The Australian General Practice Training program — reflections on the past decade

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How has general practice vocational training progressed towards the original goals established by the federal government and General Practice Education and Training 10 years ago?

Over the past two decades, the federal government has used various financial and regulatory levers to influence the organisation and activities of Australian general practitioners.[1] A contentious initiative was the 2001 decision to cease funding the Royal Australian College of General Practitioners (RACGP) Training Program and to create a government-owned company, General Practice Education and Training (GPET) to implement a national vocational training program for general practice.[2] GPET was created to establish a system of regional training providers (RTPs) and to oversee the implementation of a new system of general practice vocational training, the Australian General Practice Training (AGPT) program.

Disentangling and weighting the many influences that led to this decision is best left to other historians. Hayden White, a central figure in academic debate about the nature of history, suggests

> it is difficult to get an objective history of a scholarly discipline, because if the historian is himself a practitioner of it, he is likely to be a devotee of one or another of its sects and hence biased; and if he is not a practitioner, he is unlikely to have the expertise necessary to distinguish between the significant and the insignificant events of the field's development.[3]

However, three broad themes dominated academic, political and policy debate on general practice education in the years leading to the establishment of GPET and the AGPT program.

First, reference to fragmentation of the general practice education "continuum" was common. In 1988, the "Doherty Report" recommended that "stronger links ... be developed between university general practice units and the institutions providing vocational training for general practitioners".[4] In 1991, Kamien and MacAdam listed "cooperation with the RACGP-Family Medicine Program (FMP)" as a priority for general practice undergraduate departments.[5] *The future of general practice*, a 1992 government report, noted the "artificial separation between undergraduate and continuing education" and the "guarded relationship between academic general practice and the FMP" resulting in "little scope for ensuring continuity in what is taught".[6]

Second, establishment of the Australian College of Rural and Remote Medicine (ACRRM) challenged the hegemony of the RACGP over general practice vocational education. The ACRRM was incorporated in 1997 by the Rural Doctors Association of Australia

> as an acknowledgement of:
>
> - the importance of rural and remote medicine as a broad but discrete form of general practice
> - the need for well-designed vocational training and continuing medical education for rural doctors, and
> - the need to address the shortage of rural and remote doctors in Australia, by providing them with a separate and distinctive professional body.[7]

Third, the federal government wished to leverage the arrangements through which it funded general practice vocational education and training, to pursue medical workforce policies to manage overall numbers of GPs (and general practice Medicare outlays) and the distribution of general practice trainees.

The 1998 report of the Ministerial Review of General Practice Training considered these influences in the context of broader changes in the way medical care was being provided, referring to all these forces as: "environmental barriers and constraints leading to calls for overhaul of the GP vocational training environment". The report concluded that "the RACGP [training program] is now confronted with myriad conflicting demands brought about by influences that it cannot fully control".[8] It recommended fundamental changes, most significantly "development of local collaborative arrangements, or consortia, in education-service delivery" with a national body to promote "better coordination at all levels of the general practice education continuum".[8]

From a political perspective, the establishment of GPET in 2001 was a government response to an astute, coordinated and persistent political campaign by rural doctors' organisations. Rural doctor advocates wanted more rural influence and control over public funds that support general practice training, arguing that the RACGP Training Program had become "metrocentric".

From a workforce policy perspective, the government instituted measures through GPET to boost the supply of doctors in rural areas. These included an unequivocal requirement that all registrars undertake a minimum 6 months' training in rural areas, and financial incentives for trainees who undertook additional rural-based training.

A key educational aim underpinning the establishment of GPET and the AGPT program was regionalisation to facilitate vertical integration of training, thereby fostering an environment that would encourage innovation and competition between RTPs (over, for example, quality and cost of training and the nature and length of the educational experience). Other outcomes included a well trained, appropriately distributed workforce in sufficient numbers to meet the health needs of a growing and ageing population, and those of Indigenous Australians.

Ten years on

The establishment and subsequent history of GPET and the AGPT program between 2001 and 2011 raise many interesting questions. To what extent has vertical integration of general practice training and education actually occurred across medical school, prevocational and vocational training entities in terms of measurable outcomes? To what extent have RTPs been able to innovate, caught as they are between contractual obligations to GPET and the need to deliver training according to, at times, prescriptive college requirements? Has the overall supply of GPs (particularly in rural regions) been boosted by the new arrangements?

1 Numbers of general practice registrars-in-training by RRMA, 2003 and 2009*†‡

	2003				2009			
	RRMA 1–2	RRMA 3–5	RRMA 6, 7	Total in state/territory	RRMA 1–2	RRMA 3–5	RRMA 6, 7	Total in state/territory
New South Wales/ Australian Capital Territory	257	167	4	359	502	348	5	756
Victoria	179	165	1	304	285	292	5	512
Queensland	123	121	22	218	248	260	41	474
South Australia	64	37	1	86	141	107	5	210
Western Australia	73	34	17	100	144	61	26	196
Tasmania	13	22	0	33	39	41	0	76
Northern Territory	29	8	31	55	33	17	44	78
Total Australia	733	551	76	1126	1377	1112	125	2237

RRMA = Rural, Remote and Metropolitan Areas. * Source: General Practice Education and Training, unpublished data. † Where registrars trained in more than one RRMA category during the year, they are counted once in each. The totals for RRMA columns and state rows include each registrar only once. ‡ In 2010, the system for categorising remoteness changed from RRMA to the Australian Standard Geographic Classification — Remoteness Area (ASGC-RA). These systems are not comparable and 2010 data are not available in RRMA format. ◆

Regionalisation outcomes — vertical integration, competition and innovation

Initial hopes, at least by the federal government, for competition between RTPs did not eventuate in any substantial sense for two main reasons.

First, GPET was required to ensure training met existing "college standards". This was a late addition to the GPET constitution following lobbying by general practice organisations, and significantly defined the educational content of the new program. RTPs were free to explore innovative delivery models, but the curriculum prescribed for all RTPs to achieve these standards was essentially constant.

Second, there was an effective exclusion of completely new prime providers by criteria defining governance of RTPs that restricted participation to entities controlled by collaborations of local general practice interests such as medical colleges and Divisions of General Practice. At least two universities sought to become prime providers, but these proposals were unsuccessful.

Despite GPET's development of a vertical integration framework,[9] integration of education and training across the undergraduate, postgraduate and vocational spectrum struggled to evolve in the early years of the AGPT program, with the focus on more urgent training imperatives such as registrar selection and recruitment for an increased number of training places per year (rising from 450 to 600 in 2004). Some university-based departments of general practice have been contracted by RTPs to deliver components of registrar training, and many RTP medical educators have university appointments. In recent years, vertical integration has gained further momentum with:

- the transition to GPET of the Prevocational General Practice Placements Program — an experiential program in community-based general practice for junior hospital doctors;[10] and
- GPET-funded initiatives to foster general practice exposure within medical schools, including support for the General Practice Students Network and GP Compass programs.

GPET continues to seek collaborative opportunities with medical schools to foster integration of student placements with prevocational and vocational training. However, this has been hampered by funding mechanisms and incentive schemes for undergraduate student placements that are not sufficiently aligned with prevocational and vocational training supervisor and practice support initiatives.

The regionalised model has facilitated local decision making by identifying local health needs, local opportunities for training of registrars by resident supervisors, and more local career development opportunities for supervisors and educators. Many large RTPs have recognised the need to develop regional nodes that address the unique needs of the local population while operating within an overarching governance structure. One outstanding example has been the Kimberley Aboriginal Medical Services Council's medical education project, which has improved general practice access for area-of-need populations and has provided an effective model for engaging a diverse spectrum of stakeholders.[11]

Some RTPs, for example, Coast City Country General Practice Training (covering Wollongong, Canberra, the Riverina and the New South Wales South Coast) and Western Australia General Practitioner Education and Training, have developed "nodal" operational models, servicing multiple regional communities while achieving administrative efficiencies.

The perennial problem of efficiency versus local representation has continued, however — some smaller RTPs proved unsustainable and the original 22 RTPs (from 32 valid applicants) were reduced to 17 through a series of mergers.

Workforce training — capacity, resources and distribution

From the outset, RTPs across Australia were encouraged by GPET to develop registrar training capacity in areas of medical workforce need. Box 1 highlights significant growth in training service delivery from the initial 2003 AGPT training year — registrars have increased by 88% in metropolitan locations and 102% in Rural, Remote and Metropolitan Areas (RRMA) 3–5. RRMA 6 and 7 also experienced a significant 64% increase. However, the absolute number completing training does not yet meet the demand for additional GPs.

Box 2 shows the growth in the number of GP registrars who completed terms in Indigenous health posts by RRMA between

2 Numbers of general practice registrars training in Indigenous health posts by RRMA, 2003 and 2009*†‡

	2003				2009			
	RRMA 1–2	RRMA 3–5	RRMA 6, 7	Total in state/territory	RRMA 1–2	RRMA 3–5	RRMA 6, 7	Total in state/territory
New South Wales/ Australian Capital Territory	5	6	2	13	18	22	2	42
Victoria	4	3	—	7	2	6	—	8
Queensland	7	6	4	17	3	12	16	27
South Australia	—	1	—	1	7	7	—	7
Western Australia	2	1	5	7	—	3	19	22
Northern Territory	—	6	14	19	—	9	25	34
Tasmania	1	—	—	1	1	—	—	1
Total Australia	19	23	25	65	31	59	62	140

RRMA = Rural, Remote and Metropolitan Areas. — = Data not available. * Source: General Practice Education and Training, unpublished data. † Where registrars trained in more than one RRMA category during the year, they are counted once in each. The totals for RRMA columns and state rows include each registrar only once. ‡ In 2010, the system for categorising remoteness changed from RRMA to the Australian Standard Geographic Classification — Remoteness Areas (ASGC-RA). These systems are not comparable and 2010 data are not available in RRMA format. ◆

2003 and 2009. The growth in these numbers is broadly in line with the growth in total registrar numbers over that time. The number of Aboriginal and Torres Strait Islander registrars has risen from two to 34 over the same period.

In March 2010, the Australian Government Department of Health and Ageing announced that AGPT program places would be doubled to 1200 a year by 2014 to meet anticipated need for 3000 extra GPs by 2020.[12] While this is welcome news, it presents a challenge in recruiting additional GP medical educators and supervisors at a time when the general practice workforce is already stressed by service delivery requirements as well as demands for clinical placements in general practice from the undergraduate medical, nursing and allied health sectors. There is, therefore, a need for a comprehensive assessment of training demand in general practice to identify the additional resources required to meet the projected need, particularly in physical infrastructure for clinical training, supervisor support and development, and the establishment of a robust and sustainable workforce of skilled medical educators.

Increased demand can potentially be offset by exploring new training models, including integrated, interprofessional models in large community-based clinical facilities with a primary care focus. These larger community-based centres of care would be suitable for group activities, including education programs for patients, students and clinicians. There is also scope to expand the historical model of general practice training from a general practice "consultation apprenticeship" model to include significant time in other domains of practice such as emergency medicine, aged care, palliative care and routine procedural work. The rural generalist training approach, introduced by the Queensland Government in 2005[13] and implemented in Western Australia in 2009,[14] is likely to provide a good model for enhanced diversity in GP vocational training.

Indigenous health training

In 2003, some 2 years after its establishment, GPET developed its Framework for General Practice Training in Aboriginal and Torres Strait Islander Health.[15] Since then, a range of issues and challenges have emerged, with important lessons learned. GPET has recognised the benefit of improved collaboration with Aboriginal and Torres Strait Islander organisations, and these partnerships will continue to inform AGPT's Aboriginal and Torres Strait Islander health training initiatives. Evaluation of the Framework suggested that the comprehensive, multilevel approach to Aboriginal and Torres Strait Islander health training has been one of the program's strengths.[16] GPET, along with the RTPs, is playing a national leadership role in responding to the specific regional circumstances and needs of Aboriginal and Torres Strait Islander communities in collaboration with the relevant state- and territory-affiliated organisations.

While the regionalised training program model has worked well generally, one of the immediate issues that emerged was the uneven capacity to host general practice training in Aboriginal Community Controlled Health Services (ACCHSs) throughout Australia, with a resultant uneven distribution of registrars undertaking the training. Since 2003, the three RTPs with geographical footprints in northern Australia have consistently recorded the highest proportion of their registrars undertaking training in an Aboriginal and Torres Strait Islander health training post. Today, 66% of all general practice training in Aboriginal and Torres Strait Islander health occurs in northern Australia. Some of the challenges to expanding training capacity in ACCHSs in southern Australia include long-term supervisory vacancies and inadequate infrastructure. Solutions may require a review of the scope of current AGPT programs, and will certainly need close collaboration with other agencies involved with health service provision to Indigenous communities.

Conclusions

The AGPT program and its regionalised delivery system are now well established in Australia. It is generally acknowledged as a successful program, and is now broadly accepted by the profession and government. The system continues to be future-focused, and is cohesive, responsive to changing community needs and well positioned for future challenges and opportunities.

In retrospect, the fundamental aims and outcomes for GPET and the AGPT program remain relevant today. The decline in general

practice workforce numbers in rural and remote Australia has been halted, but an ageing workforce and an underrepresentation in the 35–50-year age demographic due to past restrictions on training numbers mean that we will need to significantly increase our entrants into vocationally registered general practice over the next decade to maintain an adequate general practice workforce in both rural and metropolitan Australia. There remains a need for a well trained and appropriately distributed workforce in sufficient numbers to meet the requirements of a growing and ageing population. While contestability of general practice vocational training has not been achieved to any major extent, there is significant progress towards vertically integrated training. The current cohesion between various general practice organisations is likely to facilitate further integration within undergraduate and continuing professional development sectors. Others aims, including regionalisation, workforce distribution, enhanced training capacity, resource development and Indigenous health training, show pleasing progress but require ongoing review, expansion and further development over time, based on experience to date and the evolving needs and demands of our health care system.

Since their establishment in 2001, GPET and the AGPT program have achieved many of the "outcomes for regionalisation" set by the federal government and the GPET Board, particularly in relation to delivery of vocational training and provision of medical education services by GP registrars in areas of greatest need — rural and remote areas, outer metropolitan regions and Indigenous communities. Underpinning these outcomes is the economic question: Have the policy outcomes of GPET and the AGPT program justified the resources required to maintain GPET and 17 regional RTP offices?

Finally, the experiences of GPET and the AGPT program should be of interest to the wider profession as components of training in many specialist disciplines move outside the traditional public hospital setting into private practices and private hospitals; and as the health system places increasing emphasis on preventive and primary care. Pressure for a formal process for recognising, meeting and administering the costs incurred by both practitioners and facilities is likely to emerge within other health professions and disciplines. It is reasonable to state that the AGPT program experience provides a useful template for change within the broader professional education and training environment.

Competing interests

Simon Willcock has been GPET Board Chair since 2005. William Coote was the GPET Foundation Chief Executive Officer from 2001 to 2004, and is the board chair of Coast City Country General Practice Training. He received a fee for his work on this manuscript.

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