General Practice Education and Training

GPET Submission to the Productivity Commission Health Workforce Study

An Australian Government Initiative

PREFACE

GPET was established to implement Federal Government policies aimed at better aligning Australia's general practice training arrangements with broad community needs within a framework that allowed the devolution of control of aspects of GP training to the regional level.

In this submission GPET describes aspects of its history and operations and puts these into a context congruent with issues and perspectives raised by the Commission in its recent Issues Paper.

GPET does not have immediate, straightforward answers to the challenges before the Commission. However in this document GPET makes several proposals for change which it believes are consistent with both the Commission's aims and the strategic goals of GPET. GPET looks forward to participating in the consultation processes to be managed by the Commission following release of its draft report. GPET believes that the proposals it has put could be usefully discussed during that consultation phase.

INTRODUCTION

GPET is a company established by the Commonwealth Government. The Commonwealth, represented by the Minister for Health and Ageing, is the only shareholder. The Minister appoints the Board. The objects of the company outlined in GPET's constitution imply a wide range of roles relating to general practice education.

The company was formed in 2001 and has fostered an Australia-wide system of Regional Training Providers (RTPs). There are 22 RTPs which contract with GPET to manage postgraduate training for new medical graduates seeking to enter general practice. There are presently around 1800 trainees undertaking a three year program, Australian General Practice Training (AGPT), which leads to fellowship of the Royal Australian College of General Practitioners (FRACGP). An FRACGP is required for recognition as a GP under the *Health Insurance Act*, that is, under Medicare.

RTPs also provide support for trainees seeking the Fellowship of the Australian College of Rural and Remote Medicine (ACRRM).

GPET has substantially boosted training opportunities in Aboriginal and Torres Strait Islander health, manages an innovative program of support for general practice trainees interested in including a research component in their training, and supports 'rural skills posts' for trainees seeking training in 'procedural' fields such as obstetrics and anaesthetics.

GPET undertakes the above tasks under a contract with the Commonwealth Department of Health and Ageing. At present there are about 1800 trainees and costs are around $60m per annum. The Commonwealth contract bars GPET and RTPs from charging 'user fees' to trainees in AGPT.

Many RTPs are developing other education-related programs. A detailed description of GPET, links to RTPs and descriptions of programs run by GPET can be found at www.agpt.com.au

The formal objects in the company's constitution (see Attachment A) imply wider roles than GPET has yet developed.

In general terms, GPET has maintained the previous RACGP training arrangements within a new administrative arrangement which devolves resources and management to local regions. RTPs are able and expected to adapt training arrangements to local circumstances and needs.

Part 4 of the Commission's Issues Paper suggests "the most fundamental requirement for achieving better workforce outcomes seems clear. It is to create

incentives and supporting institutional, funding and regulatory arrangements that encourage all parties to work efficiently, effectively and cooperatively" and raises issues such as length of training, coordination of regulatory responsibilities, coordination of training across disciplines, competency versus time-based training, use of competitive processes, etc.

This submission describes GPET's experiences since 2001 and focuses on the complex institutional and regulatory environment in which GPET exists. It is a challenge in this environment to effect changes to the system for training and educating general practitioners. The submission will conclude with some proposals that reflect themes in the Commission's recent Issues Paper.

Scope of GPET Submission to the Productivity Commission

GPET notes that "it is not the Commission's intention to report in detail on the needs of each workforce group. Instead, the Commission will be focusing on common themes and system-wide problems which governments will need to address to ensure the efficient and effective delivery of health services in coming years. The Commission encourages participants to take a similarly broad perspective….." (Productivity Commission Circular 'The Health Workforce' 22 March 2005 p2)

GPET has therefore avoided loading this submission with detailed descriptive material. However it is not possible to discuss the principles and issues outlined by the Productivity Commission in its May 2005 Issues Paper without some institutional detail. While description has been kept to a minimum, the preliminary parts of the submission look at aspects of the control and regulation of the GP workforce in ways that may illustrate the broad issues of interest to the Commission.

The Commission would be aware of the considerable data and analysis available on general practice. Two recent documents are noted:

i) The Australian Medical Workforce Advisory Committee is about to release a compendium of data and analysis on the GP workforce. AMWAC staff undertook extensive consultation and analysis working under the guidance of an AMWAC sub-committee with representatives from state and federal governments, GP organisations, consumer groups, GP trainees etc. That report will make recommendations on training numbers and their distribution for the years 2003-2013. (AMWAC, The General Practice Workforce in Australia: Supply and Requirements, 2003 to 2013).

ii) The Commonwealth Department of Health and Ageing recently published a book titled 'General Practice in Australia: 2004'. Various writers with experience and knowledge of general practice in Australia have contributed chapters. GPET

contributed to Chapter 6 on ‘Education and Training’. (‘General Practice in Australia: 2004’, Commonwealth of Australia: May 2005).

In summary, GPET appreciates that the Commission’s brief is to address “broad systemic issues” and that the Commission will seek out “market friendly” options. This submission will provide perspectives on Australia’s general practice arrangements congruent with the analytical approach implied in the Commission’s Issues Paper.

Structure of GPET Submission to the Productivity Commission

Part 1 of this submission describes the evolution of GPET focusing on: policy and political factors that led the Government to establish GPET; how the general practice training arrangements developed by GPET reflect a legislative and regulatory environment that has evolved over many years; and features of the general practice environment that determine the scope of GPET’s activities.

Part 2 of the submission considers the activities GPET undertakes against broad themes outlined in the Productivity Commission Issues Paper of June 2005 and proposes possible changes either to GPET’s role or to the roles of other entities that impact on GPET. These proposals are presented for discussion rather than as formal recommendations, given the Commission’s intention to publish a draft report and continue consultation later in the year.

1. PART 1: BACKGROUND TO GPET

1.1 Regulatory Structure of General Practice in Australia

"The history of modern Western medical education, characterised by a specific curriculum, a monetary relationship between student and teacher or school, and directed towards professional licensing, is intimately related with the history of the medical professions, related medical institutions, and the state… ….Restricting entry, connecting specific degrees or curricula to medical licensing and accrediting medical schools by professional organisations under government supervision, are all means through which medical occupations have used education to define themselves as professions and to establish their social authority via specialised knowledge". (Lawrence, Susan "Medical Education" in Companion Encyclopedia of the History of Medicine. Bynum and Porter eds, Routledge, London 1993. Volume 2, p1152)

An understanding of the regulatory structure around general practice is essential for proper understanding of the role of GPET and for adequate consideration of possible changes to address concerns raised by the Commission in its Issues Paper.

Regulation of a profession requires a system that respects professional traditions and perspectives while finding a balance with competing forces such as protection of the public and ensuring graduates have appropriate skills and ability. Recent thinking also stresses the need, given ongoing technical and organisational developments in health care, for a regulatory system that facilitates rather than impedes adaptation to changing workforce needs.

Tensions may arise when professional organisations define training requirements, determine the qualifications for practice, determine entry to the profession and define the scope of practice. It seems inherent that a regulatory system controlled by professional interests will emphasise role delineation. This impedes the incorporation of a broader range of expert input into defining professional competence.

The preliminary AHMAC submission to the Productivity Commission notes: "Approaching accreditation on a profession by profession basis contributes to the multiplicity of accreditation arrangements that characterise health education and training. This individual profession-based approach also precludes a 'whole of health system and health workforce' approach".

GPET has evolved within the complex regulatory structure that surrounds general practice in Australia. Tensions such as those referred to above are apparent.

Since its establishment GPET has focused on establishing a regional infrastructure and ensuring training arrangements meet college standards. Much time and effort, perhaps too much, has been spent attempting to assuage concerns of 'traditional' medical groups.

GPET has yet to seriously consider changes that might fundamentally alter the way Australia's GPs are educated. For example, there has been little consideration of how the general practice education and training sector could accelerate training for entrants from different sources, how the existing training might be streamlined, whether GP training could commence earlier (say in undergraduate courses), the scope for recognition of prior learning in the interests of facilitating progress or the scope for providing advanced standing to medical graduates with diverse backgrounds wanting to retrain as general practitioners.

1.2 Becoming a GP in Australia

It takes a minimum of 10 or 11 years for a school leaver to achieve recognition as a general practitioner under the *Health Insurance Act*, that is, under Medicare. A five or six year undergraduate course leading to an MB BS degree (or equivalent) is followed by at least one year as a junior hospital doctor and three years in the AGPT before achieving FRACGP. If a student attends one of the universities offering a graduate medical program the minimum time to recognition as a GP is 11 years.

The RACGP offers a Graduate Diploma in Rural Medicine which requires a further year of training and the Fellowship of the Australian College of Rural and Remote Medicine (ACRRM) requires a four year commitment (undertaken in conjunction with attainment of FRACGP).

Training for general practice in Australia occurs under a sequence of distinct and independent arrangements. The length, nature and content of education are determined autonomously within each of these independent arrangements. It is useful to list these and the sequence of entities involved.

1. A medical degree is awarded by a university. This follows either an undergraduate course of five or six years or a four year 'graduate' course, a prerequisite for which is an earlier degree of at least three years.

2. After a year's satisfactory internship (PGY1) in a public hospital, a medical graduate can be fully registered by a state medical board. To the extent that training for junior hospital doctors is formally organised it is under the control and supervision of a postgraduate medical committee or similar in each State. In 1996 the Australian Medical Council published the *National Guidelines for Intern Training and Assessment.*

3. Formal postgraduate training is organised by GPET to college (RACGP) standards with completion being attainment of the FRACGP. The college standards include requirements around the length of training, amounts of one-to-one training necessary, supervision requirements as well as a curriculum and assessment processes

4. Continuing education is monitored by the colleges, the RACGP and ACRRM, and delivered by a wide range of entities such as Divisions and pharmaceutical companies.

Doctors with primary qualifications from countries other than Australia or New Zealand applying to join the AGPT must be Australian citizens or permanent residents and fully registered with a state medical board. They therefore will have passed all components of the Australian Medical Council assessment process for overseas trained doctors (OTDs) and have hospital experience equivalent to an internship.

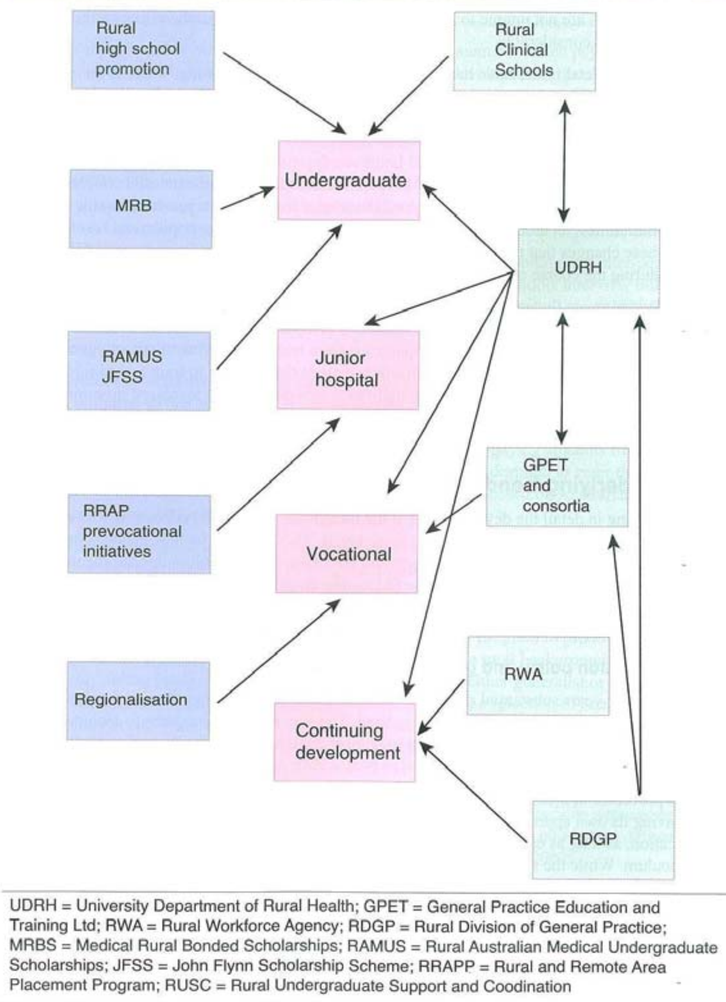


Figure 6.1 How initiatives and structures relate to levels of training

Source: 'General Practice in Australia: 2004', Commonwealth of Australia: May 2005, p271

It is of interest to consider one outcome of this complex, drawn-out process. The average age of an Australian trained doctor undertaking general practice training is 33 years.

Average Age - 2004	
Male	Female
34	31

(Overseas medical graduates undertaking general practice training are, on average, considerably older with an average age of 41 years. This is the consequence not only of formal training requirements but also of issues relating to personal circumstances.)

1.3 State Medical Boards

Recognition as a medical practitioner in Australia is a state function managed by eight separate medical boards, although ‘mutual recognition’ criteria apply across all boards. Recognition as a medical practitioner requires a medical degree from an Australian or NZ medical school and successful completion of one year’s supervised internship. Overseas trained doctors must complete the Australian Medical Council examinations (MCQ and clinical) and satisfactorily complete an internship to achieve recognition.

This submission does not deal in detail with issues associated with Overseas Trained Doctors. To apply for the AGPT, OTDs must be citizens or permanent residents and be fully registered by a state medical board, which means therefore that an entrant from overseas will have successfully completed all components of the AMC examinations.

Recognition as a medical practitioner and the right to practise unsupervised requires only state Medical Board recognition.

1.4 Royal Australian College of General Practitioners

The RACGP was established in 1953. In 1973 the Commonwealth commenced providing funds for a system of organised postgraduate practice-based training managed by the RACGP. An apprenticeship model of training called the Family Medicine Programme (FMP) developed. A history of these training arrangements commissioned by the RACGP makes the following interesting comment:

“From the politicians’ point of view this was not to be a Government funded program to train candidates for the RACGP examination. Presumably the Government had encountered sufficient difficulties with the other clinical colleges to be wary of funding an increase in the membership (and power) of the RACGP. The FMP was to offer (trainees) resources and assistance, without the need to jump through any more hoops. They could register and set up in general practice at the end of their intern year. The FMP did not challenge this. Instead, it provided support for those who believed they would benefit from vocational training.” (Wilde, Sally: “25 Years Under the Microscope: A History of the RACGP Training Program, 1973-1998. RACGP 1998, p12)

Until 1989 those entering general practice did not require any formal specialty recognition. This situation began to change in 1989 and was formalised in 1996. The Commonwealth linked attainment of the FRACGP to the medical insurance arrangements operating as Medicare. From 1989 until 1996 services provided by GPs with the FRACGP (and by GPs in practice before 1989 who could elect

to be ‘grandfathered’) attracted higher Medicare benefits than services provided by ‘new’ GPs without the FRACGP.

In 1996 further legislation tightened the system and new graduates were required to attain the FRACGP prior to recognition under Medicare. The qualification of the RACGP is the only credential currently recognised for general practice ‘vocational registration’. The *Health Insurance Act* does provide for the Minister to place regulations before Parliament to recognise the credentials of other entities.

There is a group of GPs in practice prior to 1996 who opposed this system of ‘vocational registration’ and who chose not to be ‘grandfathered’. These were known until 1996 as Non-VR GPs but are now designated in the Medicare Benefits Schedule as Other Medical Practitioners (OMPs). Services provided by these doctors attract Medicare rebates about 20% lower than services provided by doctors with the FRACGP. A medical practitioner who graduated after 1996 cannot elect to be an ‘OMP’. (Medical graduates with full registration by a state medical board can practise independently but their services would not attract medical benefits under Medicare).

The RACGP does have other avenues for attainment of the FRACGP. There is ‘the practice eligible route’ for established general practitioners and the RACGP participates in an AMC-sponsored system for assessing the general practice qualifications and experience of doctors trained overseas seeking recognition as GPs. There is also a small separately administered Remote Vocational Training Scheme.

Given current public concerns about the training and experience of Overseas Trained Doctors (OTDs) it is worth noting that there are processes allowing OTDs to practise without formal postgraduate training. These ‘area of need’ arrangements are managed by the states and state medical boards. These doctors’ services attract Medicare benefits under ‘area of need’ and ‘area of workforce shortage’ arrangements.

Two important points for the purposes of this submission emerge from the above description. First, GPET provides the only avenue for a new graduate to attain ‘vocational registration’ under the *Health Insurance Act* and therefore, for practical purposes, to practise as a GP in Australia. Second, GPET and RTPs provide the administrative support for doctors working towards attainment of the only recognised credential, the FRACGP.

1.5 Australian College of Rural and Remote Medicine

GPET provides some support for the training requirements of the Australian College of Rural and Remote Medicine (ACRRM). This college was founded in

the 1990s by medical practitioners working in rural and remote areas who believed that the RACGP was not recognising their education needs and was not providing education and training appropriate for rural and remote practice.

The Federal Government has directed its funding for postgraduate training away from the direct subsidy to the RACGP (in place from 1973 until 2001) to the system now administered by GPET partly in response to representations from rural doctors. ACRRM sought a mechanism that would give its members some influence over the direction and content of training for rural practice and some input into decisions about how Commonwealth financial support was spent. GPET and RTPs have ACRRM nominees on their boards.

GPET's contract with the Commonwealth recognises the need for GPET to accommodate ACRRM's training regimen. However, ACRRM's credential (FACRRM) is not presently recognised under the *Health Insurance Act* for the purposes of vocational registration as a general practitioner.

1.6 Commonwealth Involvement in General Practice Education and Training

The discussion at the conclusion of the preceding section is a useful introduction to the inherent tensions within these government funded GP postgraduate training arrangements. The most basic tension is between government workforce policies and education aims.

Direct Commonwealth involvement in Australian general practice began in the 1950s with the Pensioner Medical Scheme, was expanded in 1971 with the 'Gorton' scheme, and extended to 'universal' cover through Medibank in 1975 and Medicare in 1984. Until 1989 significant Commonwealth involvement in general practice was limited to payment of medical insurance benefits and to the subsidisation of postgraduate training through the RACGP Training Program.

In 1991 the Commonwealth, in conjunction with the AMA and the RACGP, published "General Practice: A Strategy for the Nineties and Beyond". This publication heralded more explicit (and continuing) attempts by the Commonwealth to influence aspects of the 'general practice market'. A host of initiatives have been implemented. These include the establishment and funding of 122 divisions of general practice, a system of accreditation of practices (as opposed to individual doctors) and attempts to use the Medicare Benefits Schedule to influence the activities of GPs, for example, by creating subsidies for activities associated with specific illnesses or specific groups such as the elderly. Informal advice is that the Commonwealth Department presently administers 38 programs seeking to shape where and how GPs work.

Of particular relevance to this submission are government workforce policies. Many programs are aimed at controlling the number and distribution of general

practitioners and successive Commonwealth governments have implemented workforce policies through the training arrangements.

In summary, until 1989 attainment of postgraduate qualifications was voluntary and carried no economic benefit beyond those available to any doctor fully registered with a state medical board. Since then the Commonwealth has used Australia's postgraduate GP training infrastructure (that it now funds through GPET and RTPs) as a mechanism to implement a range of workforce policies, particularly since 1996.

1.7 The Establishment of GPET

During the 1990s the Commonwealth implemented several programs that established substantial medical education resources outside traditional urban teaching hospitals including University Departments of Rural Health and Rural Clinical Schools. The Commonwealth also funds the divisions of general practice which are organisations of general practitioners intended to develop local communities of GPs. Significant human and other education resources are now available at the regional level.

The 1998 Report of the Ministerial Review of General Practice Training, *General Practice Education – The Way Forward* (Department of Health and Family Services 1998) recommended a number of fundamental changes to the delivery of federally-funded general practice vocational training which, since 1973, had been delivered by the RACGP.

The most significant of the report's recommendations proposed the "development of local collaborative arrangements, or consortia, in education service delivery", and the setting up of a national body to promote "better coordination at all levels of the general practice training continuum". GPET was established by the Federal Government in 2001 in response to the report.

GPET's brief was to establish arrangements at the regional level that would lead to more effective coordination of educational effort. In doing this GPET has, as far as possible, devolved day-to-day responsibility for organising and managing training to the regional level. RTP boards of management have representation from medical colleges, universities, divisions of general practice, community groups, etc. A more detailed description of GPET and its activities, links to RTPs and descriptions of programs run by GPET can be found at www.agpt.com.au

The policy objectives behind the establishment of GPET reflect the thinking and directions proposed in *The Way Forward*. Some groups, particularly those representing rural doctors, strongly supported and lobbied for the change.

The establishment of GPET and RTPs may be best regarded as a natural evolution. However some organised medical groups have preferred to portray the initiative as a radical decision to 'disempower' a professional college.

For example, in an article "Surgical Training Under Siege" (*Australian Medicine,* December 6, 2004, p 5) the President of the Australian Medical Association (AMA) referred to surgical graduates who might be trained "on the basis of price not quality" and continued: "What GPET has done to GP training, a new SPET would do for surgical training. This could well send surgical training standards spiralling downwards." The AMA did not respond to a letter from GPET inquiring whether the AMA believes the standards of GP training are "spiraling downwards" and if so what was the AMA's evidence.

The Federal Government has recently commissioned independent consultants, ACIL Tasman, to review, against broad terms of reference, the effectiveness of the policy of regionalisation. This review is looking at the overall success and cost-effectiveness of the new arrangements compared with the previous arrangements and at issues such as tendering processes and the cost structure of RTPs. The ACIL Tasman report is not yet available.

GPET has done much more than implement a new way of administering the RACGP-decreed training requirements. GPET and the RTPs provide government, medical colleges and other entities with an infrastructure to implement a wide range of training and workforce initiatives. Some specific initiatives now managed by RTPs outside of 'traditional' vocational training are detailed in Part 2 of this submission.

1.8 The Government-GPET-College Nexus

GPET surmises that the Productivity Commission may consider administrative and governance mechanisms that would accommodate the commitment, professionalism and expertise of medical colleges and other professional groups while fostering education and training arrangements which are adaptable, flexible and responsive to emerging challenges and opportunities.

It has been a significant challenge for GPET to manage the relationship with medical colleges, particularly with the RACGP. The RACGP, and ACRRM, have worked with GPET to implement the new arrangements. Progress has been slower than GPET had planned and some issues remain unresolved. It may be of interest to the Commission for GPET to reflect on issues it has faced in implementing these new arrangements.

Several issues can be defined which may be relevant.

1. The unilateral role of colleges in setting standards for which they have no fiscal responsibility presents a 'business risk' to GPET (and to government). In addition to their relatively narrow educational focus, professional standards may be developed in academic isolation without concern for economic reality, practicability or productivity. The Commonwealth, GPET and the RACGP are currently exploring implementation of its standards in ways that preserve the college's autonomy but nonetheless reflect economic reality and will not require unwarranted additional resources from the Commonwealth.

2. College standards define training requirements around matters such as selection of trainees, requirements for time spent in one-to-one teaching, the resources required in teaching practices etc. A practical issue is the respective roles of the college and GPET/RTPs in the ongoing implementation of college standards. Should a college promulgate standards to be implemented by another entity, in this case GPET and/or the RTPs, or should the college be directly involved in the administration and management of the training arrangements? This issue is complicated. Supervising doctors are formally engaged by an RTP to provide education and supervision. However these doctors also regard themselves as college members engaged in the core college activity of training and education.

Trainees undertake training primarily to attain a college qualification. Any college or other organisation whose training utilises the GPET/RTP infrastructure requires data on matters such as placements of trainees, assessments by trainers, attendance at training events, attainment of competencies etc. A college will need to compile a file on each trainee to inform its overall assessment of trainees as they move through the program.

GPET had surprising difficulty reaching agreement on the implementation of what seemed, at least to GPET, a conceptually simple, efficient, IT based distributed network accessible to and meeting the recording and reporting needs of RTPs, trainers, GPET and colleges. Concerns about 'ownership' of information and the desire for autonomous sources of data had to be resolved. There was a risk inefficient duplication would be imposed. However, these issues are now largely being resolved.

3. A significant factor in this era of open accountability and requirements for valid processes underpinned by adequate administrative arrangements is that without subsidies from GPET or government, the resource requirements to adequately participate in administrative processes may challenge even a larger college such as the RACGP.

For example, GPET manages a selection process for entry into general practice training. This complex administrative arrangement is driven by college standards that require selection to be a national system based on a national order of merit of applicants. Staff employed by GPET promote opportunities and manage the

process. There is a comprehensive and extensive national advertising and marketing program and a complex application process for 600-700 doctors involving liaison with hospitals, medical boards and referees. There is then a process for allocating applicants to particular RTPs for interviews. RTPs have to fund the interview process, etc.

4. GPET is required by the Commonwealth to monitor the quality of training and has developed an innovative Quality Framework and Quality Development process built on a systemic approach to quality. GPET must assess features of the training system about which an academic medical college can claim no special expertise such as governance, management and business improvement. GPET has had some challenges in getting agreement on the role of colleges in the implementation of this process and in incorporating that role within GPET's broader responsibilities.

GPET seeks to focus on all of the major elements within the system of postgraduate training for GPs in Australia. While this involves a central focus on the training experiences of GP registrars and those who work closely with them (e.g., supervisors, mentors and medical educators), GPET's interests in quality necessarily include the performance of training providers, integration of professional and other standards, policy outcomes for the wider community and GPET's own performance in managing its responsibilities.

In addition to adopting a systemic perspective, GPET interprets the term 'quality' to embrace a variety of concepts including:
• compliance (e.g., with standards, contracts)
• assurance (e.g., to external stakeholders)
• organisational performance (e.g., against specific quality objectives)
• capability of business processes (e.g., cycle times, error rates, amount of rework)
• performance of management systems (e.g., clarity of directions, achievement of objectives)
• continuous improvement and innovation (e.g., integrated improvement cycles, realisation of planned improvements)
• client and stakeholder focus (e.g., needs understood, satisfaction, policy outcomes).

While delivering high quality vocational education and training through Australian General Practice Training (AGPT) is of paramount importance, the objectives of the regionalised system of training are far broader. The Commonwealth requires GPET to ensure that GP education is responsive to the existing and developing needs of local communities and groups within those communities. GPET is also required to foster integration of general practice education at the regional level; that is, to establish links between medical school, postgraduate and continuing education activities and other health education activities.

A major and exciting challenge for GPET and Regional Training Providers is to ensure that these broader outcomes for regionalisation over and above the delivery of quality training are being met. Attached is an important GPET document 'Outcomes for Regionalisation: Regional Training Provider Objectives' (March 2005). See Attachment 3.

The GPET-College-Government nexus has been described in some detail. An important issue is that RTPs undertake functions beyond supporting medical vocational training. The process of assessing the development, management, monitoring and improvement of the regionalised network requires skills, expertise and processes that are not necessarily within the core business of medical colleges, which is primarily around educational standards. Convincing the colleges of the importance of taking a broad systemic view of the quality and performance of the regionalised system without appearing to belittle the importance of the colleges' standards has been a challenge.

The more general issue is the role of autonomous medical colleges in the current environment. Such organisations have long had a 'bad press'. George Bernard Shaw in The Doctors Dilemma spoke of the medical profession as "a conspiracy against the public". Modern commentators, adopting perspectives from economics or the social sciences, may seem, at least to the medical profession, to be promulgating hostile views. These writers might respond that this is nothing sinister and just the consequence of viewing the world from particular intellectual perspectives. A leading American health policy analyst recently wrote:

"What undergirds faith in our individual physicians thus empowers them collectively in issues that are far removed from explicit medical practice such as taxation, allocative fairness, public administration, and political accountability - issues on which other legitimate interests and the population as a whole may in fact have quite different positions than those promulgated by medical practitioners themselves". (Petersen, Mark. 'From Trust to Political Power: Interest Groups, Public Choice, and Health Care', in JHPPL, Vol 26, No. 5 October 2001. p1148.)

Bringing together in a workable system the skills, experience and commitment of colleges within a new administrative and regulatory system has been a major challenge for GPET.

1.9 Summary of Part 1

Part 1 of this submission has discussed the establishment of GPET, focusing on the regulatory environment that underpins general practice in Australia and how the education framework prepares doctors to practice under that environment.

GPET has reflected in this submission on its experiences on the assumption that these reflections may be of some value to the Commission.

2. PART 2 PROPOSALS FOR CONSIDERATION

The Commission will present a Draft Report in October 2005 which will become the basis of further consultation.

GPET considers that at this stage it is more useful to provide the Commission with proposals for consideration and discussion rather than formal recommendations presented as fixed views. Some of the proposals put by GPET might be seen as controversial and the consultation phase following release of the Commission's Draft Report provides an opportunity for wider input. GPET is available for discussion with the Commission and looks forward to participating in consultation processes the Commission establishes after the release of its Draft Report.

Part 4 of the Commission's Issues Paper suggests "the most fundamental requirement" is the creation of "incentives and supporting institutional, funding and regulatory arrangements that encourage all parties to work efficiently, effectively and cooperatively" while also promoting "a system that can 'self-adjust' to changing needs". The proposals below reflect this challenge.

In developing these proposals GPET has not simply accepted that it is a part of, and hemmed in by, a complex policy, regulatory and rules driven framework with limited scope to respond creatively to the environment in which it operates. Such a perspective would preclude GPET from suggesting significant changes.

Some of the proposals below are "within the square" and would not substantially disrupt or intrude on roles and responsibilities of other organisations but might see GPET establish positions on issues where it is now effectively beholden to other organisations. GPET might, for example, seek advice from independent education experts on aspects of standards, training arrangements, resource requirements for adequate training and assessment methods with a view to then enacting changes that might alter established ways of doing things.

Really significant change to the length, nature or content of training for general practice could only be implemented by processes that take account of the roles and contributions of all relevant organisations involved in the training and education of GPs from beginning medical student to established general practitioner. Therefore some of the proposals below are 'outside the square' and go to fundamental issues around the organisation and delivery of GP training. These may be more controversial and threatening to established arrangements. However this inquiry provides a rare opportunity to consider basic issues.

An observer considering Australia's medical training arrangements for the first time and, reflecting on the data provided above on the ages of those *beginning*

formal GP training, might conclude that the process from someone leaving school to becoming a GP is extraordinarily protracted.

The proposals below are presented under the following headings which reflect concepts in Part 3 of the Commission's Issues Paper, 'What Underlies These Problems?'

1. Governance arrangements
2. Recognition as a general practitioner
3. Integration of training efforts with community needs
4. Fragmented roles and responsibilities and regulatory arrangements.
5. Meeting equity and access objectives in a fiscally responsible manner.
6. Short term versus long term
7. Shortcomings in workforce planning
8. Inflexible regulatory arrangements.
9. Roles of Colleges

2.1. Governance Arrangements

The GPET establishment phase is now complete. GPET believes it can now purposefully and successfully fulfil the original vision for the company. Delivery of outcomes would be facilitated if the company was able to operate in an environment where, within broadly defined agreed aims, GPET had more autonomy and flexibility. GPET would, under such an arrangement, be able to focus on delivering longer term outcomes.

GPET's company objectives include ensuring "that vocational training is well structured and produces doctors who are capable of meeting community needs in particular those of rural and remote Australia". The company objects also require GPET to "provide advice to the Minister for Health and Aged Care regarding undergraduate and postgraduate training issues".

GPET could better fulfil these responsibilities if it was able to focus on developing and implementing strategic priorities over an extended timeframe. While GPET has achieved much in a short time, realisation of its potential has been hampered by ongoing lobbying and political interference, particularly by groups possibly motivated more by vested interests than support for the regionalised system.

2.2. Recognition as a General Practitioner

GPET strongly supports, as a basic principle, the requirement that a medical graduate undertake a systematic program of education prior to entering unsupervised general practice. It is not an option to trade off quality for quantity. Australians expect their family doctors to be trained to high standards. With

growing wealth people have high expectations, medicine becomes more complex and doctors work in a fraught legal environment. Changes to training arrangements should be in the context of a commitment to standards.

Advantages may accrue if there were other avenues for obtaining recognition as a general practitioner, in particular other entities awarding credentials that lead to recognition under the *Health Insurance Act*.

The introduction of other options might motivate credentialing organisations to introduce more flexibility and more varied training options through competition to provide training arrangements attractive to potential enrolees.

2.3. Integration of Training Efforts with Community Needs

GPET proposes that the Commission note that GPET and the regional infrastructure it has established provide an adaptable and flexible network and support use of this infrastructure wherever relevant so that educational effort is consolidated. This would counter a tendency of governments and other organisations to keep adding discrete programs to what is a fragmented and confusing landscape.

With the establishment of GPET and the RTPs, for the first time an infrastructure is available to deliver and administer medical educational initiatives in the community setting. This concept was central in the 1998 report on general practice training, *The Way Forward,* which led to the establishment of GPET. That report argued educational resources should be used flexibly in the interests of efficiency and coordination, using the terms *vertical integration* and *horizontal integration*. The Commission requests advice and suggestions on "coordination/linkages with other medical training" and "coordination with training for other disciplines".

Many RTPs are now involved in programs that address local needs outside the formal AGPT vocational training program. See Attachment 3.

As part of its Quality Development processes GPET will soon require RTPs to demonstrate they are meeting community needs.

Perhaps the concept is best illustrated by the examples listed below:

a) The NSW government utilises the rural RTPs network to implement an innovative program of training in procedural medicine (in anaesthetics, obstetrics, etc) for rural general practitioners.

b) In April 2005, there were 2,447 overseas trained doctors across Australia with restricted access to Medicare, allowing them to work in areas of workforce

shortage. (DOHA submission to Productivity Commission, May 2005). Many of these doctors are practising autonomously without specific training in general practice. GPET is finalising an arrangement whereby the Commonwealth will fund education support for such doctors in rural and regional areas, using RTP infrastructure.

c) Some RTPs coordinate general practice placements for medical students and are involved in the administration of other Commonwealth programs which support medical students interested in rural medicine such as the John Flynn Scholarships and the Rural Undergraduate Scholarship Scheme.

d) A large urban RTP has developed a successful re-entry program for GPs who have been out of the workforce.

e) Some RTPs are working with medical schools so that postgraduate GP trainees can be formally involved in the teaching of undergraduates undertaking GP terms.

f) RTPs are involved in administering the Government's Prevocational General Practice Placements Program. This is an innovative program, undertaken in cooperation with public hospitals, which provides new medical graduates with an opportunity to experience the GP environment.

g) One RTP has developed certificate and diploma courses for practice managers.

Other programs could be developed:

a) An urgent issue is the probable shortfall of recruits for general practice through the traditional entry route in the next few years given the GP trainee intakes AMWAC will recommend. GPET intends to explore what needs to change so that attractive programs can be developed for retired medical graduates or those in other careers. Such programs might run for a limited period until medical school outputs increase later this decade.

b) More initiatives may be needed to ensure doctors recruited from other countries are adequately trained before entering unsupervised practice. The community may demand this, through its political representatives, following revelations such as the Bundaberg Hospital mishaps.

These are examples of integrating the GP training infrastructure with other needs and using the training infrastructure in flexible and responsive ways.

2.4. Fragmented Roles and Responsibilities and Regulatory Arrangements

The scope for reducing the length of medical training while maintaining quality could be explored by the Commission. Concepts include provision for some medical students to begin to specialise in their undergraduate years combined - for general practice - with enhanced undergraduate training opportunities in community settings.

The complex process for training future GPs in Australia has been discussed in Part 1 of this submission. Significant change would impact on organisations beyond GPET. Many organisations determine aspects of training including universities, public hospitals, postgraduate medical councils, GPET and RTPs and colleges.

Attempts to significantly alter this pathway within the existing multitude of governance frameworks and vested interests would probably see an endless round of meetings and negotiation, countless discussion papers and few outcomes.

As a start the Commission may wish to consider the large number of separate entities funded by government and which impact on the GP workforce.

For significant change an appropriately empowered overarching body may be required.

2.5. Meeting Equity and Access Objectives in a Fiscally Responsible Manner

a) GPET believes there could be better targeting and coordination of existing incentive programs. The Commonwealth influences the distribution of GP training places. Trainees increase the number of doctors in undersupplied areas and exposure to rural practice may entice some trainees to remain in rural areas.

'Sticks and carrots' increase the amount of training undertaken in rural and regional areas. Training places in popular urban areas are restricted and the system is structured so that many training places are in less popular rural areas.

The Federal Government pays incentives, $60,000 over the three years of training, to trainees in rural locations. GPET believes that this money could be utilised more effectively by better aligning incentives with the degree of lifestyle and other disadvantage and by amendments to the administrative classification (RRMA) by which locations are deemed eligible. GPET is coordinating a working party developing proposals around these issues.

Explicit support from the Commission for a more flexible, rational and targeted system of financial incentives, administered at the RTP level, for trainees willing to spend at least some of their training time in rural areas may expedite changes.

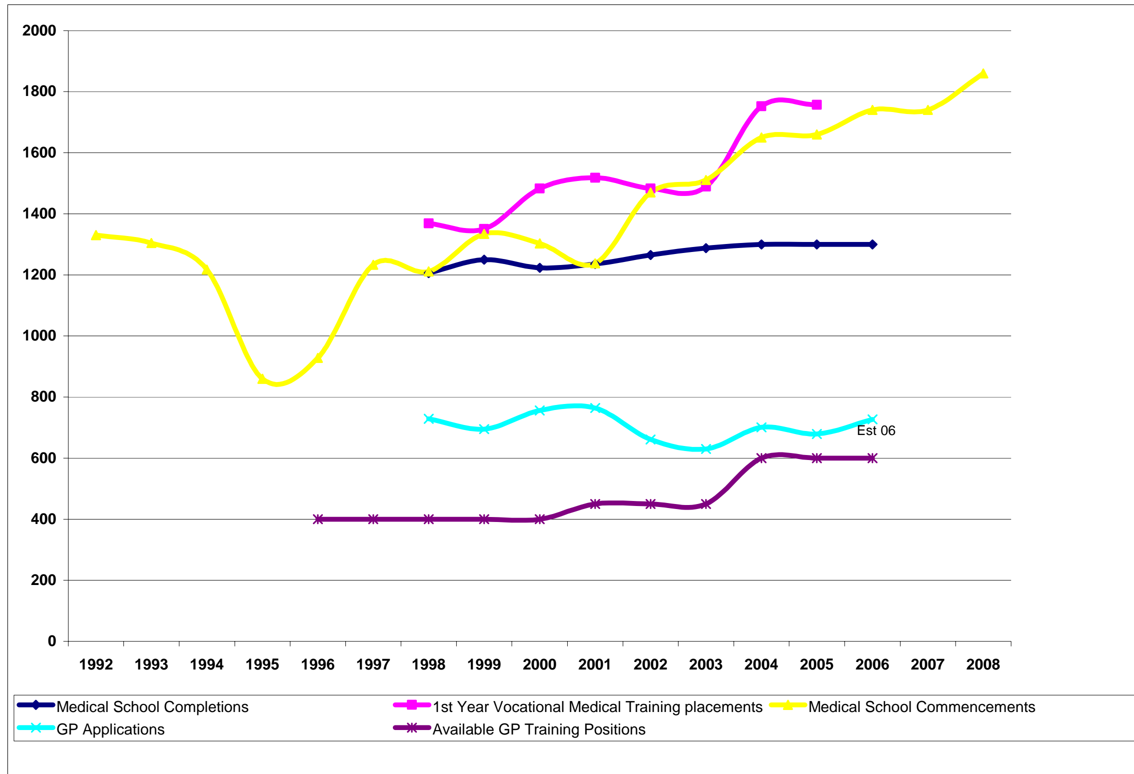
2.6. Short Term Versus Long Term

Since the mid-1990s the Commonwealth has implemented GP workforce policies through the GP postgraduate training arrangements. This coincided with a period when views on the 'correct' number of GPs kept changing.

In the mid-1990s AMWAC determined that an oversupply was emerging. In 1996 the Commonwealth, on advice from AMWAC, limited the total number of doctors entering general practice training to 400. In 2000 AMWAC recommended an increase to 450 places. In 2003 this was raised to 600 places. The recent AMWAC study into Australia's need for general practice training suggests a large expansion in GP training places, maybe to around 1000 per annum. (AMWAC GP reports of 1996, 2000 and 2005)

In the past few years general practice has attracted insufficient applicants to fill 600 training places. It will be difficult to achieve the revised recommended intakes, at least until the total number of medical graduates begins to increase later this decade following recent increases in numbers of medical students and medical schools.

At the same time as the number of GP training places were being increased, training places in other disciplines were greatly increased. The reality is that because of long time-lags there is now a major gap, with medical school output far short of the number of training places in all medical disciplines.



Source: AMWAC & GPET

GPET raises this issue not to put forward an explicit proposal but to highlight the complexity of the situation. GPET believes that too much reliance on 'getting the numbers right' is unwise. While some reliance must be put on best attempts to determine 'traditional' entry numbers, emphasis must also be put on ensuring the system of training can adapt quickly to exigencies. As mentioned above, there needs to be urgent consideration of possibilities beyond the 'traditional' training route.

2.7. Shortcomings in Workforce Planning

GPET does not wish to comment in detail or make proposals on technical issues associated with medical workforce planning. GPET must adjust to the demands placed upon it by those charged with making decisions. The uncertainties pervading workforce projections again highlight the need for flexible training arrangements that can respond to changing demands unimpeded by unnecessarily restrictive rules or traditions.

There are, however, some broader issues driven by features of the overall health system which have implications for the structure of the GP workforce and the nature of general practice education. These are presented here as issues for possible discussion with the Commission.

a) In the main, health workforce planning in Australia analyses and makes recommendations about individual specialties. There has been little attempt to develop processes that look at the needs of all professions required to deliver specific health services.

For example, there has been little consideration in Australia of the relationship, from a medical workforce perspective, between requirements for general practitioners and requirements for specialists. AMWAC considers each specialty, including general practice, quite separately. While the case could be overstated, there are significant interdependencies.

There has been debate for years around the future role of general practitioners. A 'downmarket' scenario sees GPs marginalised, specialists undertaking most procedures and the management of serious disease, with GPs left to manage minor matters in competition with other 'health providers'. An 'upmarket' scenario sees GPs adopting some technologies presently monopolised by specialists and managing the more common serious conditions. Another scenario proposes a new model of general practice with GPs part of multidisciplinary teams.

Powell-Davies and Fry, in a recent survey titled 'General Practice and the Health System' offer another perspective and describe "two conflicting perceptions of general practice". These are "a service that is largely autonomous and stands apart from the wider health system" and "a service that is essentially the 'front end' of the health system and that depends heavily on its relationships with other service providers to carry out its role of providing, coordinating and mediating care". (Powell-Davies and Fry, 'General Practice in the Health System' in General Practice in Australia 2004, p422. DOHA 2005)

b) The workforce consequences of medical care financing in Australia support a sceptical view of workforce planning undertaken in isolation from other policy considerations. MBS underpinning of GP services is organised so that GPs can practise and work where they like, for how long they like and to a large extent to do what they like. Major financing initiatives such as the recent substantial increases in MBS rebates might have exacerbated maldistribution, all other things being equal, if some GPs had been under pressure to at least consider relocation to less attractive areas.

c) The demand for GP services and therefore for GPs is driven by a wide range of factors including financing arrangements. For example, there is a growing realisation among general practitioners, particularly in urban areas, that it is 'safer' from a legal perspective, and often more lucrative, to restrict their scope of practice to 'niche' areas, for example sports medicine or the treatment of skin lesions. The current financing underpinning of general practice through the MBS does nothing to counter, and to some extent facilitates, such developments.

d) The current boom in private specialist procedural work, driven by ever-expanding technical possibilities and riding on government subsidies to the private health insurance industry, is mentioned only to note the workforce implications for general practice. The recent large growth in specialist training posts complicate the task of attracting graduates to general practice given the benefits attaching to a specialist career. General Practice in Australia:2004 has data (p62) indicating that in 1984-85 "GPs and specialists received incomes that were 4.64 and 6.31 times Average Yearly Earnings" and that by 2001-2002 "GPs' gross fee income had declined to 4.11 times AYE and specialists incomes had risen to 7.55 times AYE".

e) The situation is not as complex as in the USA but similar workforce issues can be identified. A recent US review concludes "what is meant by a physician surplus, or, for that matter, a physician shortage is a problematic technical problem that leads inexorably to a political exercise.

"In recent years there has been a remarkable turnabout in medical opinion that a surplus exists to one that emphasises a shortage…..That such arguments can be made in view of the ever-increasing number of physicians is testimony to the continued ability of medicine to define terms of debate …. (this) ….reveals a deeper capacity of the U.S. health care system to absorb resources in a way that befuddles efforts to engineer control of system growth and pricing of services.

"Can it be that the US system of financing, reimbursing, and organising medical services is so fragmented and so uncontrolled by any overriding authority that the capacity of medicine to grow….is quite profound……In the context of a larger and larger share of national resources devoted to health care, it may well follow that medicine will expand relatively unimpeded, and perhaps in new forms, in association with this economic trend, regardless of the desirability of such growth, forever accompanied by debate about whether there are too many or too few physicians." (Stephen Mick 'The Physician "Surplus" and the Decline of Professional Dominance', Journal of Health Politics, Policy and Law, Vol. 29, No 4, August-October 2004, p908-909 and p919)

A sceptic might suggest that in its examination of "shortcomings in workforce planning" the Commission might accept that attempts at formal medical workforce planning that ignore interdependencies are doomed to failure.

2.8. Inflexible Regulatory Arrangements

Reliance on the traditional apprenticeship model of medical education puts great demands on GP education and training capacity. GPET regularly hears from RTPs that the training capacity of the Australian general practice network is now stretched. The numbers in postgraduate training through GPET are expanding at

the same time that medical schools are seeking to provide medical students with more exposure to general practice.

GPET is not arguing against the apprenticeship model. However, this 'traditional' arrangement does not necessarily facilitate exposure to interdisciplinary, team-based work. Many illnesses burdening Australia's ageing population, particularly chronic diseases, need to be addressed by more than one discipline with cooperation among a team – doctors, nurses, physiotherapists, etc. Much medical education occurs in acute care settings but increasingly the system must focus on chronic conditions managed by such multidisciplinary teams in community settings.

The Commission could consider policies to facilitate developments which would see more training occurring in chronic care settings. As well as meeting a need this would ease the pressures on teaching general practices. The scope for facilitating joint training of health disciplines could also be explored.

2.9. Roles of Colleges

This last section of the GPET submission offers some observations and some tentative proposals, for discussion, relevant to difficult issues around maintaining professional prerogatives in an environment where many are suggesting radical changes to Australia's health education and workforce arrangements.

The training and education arrangements GPET administers depend on the professional dedication of many hundreds of Australian general practitioners who elect for altruistic reasons to be involved in training and to develop expertise in education. Many doctors regard such activity as a critical component of a professional career.

This commitment reflects traditions and arrangements that have evolved over centuries. The recent Royal Australasian College of Surgeons submissions to the ACCC stress the voluntary contributions made by college members. Similar arguments could be made for general practice, with college members giving their services across a wide spectrum of training and assessment activities.

Australia's general practice training arrangements are dependent on the goodwill of general practitioners in even more fundamental ways. Training occurs largely in private practices with GPs not only providing physical facilities but also accepting the challenges (and risks) associated with taking inexperienced new graduates into their practices and supervising their activities.

General practitioners and doctors in all medical disciplines will continue to look to their professional colleges to guide their involvement in education through the

definition of standards, the provision of advice and support and through educational activities.

In Part 1 of this submission there is discussion of the challenges faced and successes achieved by GPET in developing a new framework within which it could implement its policy and governance imperatives and within which colleges, particularly the RACGP, could be confident college interests and autonomy were preserved and training requirements met.

It is interesting that a recent article suggests "the Australian postgraduate medical training sector has developed in an implicit and fragmented way, with limited collaboration and coordination between relevant groups…..and the entire system is devoid of coordinated governance…This makes it difficult for the system to adapt to the demands of an ever-changing healthcare system".

This article is written from the perspective of specialist training and the authors conclude by recommending "it is time to review the oversight and governance of postgraduate medical education and training at a state and national level to ensure its vitality and durability". (Dowton et al, "Postgraduate medical education: rethinking and integrating a complex landscape. Medical Journal of Australia, Volume 182 Number 4, 21 February 2005, p177-180)

Surprisingly there is no reference to the changes in general practice training which the GPET initiative represents. The arrangements GPET has implemented resemble the "practical aspects of managing training" the authors believe should be under consideration.

For example, the authors see a need for "reliable information management systems that link education and training with workforce planning"; "development of shared curricular expertise and systems across disciplines and especially between colleges and universities"; "system-wide standards for hospitals and community healthcare delivery settings for supervision, educational infrastructure, service/training balance, support for clinicians as teachers, as well as mechanisms for monitoring, evaluating and providing feedback"; "particular attention to the needs of rural, regional and outer metropolitan areas in major capital cities"; and "further development of integrated education and training networks". Effective leadership, the authors suggest will require "greater clarity and transparency of roles and relationships between key stakeholders", "strong local management of training", "improved coordination of and accountability for training at several levels" and "a satisfactory balance between training and clinical service".

If the Commission accepts that some major initiative is justified it might consider proposing the creation of an entity to facilitate more formal sharing of resources, expertise and experience among medical colleges. Such an entity might counter a tendency to balkanisation among colleges and facilitate attainment of outcomes

consistent with those raised by the Commission such as more flexible training arrangements, ‘mutual recognition’ of prior experience, sharing of courses, facilitation of career changes and career development, and sharing of resources.

Such an entity may assist colleges to present a robust intellectual defence of their position, privileges and responsibilities including clarifying for the broader medical profession and for the community how they are adapting their processes to reflect technical developments and developments in education and governance.

A more radical proposal might see the establishment of a coordinating body empowered to manage aspects of postgraduate training beyond the coordination and sharing of resources among colleges. Such a body could be vested with responsibilities around more ‘political’ issues such as assessing overseas qualifications, recognising ‘completion of training’, distribution of training places, distribution of funds, etc. This could see an entity somewhat akin to the recently established Postgraduate Medical Education Training Board (PMETB) in the UK. A proposal for a similar body in Australia would be contentious and implementation would require a balance between the need to consult widely and the imperative to act decisively.

No such entity exists in Australia nor do any existing bodies appear to be appropriately constituted to perform the task and gain the support of stakeholders. How such a structure might be achieved in the Australian context, with fragmented responsibilities across federal and state governments, universities and professional bodies is a challenge the Commission might consider.

3. SUMMARY

> "Reshaping the health manpower complex so that it is responsive to the nation's requirements…becomes lost in the mad scramble of institutions and professional groups to perpetuate themselves and in excessive preoccupations with input rather than output, and with the efficiency of component parts rather than the effectiveness of the whole". (David Tejada-De-Rivero in *Health Manpower Planning*, WHO, Geneva, 1978, p6.)

GPET has attempted in this submission to describe aspects of its history and operations and to put these into a context congruent with issues and perspectives raised by the Commission in its recent Issues Paper. It is a complicated and sometimes fraught environment. GPET does not claim to have immediate, straightforward answers to the challenges before the Commission. However GPET has made proposals for change which it believes are consistent with the Commission's aims. GPET is available to discuss these proposals with the Commission.

Attachment 1

Productivity Commission Health Workforce Study – Terms of Reference

1. Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention, including:
   a) the effectiveness of relevant government programmes and linkages between health service planning and health workforce planning;
   b) the extent to which there is cohesion and there are common goals across organisations and sectors in relation to health workforce education and training, and appropriate accountability frameworks;
   c) the supply, attractiveness and effectiveness of workforce preparation through VET, undergraduate and postgraduate education and curriculum, including clinical training, and the impact of this preparation on workforce supply;
   d) workforce participation, including access to the professions, net returns to individuals, professional mobility, occupational re-entry, and skills portability and recognition;
   e) workforce satisfaction, including occupational attractiveness, workplace pressure, practices and hours of work; and
   f) the productivity of the health workforce and the scope for productivity enhancements.

2. Consider the structure and distribution of the health workforce and its consequential efficiency and effectiveness, including:
   a) workforce structure, skills mix and responsibilities, including evolving health workforce roles and redesign, and the flexibility, capacity, efficiency and effectiveness of the health workforce to address current and emerging health needs, including indigenous health;
   b) analysis of data on current expenditure and supply of clinical and non-clinical health workers, including the development of benchmarks against which to measure future workforce trends and expenditure; and
   c) the distribution of the health workforce, including the specific health workforce needs of rural, remote and outer metropolitan areas and across the public and private sectors.

3. Consider the factors affecting demand for services provided by health workforce professionals, including:
   a) distribution of the population and demographic trends, including that of indigenous Australians;
   b) likely future pattern of demand for services, including the impact of technology on diagnostic and health services; and

c) relationship between local and international supply of the health workforce.

4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term, including:

a) practical, financially-responsible sectoral (health, and education and training) and regulatory measures to improve recruitment, retention and skills-mix within the next ten years; and
b) ongoing data needs to provide for future workforce planning, including measures to improve the transparency and reliability of data on health workforce expenditure and participation, and its composite parts.
c) In doing so, the paper should take into account existing Australian research and overseas developments that have demonstrated success in providing a flexible response to emerging trends.

5. Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.

6. Consult widely, including with peak industry, representative and community organisations, and relevant government agencies and public authorities.

7. The Commission is to produce an issues paper by 31 May 2005, provide a draft report, and produce a final report by 28 February 2006.

Attachment 2

GPET Company Objects

The formal objects of the Company are to:

- ensure high quality general practice education and vocational training across Australia that is responsive to the existing and changing needs of the community and individual sections of the community;

- promote Australia as a world leader in establishing innovative and effective mechanisms for general practice education and training;

- work closely with the medical profession to ensure that all GP education and vocational training continues to meet the standards which are set by the profession's relevant colleges;

- establish a national framework for regionalisation and contestability of vocational training for general practitioners, including the funding and allocation of places, and monitor progress with implementation;

- ensure value for money in the provision of vocational training;

- ensure that vocational training is well structured and produces doctors that are capable of meeting community needs, in particular those of rural and remote Australia;

- promote vertical and horizontal integration of education and training at a regional level;

- establish a national framework for the evaluation of general practice education and training outcomes; and

provide advice to the Minister for Health and Aged Care regarding undergraduate and postgraduate training issues.

Attachment 3

RTP Objectives: Outcomes of Regionalisation

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Outcomes for Regionalisation: Regional Training Provider Objectives

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Acknowledgments:

Input from RTPs, both collectively and individually, and from GPET staff in preparation of this document is gratefully acknowledged. All suggestions have been considered and the majority have been incorporated.

Introduction

GPET was established by the Commonwealth Government in 2001 to oversee and support a system of high quality regionalised general practice education and training throughout Australia. GPET works closely with the medical profession to ensure that GP vocational training meets the standards set by the profession's relevant colleges.

While delivering high quality vocational education and training through Australian General Practice Training (AGPT) is of paramount importance, the policy objectives of the regionalised system of training are far broader than training delivery alone. The Commonwealth requires GPET to ensure that GP education is responsive to the existing and developing needs of local communities and groups within those communities. GPET is also required to foster integration of general practice education at the regional level; that is, to establish links between medical school, postgraduate and continuing education activities and other health education activities. In addition GPET aims to position Australia as a leader in establishing innovative and effective mechanisms for general practice education.

A major and exciting challenge for GPET and Regional Training Providers (RTPs) is to ensure that the broader outcomes for regionalisation over and above the delivery of quality training are being met. GPET has an important part to play in providing national leadership and in reporting on system-wide achievements, but the broad objectives of regionalisation will only be achieved through the activities of RTPs at the regional level. This document provides guidance to RTPs on their role in the achievement of those objectives. GPET's overarching role in supporting and reporting on the outcomes of regionalisation at a national level is dealt with separately elsewhere.

In considering the nature and scope of the outcomes for regionalisation of GP education and training, GPET has defined ten broad outcomes that encompass the aims of regionalisation. There may be some overlap among the ten outcomes, reflecting some overlap in underlying policy drivers. GPET has developed 'signs of success' as indicators of whether RTPs are working towards these outcomes at a regional level. These 'signs of success' are not mandated; rather they are intended to guide RTPs in choosing indicators of success that could be used for planning and monitoring progress at the regional level. They are also meant to be considered in the context of regional needs and capacities.

The currently agreed broad objectives, which are subject to refinement as the work proceeds, are:

1. High quality education and training for general practice
2. Regionally managed training that is responsive to and meets community needs
3. Access to GP services
4. Integration of regional educational programs and resources
5. Improved training and services in Aboriginal and Torres Strait Islander health
6. Innovation in vocational education and training

7. Promotion of Australian general practice education and training
8. Increased research opportunities in general practice
9. Contestable provision of regional vocational training
10. Value for money in regionalised training delivery.

This paper discusses each of these objectives and includes 'signs of success' related to each objective. GPET intends to refine these aims and signs of success, and after discussion with interested parties, particularly regional training providers, to incorporate them into the GPET Quality Framework. Some aspects will be incorporated as requirements into GPET/RTP contracts to clarify the relative roles and responsibilities of GPET and the independent RTPs with which it contracts for AGPT.

1. High Quality Education and Training for General Practice

RTPs contribute to the continuum of professional education undertaken by general practitioners by preparing registrars for general practice and/or rural and remote medicine through the regional implementation of Australian General Practice Training.

In order to produce competent and confident practitioners able to practice in a variety of settings, including rural and remote areas, RTPs are expected to:

- deliver training and education programs based on the RACGP curriculum and, where relevant, the ACRRM curriculum as well
- facilitate the integration of experiential learning, curricula objectives and eligibility for vocational registration and college fellowship by translating the curricula to match the registrar's future professional role
- ensure that registrars have access to high quality teaching, training and support networks that offer learning experiences that develop the appropriate skills and attitudes required for the professional practise of medicine, and
- provide a regionally managed vocational training program that draws on local expertise and resources, is responsive to and proactive on local workforce issues, health needs, cultural and social differences, and the national policy goals of regionalised training and other national policy goals (e.g. national health priorities) as relevant.

Signs of success could include:

1. RTPs demonstrate value added education and training programs that, as a minimum, comply with the vocational training standards of the RACGP and show evidence of adaptation to the regional context.
2. the RTP has processes in place to ensure its approach to educational delivery is reviewed regularly and embraces new approaches and understandings that promote excellence in educational delivery
3. the RTP is able to articulate the indicators used to assess the quality of its educational program

4. demonstrated high satisfaction levels with the training experience, taking into account regulatory and other factors beyond the control of the RTP
5. the RTP uses regionally-based networks to develop a range of high-quality training practices and to address local workforce needs and policy priorities in educational planning
6. the RTP gains and retains accreditation for delivery of AGPT from GPET
7. the RTP works consistently to develop the quality of its management and program delivery
8. the RTP, through its governance and planning processes, actively works to implement GPET's policy frameworks for Aboriginal and Torres Strait Islander Health Training, Quality Development, Vertical Integration and Enhanced Rural Training.
9. The RTP's educational success and contributions to the quality of AGPT are acknowledged nationally and/or by other providers.

2. Regionally Managed Training that is Responsive to and Meets Community Needs

GPET and the RTPs aim to establish and implement responsive, innovative and integrated general practice education which meets the differing needs of communities, individuals and general practitioners across Australia. It is important that RTPs have in place structures and processes to facilitate the achievement of these aims.

RTPs may work with regional stakeholders and/or attract other resources outside of the GPET contract to meet particular regional needs or develop synergies with their endeavours in GP training.

Signs of success could include:

1. Corporate structure, board membership and/or related structures to enable local responsiveness that may include:
   a. locally based representation by general practice stakeholders/organisations including divisions, RACGP and ACRRM where appropriate
   b. representation from other local organisations involved with general practice education such as universities, state health authorities, etc
   c. representation from community organisations and indigenous groups
   d. a board structure with appropriate access to expertise in undertaking its governance role.

2. The RTP Board's focus on regionalisation, such as evidence that the Board:
   a. has defined and continues to define specific local policy aims to guide attainment of outcomes for regionalisation within the RTP region
   b. has processes for assessing local health needs and resources to assess and agree upon how educational objectives can be met within the region

c. monitors the implementation and progress of aims
d. ensures there are strategies for local implementation of the board-endorsed policy aims.

3. The program includes opportunities for registrars to engage with and learn about local health service providers relevant to general practice including for example:
   a. local allied health providers
   b. aged care arrangements
   c. ambulance services
   d. Aboriginal medical services, etc..

4. The program ensures registrars have opportunities to engage with other relevant local health and medical education activities through involvement with, for example:
   a. divisions of general practice
   b. local undergraduate teaching activities
   c. educational activities of other health disciplines.

3. Access to GP Services

The Australian General Practice Training Program was established to provide educational and organisational infrastructure to support local general practice services that meet the needs of the Australian community. Increasing access to and supply of general practice services is a key result of the Australian General Practice Training program. AGPT is the primary entry point for a career in General Practice in Australia. The training program experience is a significant determinant for GP registrars regarding their continued career in General Practice. The GPET constitution notes that the training program must "ensure that Vocational Training is well structured and produces doctors who are capable of meeting community need, in particular those in rural and remote Australia". Further, the Department of Health and Ageing-GPET agreement states: "Allocation of training places for Registrars…..must take into account the Government objective of increasing supply of medical services and practitioners to regional Australia".

In practical terms the Australian community expects that: GPs are trained to provide high quality care; that more GPs are based in rural, remote and outer metropolitan regions; and that GPs are equipped to meet the evolving needs of Australians including, where appropriate, training in procedural skills. To meet these key policy outcomes, RTPs should implement management strategies which result in increased access to and supply of GP registrar services in identified areas of need within the region. These areas of need would usually be identified by the RTP and/or the regional community. In some cases they might be formally designated by the Commonwealth. For the duration of the training time for any cohort of registrars, an area of need is defined by the RTP

While it is acknowledged that factors beyond the control of the RTP (including government policy) will affect the decisions of GPs to come to and/or remain in a particular area at the conclusion of their training, the RTP has considerable opportunity

to consider the distribution of registrars and access to their services in areas of need during training. In addition, the quality of registrars' overall experiences in the region is likely to be a factor in retention and will contribute to the reputation of the RTP in attracting future registrars to the area, potentially enhancing access to registrars' services in the region. Balancing the concept of improved access to services in areas of need with maintenance of quality training in a complex policy environment represents a critical management challenge for RTPs that is of considerable importance to their sustainability.

Whether or not the RTP is able to influence GP attraction/retention in the region, it is acknowledged that the main immediate avenue available to RTPs for addressing service need is the distribution of registrars and training practices. In some areas a "traditional" model of training delivery may, *prima facie,* seem unworkable. Nonetheless RTPs are urged to contemplate alternative models of delivery as part of their regional responsiveness, including exploring possible variations to traditional models with the professional colleges and/or considering distance education programs or other opportunities where relevant.

Signs of success could include:

1. evidence that the RTP works towards the retention of GPs and the development of training capacity in areas of need
2. awareness of the nature and location of areas of need within the region
3. placement allocations within the RTP maximise access to GP registrar services within identified areas of need.
4. implementation of management strategies to deliver quality training opportunities within areas of need within the training program and business requirements
5. working towards the retention of GP registrars in identified areas of need following the completion of the training program.
6. improved levels of access to high quality general practice training opportunities in identified areas of need.
7. within budget parameters, the implementation of incentives and systems to ensure continuing access to quality training practices and a positive training experience for GP registrars.
8. increased procedural skills training in areas such as anaesthetics, surgery and obstetrics or other areas of need as relevant to the region's existing or emerging needs.

4. Integration of Regional Educational Programs and Resources

Education for general practitioners commences with general medical education, proceeds through the hospital intern years and vocational training and continues with ongoing professional development and further postgraduate education. Separate and disaggregated systems for the management of various stages of general practice

education reduce the overall ability of providers to respond to changes in health and education as a whole. Greater cooperation between sectors and systems will reduce gaps and duplication of effort in the educational effort. Education for other health professionals has similar needs to that of GPs and there is an opportunity for varied professional groups to learn together so they may co-operate more effectively in provision of patient care.

Integration of education includes all efforts to improve the coherence and coordination of education across the spectrum of learning - from undergraduate through to continuing professional development. As well, the need for primary health care teams, with partners in health delivery such as nurses and allied health professionals, can be catered for. Ideally RTPs would be in a position to improve the coherence, breadth and relevance of education by linking with planning and delivery of educational effort across sectors and professions,

Dimensions of work include linking:

- local to national effort
- stages of learning across the continuum - supporting medical students and general practitioners to develop and maintain professional competence throughout life and to support the ongoing development of expertise required by their professional role
- the participants in education provision, including the universities, the RACGP, ACCRM, GPET, divisions of general practice and private providers and teaching practices
- primary care health providers including GPs, allied health, and nurses to develop and support team effort.

Signs of success could include:

1. participation and leadership in planning and evaluation of integration of education
2. collaboration with cross-sector development and delivery of educational programs which respond to regional needs
3. cooperative efforts across RTPs
4. cross-sectoral and multi-professional participation in designing and delivering education
5. opportunities for learning by regional health care professionals in the sphere of general practice training
6. use of technology where appropriate to support both formal and informal education
7. RTP interpretation of the Vertical Integration Framework to meet regional needs.

5. Improved Training and Services in Aboriginal and Torres Strait Islander Health

As Aboriginal Peoples and Torres Strait Islanders encounter significant disadvantage with regard to health outcomes and general practitioner workforce distribution, RTPs should work to implement GPET's Framework for General Practice Training in Aboriginal and Torres Strait Islander Health.

The Framework supports:

- establishment and support of governance of Aboriginal and Torres Strait Islander health training through regional partnerships with Aboriginal and Torres Strait Islander groups
- provision of information and support to Aboriginal and Torres Strait Islander community controlled organisations to enable them to participate actively in the education of registrars
- additional support and training for general practice registrars who identify as Aboriginal or Torres Strait Islander
- facilitated access for registrars to well-supported and effective Aboriginal and Torres Strait Islander teaching posts
- effective and appropriate training in Aboriginal and Torres Strait Islander health for all general practice registrars.

While RTPs are not directly responsible for delivery of services, their policy directions in training and their efforts to engage with the Aboriginal and Torres Strait Islander communities in the region are critical to improved service delivery for those communities. While not actually delivering services, the RTPs have an interest in monitoring the impact of their training on service delivery as an outcome measure.

Signs of success could include:

1. where applicable, progress against the key result areas of the Aboriginal and Torres Strait Islander Health Training Framework
2. engagement with local Aboriginal and Torres Strait Islander community groups to increase the number of registrars training in community controlled health services or other relevant settings
3. where applicable, reciprocal representation on appropriate planning groups and/or board Committees
4. all Australian General Practice Training registrars complete the core Aboriginal and Torres Strait Islander health curriculum
5. an increase in the number of regional Aboriginal and Torres Strait Islander teaching posts
6. an increase in the number of AGPT registrars undertaking vocational training in Aboriginal and Torres Strait Islander health services and support for registrars working in Aboriginal and Torres Strait Islander health
7. the provision of cultural awareness training across RTP activities
8. support programs for registrars who identify as Aboriginal and Torres Strait Islanders.

6. Innovation in Vocational Education and Training

The regionalised environment of Australian general practice education and training is intended to foster creative and flexible approaches to vocational training through regional leadership in educational innovation. Aside from responding to regional needs and circumstances, regional innovations would ideally contribute to meeting national needs and be suited to wider adoption by other providers. Vocational Training should be of consistently high standards across Australia. Those who complete training should be capable of unsupervised practice anywhere in Australia. Provided that consistent standards are maintained there are few constraints on the creativity of RTPs.

In the context of outcomes for regionalisation, "innovations" are defined as advances in approaches to education and training that represent significant and successful departures from current established practice and are, or are likely to be, adopted widely. As well as being departures from current practice, innovations are expected to be characterised by being goal-orientated, tenable, evidence-based (where available) and effective in relation to their proposed outcome (or have a planned evaluation process to determine their effectiveness). New approaches that achieve the same result as existing processes, but do so more efficiently, could also be regarded as legitimate innovations.

While some innovations may require (and/or attract) additional resources, others will be able to be achieved within existing resources by working differently as part of the RTP's improvement programs. Although RTPs are not directly responsible for widespread adoption of innovations across the network, it is expected that innovations would be promoted and validated through national leadership e.g. through presentations to conferences, publications and the like from which broader adoption might flow.

Innovations in education and training could relate to improvements in inputs, processes, outputs and outcomes in any combination. They could address, but need not be limited to, the following:

- Underlying educational concepts (e.g., variations to the "apprenticeship" model)
- Program design
- Educational content/resources
- Systems and modes of delivery, including new technology
- System/process management
- Standards, monitoring and assessment (e.g. of competence, progress, prior learning)
- Educational responsiveness to national and local health care priorities
- Overcoming cultural and cross-cultural issues
- Professional development for educators
- Self-directed learning
- Integration of educational planning/delivery
- Educational remediation and risk management
- System-wide improvements (e.g., GPET priorities arising from quality reviews).

Signs of success could include:

1. the RTP's commitment to innovation, within the parameters of funding and resources
2. collaborative arrangements that support innovation
3. the number and scope of innovations that are in progress
4. the number and scope of innovations that have been implemented and evaluated
5. improved outcomes achieved
6. extent of mainstreaming of innovation within the provider
7. the RTP's leadership in promotion of innovations
8. extent of adoption of regional innovations across Australian General Practice Training
9. educational benchmarking activities undertaken for improvement.

7. Promotion of Australian General Practice Education and Training

Promotion of Australian general practice education and training aims to create a positive image for general practice as a career and for general practice training in particular, to junior doctors and medical students, as well as to the medical and broader communities. Particular attention needs to be given to areas to which it has been most difficult to attract graduate doctors, e.g. rural, remote and outer metropolitan areas and Aboriginal and Torres Strait Islander health. Promotion also includes: the promotion of AGPT overall; the regionalised system of general practice training delivered through RTPs; educational and training initiatives such as innovation, indigenous health training and vertical integration; and of the RTPs themselves, both collectively and individually. GPET contributes to promotional efforts nationally but is concerned that RTPs are also achieving an acknowledged regional presence through promotion of their aims and achievements locally. This should also encompass the positive experiences of registrars and supervisors.

To create a positive image and higher profile for general practice education and training it is necessary to collect and analyse high quality information regarding general practice education and training and to disseminate this to key stakeholders, the wider medical profession, government and the community in a positive fashion. To help achieve this, RTPs are advised to create marketing and communications strategies at the regional level and to coordinate these strategies with GPET's national reporting, marketing and communications strategies.

Signs of success could include:

1. positive attitudes towards RTPs and AGPT from all stakeholders, particularly registrars and supervisors
2. strengthened regional profiles for individual regional training providers

3. regular, systematic contact with stakeholders, e.g., colleges, registrar and supervisor organisations, divisions, GPs
4. recruitment of GP registrars, in particular to less popular areas – e.g., through marketing rural general practice to junior doctors and medical students
5. recognition of community and health care benefits that are specifically attributable to RTPs
6. GPs who graduate from the AGPT are role models for the full range of skills attained during training
7. successful regional marketing strategies implemented by RTPs
8. RTP marketing strategies are coordinated with GPET's national strategies
9. increased profile nationally of regional training, RTPs and AGPT
10. GPET, with its RTP network, is recognised as the primary national organisation in GP vocational training

8. Increased Research Opportunities in General Practice

In recognition of the importance of research to the development and progression of the discipline of general practice, GPET provides opportunities for skills development in research in general practice, facilitates opportunities to share knowledge and research through workshops and the annual convention, and encourages participation in research and academic activities including teaching. This commitment recognises the importance to general practice of the current and future generation of researchers and teachers who contribute to the development and transmission of knowledge.

In fostering research in general practice RTPs should endeavour to:

- foster a research-oriented culture within the RTP
- foster an evidence-based approach to the provision of GP education and training
- identify local opportunities for research work including relevant projects and appropriate teaching posts
- assist interested registrars to initiate and undertake an academic post
- develop appropriate relationships with research based organisations and individuals to share resources and encourage mutual involvement and skills development
- provide opportunities for registrars, supervisors and medical educators to meet and share research and knowledge
- facilitate the research and teaching activities of GP supervisors through developing links with universities and other research based organisations
- develop links with organisations that support research in general practice.

Signs of success could include:

1. improved research skills to support good medical practice
2. well-researched and demonstrated improvements to GP training in regional contexts

3. registrars undertaking Academic Special Skills Posts and Advanced Academic Posts
4. RTP has active links with organisations that support research in general practice through collaboration, resource sharing, and reciprocal arrangements
5. RTP supports key staff to undertake research or develop research and educational skills
6. evidence of activities that enable GP supervisors and medical educators to link with local clinical schools, university departments of rural health, universities etc to develop teaching and research skills
7. participation in the publication of research papers and presentations at conferences and scientific fora
8. research being utilised to inform the strategic planning of RTPs.

9. Contestable Provision of Regional Vocational Training

RTPs are independent businesses that must be sustainable and meet contestability and competition requirements in the use of public funds. GPET must meet requirements that derive from the Commonwealth Procurement Guidelines and the Government's national competition policy. GPET requires a public tender process for the award of business to regional providers.

For RTPs, GPET expects contestability and competition to manifest in two ways: first through the tender process, and then through ongoing RTP business. Expected elements in both processes are a regional needs analysis that forms the basis of arrangements, regional partnerships with stakeholders, and management and delivery of training to required minimum standards and beyond. Costs of activities, services and staff should be within GPET cost parameters that accommodate for regional differences. Funding additional to that provided by GPET can supplement activities and incentives to enhance the performance of a regional provider. In short, regional needs must be considered and regional advantages exploited.

Signs of success could include:

1. active monitoring of regional needs and business opportunities
2. diversity in training delivery methods and variations in registrar packages that meet regional needs and provide registrars with content/method choices vis-a-vis other providers
3. selection of registrars into the RTP allows for merit-based competition among applicants
4. positioning the RTP in its business and industry environments is an integral aspect of strategic and business planning
5. performance-based contracting with suppliers
6. consideration of competitive procurement options wherever practicable
7. business diversification.

10. Value for Money in Regionalised Training Delivery

The business strategies for regionalisation include empowerment of regional entities through contractual agreements. There are opportunities for GPET and RTPs to implement initiatives, in particular diversity in the provision of vocational training. Value for money is the cornerstone of the business arrangements, underpinned by principles of efficiency and effectiveness, accountability and transparency, ethics and business development.

RTPs must demonstrably provide value for money. Value is two faceted, involving the costs of organisational structure and training delivery along with the quality of training outcomes. Accepting the lowest price is not necessarily an indicator of best value for money.

Regional training providers are expected to provide training for the successful graduation of general practitioners in accordance with RACGP standards.

Signs of success could include:

1. the RTP demonstrably adds value to the training program and is not merely an intermediate fundholder for third party delivery of training
2. registrars graduate within optimal time in relation to their circumstances
3. the RTP aims for all registrars to achieve quality training with optimal use of resources
4. the RTP's operations run within financial targets
5. registrars are satisfied with their training and their experience with the RTP
6. there is confidence and competence of graduates for unsupervised general practice
7. training outcomes match GP role requirements
8. services are obtained through performance-based arrangements in regard to cost and quality
9. board and infrastructure costs are reasonable relative to the direct training costs
10. integration of general practice into the community and health network, so as to add value to the delivery of GP training
11. comparative business performance (as data become available).