best scenario for the regional distribution of the required supply of procedurally skilled and non-procedurally skilled rural doctors at this future time.

Key Areas for collaboration
- Develop of junior doctors positions and training in regional hospitals.

Key Areas for collaboration
- Create systemic access to procedural training for GP Registrars seeking to include major procedural skills as part of their medical profile.

Key Areas for collaboration
- Determine and fund accurate numbers required for entry into GP and GP Procedural training – based on current knowledge regarding retirement rates of current rural GPs and retention and attrition rates of graduating GP Registrars.
RTPs presentation (continued)

Key Areas for collaboration

- Strengthen linkages and integration (not amalgamation) between entities responsible for different parts of the pipeline

Conclusion

- All parties involved in this forum have an integrated responsibility to determine how best to match demand and supply against workforce needs whilst as independent entities also working to meet our distinct responsibilities to best effect.

Conclusion

- Gaining a 'reality-check' by the forum participants on Country Health SA's/RDWA's knowledge and perspective of these issues is the most constructive use of the knowledge in the room - and the time being offered to progress this work.

Conclusion

- Determining an integrated strategy we can all work to that allows us to successfully contribute at different points of the 'pipeline' – will provide us with the best opportunity to achieve the collective outcome of the 'right doctors with the right skills in the right places with the right support'.
Road to Rural General Practice