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Commissioners Mike Woods, Helen Owens and Robert Fitzgerald
Productivity Commission Health Workforce Study
PO Box 80
Belconnen ACT 2616

Dear Commissioners,

Re: **Health Workforce Education and Training**

Thankyou for the opportunity to comment on your draft proposals, most particularly Proposal 10.3, involving education and training.

1) Incentive driven approaches, I would like to bring to your attention a model of rural incentive, that was devised by the General Practice Registrars Australia (GPRA). This has been presented to the General Practice Reference Group (GPRG) and was regarded very favourably as a model that has the potential to enhance the rural training experience of a general practice registrar.

It is anticipated that this will increase the subsequent recruitment and retention rates of rural medical practitioners. Similarly, it has been brought to the table at the General Practice Education and Training (GPET) Rural Incentives Working Party and is under further development. The GPRA draft can be found at
http://www.gpra.com.au/docs/GPRA%20Registrars%20Rural%20Incentives.pdf

2) Effectiveness of Regional Training, having recently completed my General Practice (GP) training within the new regionalised system (the Australian General Practice Training Program) it has become apparent that there are a number of areas that are very inefficient, costly and create unnecessary hardship on the training registrars and their families.
I would like to highlight some changes that could;
enhance the regionalised GP training model,
make it more attractive to GP registrars (especially those in rural settings), and
carry significant cost savings to the AGPTP, (the training program).

Current training program, involves PGY2 (or above) doctors completing a year in the public hospital system, after they have applied to a Regional Training Provider (RTP), and committed themselves for a further 12 – 36 months of training often in General Practice, or special interest areas.

Registrars additionally commit themselves to either the rural or general pathways. Rural pathway registrars need to spend atleast 18 months in a rural setting, whereas general pathway must spend a compulsory 6 months rural and 6 months in an outer metropolitan area of need.

During this time they are required to sit the Fellowship exam of the Royal Australian College of General Practice (RACGP). In due course, upon completion of training they are awarded the Fellowship of the RACGP (FRACGP).

There is provision to pursue training towards the current additional qualifications of Graduate Diploma in Rural Practice (Grad Dip Rural) or the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM), under the newly Enhanced Rural Training Scheme.

Current problems,

- the regionalised model remains very inflexible, and registrars remain committed to small geographic regions, especially the rural trainees. Very difficult inter-region transfer. Almost impossible rural to general pathway transfer.
- See http://www.gpra.com.au/docs/Achievables%20final.pdf for an outline of rural training problems and solutions to improve the training experience of the training rural health workforce.
- Despite a recent increase in registrar applications (2006 intake), there remains a shortfall in training registrars within the AGPTP, much of this is perception based as other speciality training programs become more flexible.
- Current rural 'incentive/re-imbursement' schemes use coarse criteria and are unfair.
- Supported regional (RTP provided) training for the majority of registrars, ie dedicated training sessions, is only available for 12 months of the 3 or 4 year program.
- GP supervisors are only re-imbursed for training provided in the first 12 months of training in a General Practice setting.
- General pathway registrars who are allocated their rural term (6 months) in their second 12 months (subsequent time) are not entitled to any relocation subsidies, and receive no funding for dedicated training.
- RTP boards generally have members from ACRRM and RACGP working in unison, however the training is almost universally directed toward the RACGP Fellowship exam.
- The Fellowship exam is a test of minimum standard for independent practice, and as such is more suited to an entry point assessment of suitability.

- Conflict and confusion arises at the registrar level with regards to further training options – Grad Dip Rural and FACRRM.
- RTP boundaries are not remaining geographic as training practices align themselves with remote RTP's, presumably as a result of the very difficult transfer opportunities for registrars.
- General pathway registrars are having to face two 6 month postings that usually involve either a family move or separation.
- A number of registrars who have long term rural workforce intent are applying for the general pathway because it has more geographic flexibility, with the potential to train in 3 or more RTP's.
- Many of the rural RTP's, by necessity, are enrolling International Medical Graduates (IMG's) who generally, and genuinely, have greater need to be considered for general pathway allocation.
- Multiple RTP administrations supporting registrars in a 3 or 4 year program, when for the majority they are only directly involved (financially) in providing training for 12 months of the program. As those on the 4 year program will tend to attract separate funding for Advanced Rural Special Posts (ARSP's) and the Enhanced Rural Training Scheme.

Proposed changes,

- Remove the additional barrier of the training pathways, as it only remains as a further inflexible disincentive, the rural training workforce can be remain numerically the same, by the provision of urban and rural quotas, this actually gives GPET tighter control on the numbers allocated to these quotas on an annual basis, dependent on the numbers of applicants in any given year. The situation of the urban RTP's/centres absorbing large numbers can be controlled, unlike presently where all rural RTP's tend to attract applicants after they have not been placed in the urban RTP's of their choice.

- All registrars should be required to spend a 12 month term in an area of need, whether that be rural or outer metro, dependant on their personal situation and training wishes. You are more likely to get registrars happy to relocate their families to rural centres for this period of time (instead of 6 months). Communities are more receptive to the commitment shown by doctors who relocate, and the likelihood of a supportive environment and enjoyable training experience is significantly increased. It is reasonable to expect that this would translate to a willingness to remain in a rural centre if the family and training doctor have a positive experience. AMWAC figures (Dec 2002), suggest only 9% of GP trainees would never practice in the bush, there are 60% who could easily be encouraged with appropriate incentives and support.

- This 12 month term would be done in the second year of the program, after the hospital year. It is this term only that would need to be supported by the formal training provided by the RTP's. Appropriate incentives could be

attached to training positions as per the incentive model described above. The value of this incentive model could be enhanced by the fact that it only needs to be provided for the 12 month period, rather than the lesser annual rate over a 3 year period currently. Those registrars who decide to remain in rural practice can go onto attract Rural Retention Grants that already exist outside of the training program, as their 12 month qualifying period will have already been met. Those who return to the urban centres forego any further financial/incentive support.

- Those who remain rurally committed, can attract further funding for focused training in ARSP's or the Enhanced Rural Training Scheme. RTP's would provide some of the co-ordination and support for these registrars within these funding frameworks.

- After the 12 month term above, the registrar is eligible to sit for an examination, that provides a mutually agreed set of core skill competence. This will have been developed jointly by the RACGP and ACRRM, and would have a similar format to the existing Fellowship examination. The local RTP board, usually containing ACRRM and RACGP members, can oversee the development of appropriate training that meets these expectations. Passing of this exam allows the registrar to be vocationally recognised with Medicare Australia (formerly HIC). The RTP has formally completed their training responsibility. If there is failure of the exam, then the registrar remains the training responsibility of the RTP, for further training support.

- Upon passing the exam, the registrar however will not be entered into a College vocational register, (and subsequently awarded Fellowship) until they have completed a full 3 year professional development cycle, and its attendant assessments, with the College of their choice. This ongoing training, utilises adult learning models and allows free geographic movement of the registrar to accumulate further skills as desired. Obviously rural-focused skill programs will attract funding as outlined above, possibly provided by some RTP's.

Expected outcomes,

- A training program that is very much more flexible in the long term, and attractive to registrars. Families that are not required to be separated, and a slow increase in the desirability of the GP training program and applicant numbers.

- A much improved incentive program, that may cost less overall. It is more individually responsive and may enhance rural retention of participants.

- A training program that only requires 12 months of formal RTP support (2nd year), for the majority of registrars, and the very obvious cost savings therein.

(The first 12 months is within the existing hospital system, and the 3rd/4th year have already existing and separate incentive/training funds.)

- True RTP autonomy in the provision of innovative and competitive programs, enhanced by the perceived flexibility of registrar allocation. A registrar still applies to an RTP, but only for a 12 month period, and then has the opportunity to apply to a different RTP if they offer enticing 'advanced' programs.

- Actually realising the full potential of regionalisation, with the individual RTP organisations owning the program, at a regional level, and working jointly on a common exam goal.

- The placement of the Colleges (RACGP and ACRRM) in a competitive environment, where the merits of their ongoing professional development programs and subsequent Fellowships will self-select membership.

- The opportunity for registrars to attain a FRACGP, Grad Dip Rural or FACRRM, after having met a common primary 'endpoint', prior to pursuing programs that meet doctor's individual needs.

- The attraction to many of the non-vocationally registered doctors (post-1996) who may see the benefits in sitting a common 'endpoint' exam to vocational recognition.

Such changes to the program, although appearing numerous, would require relatively minor adjusting of already existing models – financial, education and assessment. The product would be expected to be an Australian General Practice Training Program that produces the same high quality GP's but at a reduced cost, that relies more heavily on a competitive training environment where the consumer (the GP registrar) determines the success of individual regional programs.

I am happy to provide further detail to the modelling, should this be beneficial.

Yours faithfully,

Dr Luke McLindon
MBBS, FRACGP