

The Future General Practice Education and Training System

Discussion Paper

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Purpose of this Report

At a meeting of the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), General Practice Education and Training Ltd (GPET), General Practice Registrars Australia Ltd (GPRA) and the Department of Health and Ageing (DoHA) on the 16th September 2008, it was agreed that the Department would provide assistance to RACGP, ACRRM, GPRA and GPET to develop a paper that articulates broad recommendations for developing general practice (GP) education and training that is responsive and applicable to the future health needs of Australia.

A working group was convened to develop evidence-based recommendations for the future of the general practice education and training system.

This report represents one of several individual and joint submissions from the contributing organisations to the range of health system reform processes currently underway.

25 March 2009

Executive Summary and Recommendations

General practitioner numbers have not kept pace with population growth in the last 10 years and have significantly declined in rural and regional areas. There is an urgent need to train more general practitioners from the burgeoning cohort of Australian medical graduates to ensure the health needs of Australians are met into the future.

General practice of the future will be increasingly made up of integrated teams of health professionals managing chronic disease and promoting wellness and preventative health care. Teaching of health professionals within practices will increase and become a normal activity for most general practices. Preparation for the increased clinical teaching role and responsibility in general practice will require increased planning, preparation and investment.

The current education and training system provides a robust platform on which to build and improve however, the Group believe that in order to ensure a system where all Australians have access to a GP and where GPs continue to be effectively and efficiently trained to deliver high quality services, continual review, evaluation and improvement is required.

The following recommendations are designed to build a GP education and training system that will provide a high quality general practitioner workforce well into the future. Some of the recommendations contained in this document will require increased collaboration between Colleges, GPET, GPRA, Divisions of General Practice and Regional Training Providers. Others require the direct intervention of the Australian and State and Territory Governments.

The organisations involved in the development of the positions and recommendations detailed in this paper are committed to working with all stakeholders to reach a system of general practice education and training that will meet the future needs of Australian GPs and the delivery of a quality equitable and consumer based primary health care system across Australia.

Recommendation 1: *That the Australian Government ensure that appropriate number of GP training places are funded and allocated to meet the current and future workforce requirements for the primary health care needs of Australia, taking due consideration of the demographics of current workforce (i.e. ageing and non-procedural)*

Recommendation 2: *That the Colleges, GPET & GPRA are included in any workforce planning related to the general practice workforce. Such workforce planning should take particular note of changing demographics and expectations in the Generation Y and Generation Z training cohorts*

Recommendation 3: *That the distribution of funded GP training places should reflect geographic access, workforce shortage, health and socio-economic needs of the community*

Recommendation 4: *That the capacity of the GP education and training system be examined at a macro level to ensure the full continuum is adequately supported to deliver coordinated and high quality teaching. This includes adequate numbers of appropriately skilled teachers and recognition of teaching as a vital component of service delivery within the health system, and financial and other recognition where additional duties and responsibilities are assumed in the private and community setting*

Recommendation 5: *That the number of general practice clinical supervisors is increased to reflect increasing trainee numbers whilst ensuring quality teaching is maintained*

Recommendation 6: *That the role of teaching in general practice be recognised and that appropriate funding mechanisms are further developed to support this role*

Recommendation 7: *That models continue to be developed where registrars and other practice team members are encouraged, supported and remunerated for teaching*

Recommendation 8: *That additional funds to support increased levels of teaching infrastructure and accommodation facilities for training posts be distributed **urgently** to enable expansion of capital and facilities to be commenced as medical graduate numbers increase. Recent COAG announcements could support such initiatives*

Recommendation 9: *That the developments in internet and e-health delivery be harnessed to support general practice training. Recent COAG announcements could support such initiatives*

Recommendation 10: *That appropriate support be given to extend training opportunities within accredited hospital training posts or other relevant workplaces.*

Recommendation 11: *That marketing and recruitment strategies are collaboratively developed and implemented by the profession to increase awareness of general practice as a high status, diverse and rewarding career*

Recommendation 12: *That remuneration and incentives structures are defined that will make a GP career and GP training attractive options*

Recommendation 13: *That the factors that influence career choice and location continue to be actively monitored and reported*

Recommendation 14: *That evidence-based, appropriate recruitment and remuneration strategies which include but are not limited to role modelling, peer to peer support, early positive exposure, social marketing and professional networking are implemented*

Recommendation 15: *That General Practice organisations work with the Medical Deans of Australia and New Zealand (MDANZ) to increase early ongoing and positive exposure to general practice during medical school programs*

Recommendation 16: *That opportunities to create new community based academic centres of excellence (e.g. Community Clinical Schools) in areas of high health and socio-economic need be explored. At the same time the capacity of current rural clinical schools and regional training providers will need to be increased. Recent COAG announcements could support such initiatives*

Recommendation 17: *That government invest in initiatives that will increase opportunities for expanded community based prevocational positions, eg PGPPP, so that interest and exposure to general practice is maintained and opportunities to shorten training times are maximised*

Recommendation 18: *That strategies to support and facilitate increased levels of training, education and support for Indigenous doctors and doctors wishing to work in Indigenous health are identified and implemented*

Recommendation 19: *That the AMC be authorised and supported to act as the body to govern the role of and performances of the Colleges in General Practice vocational education and training*

Recommendation 20: *That general practice standards for education and training continue to be set and arbitrated by the profession's relevant colleges, ACRRM and RACGP. This includes a key role in setting and monitoring training standards, curriculum development, accreditation of sites and training organisations, assessment processes and selection for training programs*

Recommendation 21: *That the RACGP and ACRRM are appropriately acknowledged and supported in the form of policy, process and (where appropriate) resources to undertake the role outlined in recommendation 20 across the continuum of medical education and training*

Recommendation 22: *That improvements be made in coordination and communication of clinical training provision to most efficiently use existing resources and better support vertical integration of teaching and education within practices*

Recommendation 23: *That opportunities are identified to evaluate and to increase vertical integration through undergraduate to vocational training*

Recommendation 24: *That opportunities to streamline accreditation processes across the continuum be identified and implemented in order to facilitate integrated teaching practices and reduce red tape*

Recommendation 25: *That governments introduce and coordinate incentive payments to encourage integrated teaching practices*

Recommendation 26: *That the RACGP and ACRRM continue to work toward the development of a framework to maximise opportunities for Recognition of Prior Learning and Mutual Recognition processes between the two General Practice qualifications and between General Practice and other Specialty training programs*

Recommendation 27: *That a documentation system be developed that will capture learning across the GP Education and training continuum and align with the Recognition of Prior Learning and Mutual Recognition frameworks*

Recommendation 28: *That there is support provided for increased focus on opportunities for cross-profession training for health care professionals*

Recommendation 29: *That there is ongoing and increased levels of support, focus on opportunities, and recognition for procedural skills and other expanded scopes of training for GPs, GP Registrars and practice nurses*

Recommendation 30: *That government ensure that appropriate programs are available and accessible to improve the support, orientation and ongoing skills development of International Medical Graduates working in Australian general practice*

Recommendation 31: *That funding be made available to allow stakeholder engagement to discuss and develop International Medical Graduate education and training frameworks in GP and community based settings*

Recommendation 32: *That coordination and management systems be improved, at a regional level particularly, to reduce duplication of processes and resources directed to training delivery*

Recommendation 33: *That a significant proportion of the recently announced funding by COAG for Simulated Learning Environments (SLE) be directed to providing increased access to and use of SLE for GP training and education*

Recommendation 34: *That the Australian Government invest in the development of a framework for a comprehensive evaluation of the current training system across the GP training continuum (i.e. undergraduate, Pre-vocational, and Vocational components)*

Recommendation 35: *That there is investment to implement the framework proposed in recommendation 34 with capacity for ongoing external evaluation of the current training system and its objectives*

Recommendation 36: *That research be commissioned on options to improve perceptions of general practice as a specialty area of practice*

Recommendation 37: *That continuing longitudinal research into GP workforce patterns be commissioned to inform future workforce planning, ensuring that assumptions, data, analysis and modelling adequately account for the diversity of the general practice workforce. Such research should at a minimum include consultation with ACRRM, RACGP, GPET, GPRA, Rural Doctors' Association of Australia, and Australian Medical Association*

Recommendation 38: *That funding is provided to undertake research and evaluation of innovative teaching and supervisory models in the general practice training environment*

Introduction

There is an increasing body of evidence that a strong primary health care system is key to improving health outcomes and reducing health costs¹. An ageing population coupled with an increasing burden of chronic disease mean that there has never been a greater need to ensure the future supply of general practitioners in Australia.

The education and training of general practitioners is central to ensuring an adequate supply of GPs in the future yet despite this knowledge, Australia is falling behind in the ratio of GPs to the population.

The general practice medical workforce is made up of generalist trained primary care physicians or general practitioners who largely work in privately owned businesses that form a large private infrastructure of general practice throughout Australia. This GP workforce is maldistributed with shortages particularly in rural and remote Australia². It is not growing³, and with the numbers of Australian medical graduates entering general practice declining significantly in the last 10 years⁴, there is an increasing reliance on international medical graduates. In rural areas general practitioners often work beyond the primary care sector providing secondary or acute care services in hospitals as well.

The general practice workforce of the future needs to be in a position to deliver the key elements of primary care. These are described by Starfield as follows:⁵

“Primary care deals with most health problems for most people most of the time. Its priorities are to be accessible as health needs arise; to focus on individuals over the long term; to offer comprehensive care for all common problems; and to coordinate services when care from elsewhere is needed. There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs.”

If Australia is to be able to deliver a first class primary care system, then it must ensure that the current barriers to the supply and distribution of GPs are overcome.

This document identifies those barriers and presents the argument for change.

¹ Macinko J, Starfield B, Shi L. (2003). The contribution of primary health care systems to health outcomes within Organisation for Economic Development (OECD) countries 1970 -1998. *Health Serv Res.* Jun;38(3):831-65

² Australian Government Department of Health and Ageing (2008). *Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008*. Commonwealth of Australia., Canberra.

³ Australian Institute of health and Welfare (2008). Medical Labour force 2005. *National health labour force series no. 40. Cat. No. HWL 41*. Canberra: AIHW

⁴ Australian General Practice Training (2008). Submission to National Health and Hospital Reform Commission. General Practice Education and Training. Canberra

⁵ Starfield B. (2005). The Primary solution. *Boston Review*. November/December 2005

Where Are We Now?

Two College pathways

The current system of GP education and training now provides the opportunity for medical registrars to train in two different College pathways to achieve recognition as a General Practitioner through either or both the RACGP or ACRRM pathways of training. These pathways are primarily delivered within the Australian General Practice Training (AGPT) program which is administered by GPET. The Remote Vocational Training Scheme and ACRRM also deliver small scale alternative programs which lead to vocational recognition. Censors of both Colleges have now agreed on a Memorandum of Understanding which should enable GP Registrars to select training pathways more effectively.

Rural Training

Rural training has been a strong emphasis of the current training system for fifteen years. There is a rural pathway which ensured 250 of the 600 entrants in recent years undertook training in a RRMA 3 to 7 area. An Enhanced Rural Training Framework developed by GPET has also ensured appropriate structures and resources are in place to support GP Registrars in rural training. GP Registrars in a rural specific pathway can train towards the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) and the Fellowship of Advanced Rural General Practice (FARGP), as well as participate in innovative opportunities to train in rural generalist programs developed by several jurisdictions (Queensland, Western Australia).

Regionalised training

A system of regional training provider organisations (RTPs) has delivered GP vocational training over the last 7 years. In 2005, the *ACIL Tasman*⁶ report, which was an evaluation of regionalisation of general practice vocational training, made a number of recommendations to strengthen regional delivery, including increasing flexibility in the program, reviewing selection into the program, and strengthening incentives for rural training.

RTPs have developed broad roles for training delivery in their areas. Many have also expanded their roles beyond vocational training. For example some RTPs also have a role in delivering the Prevocational General Practice (PGPPP) in their area.

Indigenous health

Indigenous health training has also increased in response to regional community health needs, with a national framework for delivery of such training. The number of indigenous health posts has also increased significantly.

Marketing

GPET and the RTPs⁷ have developed a strong marketing focus to attract graduates into GP training, particularly into rural and regional areas and specific areas of need such as Aboriginal health. GPET has also undertaken modelling of future workforce needs in numbers and distribution.

⁶ ACIL Tasman. (2005) *Evaluation of regionalisation of general practice vocational training*. ACIL Tasman. Melbourne

⁷ GPET (2008) *Annual Report*. GPET. Canberra. <http://www.agpt.com.au/PoliciesPublications/AnnualReport/> (Accessed December 2008)

Quality of training

A comprehensive accreditation system for regional training providers with GPET, RACGP and ACRRM participating in the process has led to an expectation of high standards of training and continuing quality improvement in the delivery of the regionalised training system.

Vertical integration

The development of a regionalised structure of training in 2001 that mandated linkage between Universities, Divisions of General Practice, both Colleges and the new training provider organisations at the outset of the new training system, fostered the opportunity for vertical integration of training delivery at the local level. GPET developed a framework for vertical integration to assist in this process and there are now examples of such integration across the system.

At the learner level there are examples of joint University and RTP workshop delivery and more seamless pathways of training. A significant development has been the establishment of the General Practice Students Network (GPSN). An organisation run by medical students for medical students, GPSN seeks to foster greater awareness of General Practice as both a lifestyle and a career. GPRA is the administrative body for GPSN allowing for close interaction with GP Registrars and regional training providers. Mentoring programs, scholarship placements in general practice and joint workshops link medical students to GP Registrars providing positive role modelling and early exposure to General Practice. GP Compass, a new GPRA initiative will see the establishment of a new peer supported network within the hospital system that will bridge the gap between GPSN and GPRA. This vertical integration between Registrars, interns and medical students is aiming to provide seamless positive exposure to General Practice in a peer supported environment.

At the teacher level many of the GP teachers are now teaching at the medical student, prevocational and vocational levels and often have joint appointment across the spectrum. GP Registrars are also increasingly taking up a teaching role. Although this role is yet to be formalised by recognition in the training curriculum, the training program requirements would be strengthened by the formal recognition of Registrars as Educators. This would also be an opportunity to enhance teaching capacity in the training system. Teaching roles for registrars should be well supported and become an explicit part of training, attracting appropriate remuneration. At the general practice level, many training practices now provide clinical training opportunities for different levels.

At an organisational level there has also been a degree of vertical integration with some University Departments delivering programs to medical students, prevocational doctors and GP Registrars. GPRA is in the process of forming a collaborative national network that will enable hospital interns, medical students and GP Registrars to network with each other and interact with regional training providers and GP stakeholder organisations through a common platform. Some regional training providers are also involved in prevocational training. All of the regional training providers have a cross-organisational involvement at a governance level.

While much has been achieved in vertical integration, there is still no consistency of approach across the country. While this may be a strength in terms of adapting to regional needs and resource availability, there is a need to ensure that best practice integration models are widely reported and shared.

Where Are We Going?

The future health context

General Practitioner education and training is a key plank in developing and supporting the role of general practice in the primary health care system of the future. The health care landscape in which general practitioners now operate has changed from a decade ago and there are a number of key factors impacting on the delivery of primary care services that need to be considered in any discussion about education and training of health professionals. A brief history of GP education and training in Australia is provided in Appendix 1.

Community needs and the health system

Expenditure on health in 2005-6 was approximately 9% of Gross Domestic Product with government funding two thirds of this at \$86.9 billion. Some \$4 billion of this was used to fund GP item Medicare rebates.⁸ There is good evidence that strong primary health care systems drive down costs and improve health outcomes and that the general practitioner (primary care physician) is central to this.^{9 10 11 12}

The Australian population is ageing and this has implications for the health system as the over 55s are the heaviest consumers of medical services. By 2047 the proportion of over 65s is projected to double to 25% of the population and the over 85s to triple to 5.6% of the population.

The chronic disease burden which is the core business of general practice is expected to impose even heavier burdens on the demand for health services, and therefore health workers. It has been estimated that between 2001 and 2026 the incidence of diabetes will increase by 176%, dementia by 107% and chronic musculoskeletal disorders by 79%.¹³

The health of Indigenous Australians is also a key challenge for this generation of general practitioners. Commitments have been made to closing the gap in Indigenous health outcomes within the next 25 years.

Expectations of the health consumer have changed with increasing health literacy¹⁴, as have expectations of shared decision making. Equitable access to health care including at the primary care level is an expectation despite declining health professional numbers. Advances in technology create new challenges in education as well as delivery of health care, but also provide an opportunity for new methods of delivering primary health care and medical education.

⁸ Britt H et al. *General practice activity in Australia 2006-7*. General practice series no. 21. Cat. no. GEP 21. Canberra: Australian Institute of Health and Welfare. p1-2

⁹ Macinko J, Starfield B, Shi L. (2003). The contribution of primary health care systems to health outcomes within Organisation for Economic Development (OECD) countries 1970 -1998. *Health Serv Res.* **38(3)**:831-865

¹⁰ Starfield B. (2005). The Primary solution. *Boston Review*. November/December 2005

¹¹ Australian Medical Association (2008). *General practice in primary care: responding to patient needs*. <http://www.ama.com.au/web.nsf/doc/WEEN-7KV698> (accessed November 2008).

¹² Royal Australian College of General Practitioners (2008). The improvement of general practice primary care services: submission to the National Health and Hospitals Reform Commission. <http://www.racgp.org.au/reports/26806> (Accessed October 2008).

¹³ Dr Anna Peters, Research Summary, Disease trends 2007, Victoria Health www.vichealth.vic.gov.au/assets/contentFiles/research_DiseaseTrends

¹⁴ Edwards A, Elwyn G, Wood F, Atwell C, Prior L, Houston H. (2005). Shared decision making and risk communication in practice: a qualitative study of GPs' experiences. *Br J Gen Pract.* Jan;55(510):6-13.

Therefore, without substantial investment in the primary health sector, our hospital-dominated health system will be unable to manage escalating workloads and costs.

The general practice context

The general practice environment has also changed. An increasing emphasis on team based approaches to the delivery of primary care services, and the introduction of Medicare items that can be provided by nurses and allied health professionals has resulted in a substantial growth in the numbers of additional health professionals working in primary care settings. For example, practice nurse numbers have increased in recent years from just over 5000 in 2005 to almost 8000 in 2008.¹⁵

There has been increasing government interest in developing the role of the nurse in the primary care environment and looking at other complementary role options such as physician assistants. While Colleges support expansion of roles to alleviate workforce shortages, it is vital that risks to the community are not created by further fragmentation of care or credentialing of under-qualified healthcare workers to provide care that is unique to the skills and competencies of the general practitioner.

Strong evidence exists of positive patient health outcomes from the continuity of care provided by a GP.¹⁶ Improvements in future care delivery must consolidate these outcomes.

The business context of general practice is also changing with some general practices no longer owned as a business by the general practitioners working in them. “Corporate” practices or practices owned by large business organisations, often with public company listing, are increasing in numbers, particularly in urban and large regional centres. The distribution of public funds in this manner has never been questioned but may be desirable in planning the future education environment. Not-for-profit practice and integrated primary health care structures are also increasing in number in areas of need, both rural and urban.

Consumer expectation is that access to a primary care doctor should be both temporally and financially achievable within reasonable limits.

The future General Practitioner

The training of today is for the GPs of tomorrow. How will GPs practice in 10 years time? Defining the scope and role of GPs is the ongoing key work of the Colleges, in wide consultation with stakeholders, as has occurred to date.

The central role of the GPs or family physicians in primary care has been clearly demonstrated.^{17 18 19 20}

There is a need to continue to emphasise the centrality of the patient-doctor relationship, developed over time and with experience, as a means to facilitate improved patient health outcomes. As Starfield states,

¹⁵ Presentation of Results of the Australian Practice Nurse Study. 10 Australian General Practice Network Forum. Darwin November 2008

¹⁶ Starfield, B. S., Leiyu & Macinko (2005). Contributions of Primary Care to Health Systems and Health. *The Milbank Quarterly*, **83(3)**, 457-502.

¹⁷ Starfield B. (2005). The Primary solution. *Boston Review*. November/December 2005

¹⁸ Gunn J. et al. (2008). *What is the place of generalism in the 2020 primary care team? Final report*. Australian Primary Health Care Research Institute (APHCRI). Australian National University. Canberra

¹⁹ Department of Health UK. (2008). *NHS Next Stage Review Our Vision for primary and Community Care*. Department of Health UK.

²⁰ Australian Divisions of General Practice. (2005). *Primary Health Care Position Statement*. ADGP Canberra

*“There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs”.*²¹

The general practitioner is the primary care generalist doctor in the Australian system and has a unique function and set of skills. There is increasing evidence that the generalist doctor in primary care is critical to quality care.²² There are some key trends that are already emerging which will define the general practitioner and rural doctor of the future:

- *The increased population health role at a practice and community level with the general practitioner and general practice as central to preventive health care for patients and communities*
- *The general practitioner as central to the management of chronic and often complex disease, and the expert in generalist care in the primary care setting and often in the secondary care sector as well, particularly in the rural context*
- *The general practitioner as pivotal in the interface between the hospital and community sector. This must be maintained and developed to ensure patient continuity of care, including reintegrating the GP into hospital based care*
- *The importance of multidisciplinary team based care in the primary care sector with the role of the GP as stewarding patient care and providing clinical governance leadership to the team*
- *Indigenous health care as one of the emerging priorities for all GPs*
- *In addition to comprehensive generalist practice, specific skills sets are needed by GPs and their teams in particular contexts, especially procedural skills in the rural context. Other expanded forms of practice are also evolving, for example chronic disease, palliative care, migrant health, mental health, etc.*
- *The changing workforce patterns for GPs of the future with, for example, increased part time work and an increased interest in development of special interest practice in the context of a background of generalist practice*
- *The future general practitioner is more likely to be an employee or associate in a practice rather than the general practice business owner*
- *The increased population health role at a practice and community level with the general practitioner and general practice as central to preventive health care for patients and communities*
- *The increasing role of the GP as advocate for the patient in navigating a complex health system*
- *The expanding teaching and research role for GPs*
- *The changing technologies and scope for near patient testing, management of complex illness in the community, more virtual medicine and care at a distance, and for more diagnostic testing in general practice.*

Any education and training system will need to prepare the future doctors for these future roles in the evolving health system.

²¹ Starfield B. (2005). The Primary solution. Boston Review. November/December 2005

²² Gunn J. et al. (2008). *What is the place of generalism in the 2020 primary care team? Final report.* Australian Primary Health Care Research Institute (APHCRI). Australian National University. Canberra

Generational changes – lifestyle balance

The doctors of the future have different expectations and aspirations. Generation X, for example, have been said to possess a strong need for independence, flexibility, and autonomy in the workplace with implications on how and why they may choose certain types of career.²³ Generation Y, on the other hand, have been said to be motivated by personal growth and are unlikely to hold the same job in an organisation for life. With a desire for developing transferable skills the Generation Y group will be remarkably different to their predecessors and have different constructs for making career choices. Both groups challenge the traditional hierarchical career structures of their predecessors, whereby age and experience correlate directly with seniority.²⁴

The general practitioner education and training system of the future

The current and future contexts set the scene for looking at the GP education and training system. As a key player in the delivery of primary care, education and training systems will need to produce GPs who are prepared for practice in the next decade and beyond.

Analysis of future community needs, trends in scientific and technological developments, health system workloads and costs, will inform the evolution of the future of general practice education and training. Some of the key factors to consider will be:

- *Key roles of Colleges in setting standards and in accreditation processes*
- *Workforce numbers and distribution*
- *Integrated primary health care models of care*
- *Future changing health professional roles, relationships and skills sets (including extended skills for emerging medical challenges and expansion of new roles including nurse practitioner and physician assistants)*
- *Teaching infrastructure requirements*
- *Clinical training capacity including the need to increase the numbers of expert GP teachers*
- *Education and training financing systems*
- *Changing health literacy of the population*
- *Information technologies used to enhance the quality of patient care including e-Health and point-of-care testing*
- *The future general practice infrastructure and its funding ownership in addition to business operation and its impact on training*
- *The remuneration systems for future general practitioners and their impact on training*
- *Recognition of changing workforce demographics and aspirations*
- *Expanded generalist roles and the shift of much secondary and some tertiary care into the community*
- *Generation X and Y attitudes to personal and professional needs*

Integrating general practice training (and a proportion of training for other primary health care disciplines) into clinical practice will require planning and investment across these parameters. Such investment should be focused first in areas of greatest need taking consideration of factors such as geographic distribution and access, medical workforce

²³ Yrle, A., S. Hartman, and D. Payne (2005). Generation X: acceptance of others and teamwork implications. *Team Performance Management, Bradford* 11 (5/6): 188, 12 pgs.

²⁴ Turetsky, D. (2006). Generations at work: new expectations & incentive requirements. *Workspan, Scottsdale* December: 24, 4 pgs.

supply, and socio-economic and health need across demographic domains. However, shortages across all demographic domains currently exist and will need to be addressed.

Vision for a future system

In considering a future system, it is worth articulating a vision for that system and some suggested outcomes for its future development.

A proposed vision for the future system might be:

The whole of the Australian population having access to a GP workforce that is effectively and efficiently trained to deliver high quality services to improve their health care

Outcomes for a future system

A GP workforce that is being recruited as a specialty of choice:

- from Australian medical graduates, including Indigenous doctors
- from appropriately trained and supported International Medical Graduates as needed.

A GP workforce being trained in:

- appropriate numbers and distribution to meet the current and growing health needs of Australia
- required disciplines with appropriate skill sets and roles, including clinical medicine, Indigenous health, rural and remote medicine, procedural skills, research and education
- multidisciplinary team settings and skills
- all regions of Australia

Training being delivered needs to take into account:

- needs of communities
- capacity of GP system to provide quality training experience
- appropriate and effective governance arrangements
- rural and regional settings, and other areas of significant socio-economic and health disadvantage in all geographic settings
- delivery in a vertically (throughout the career journey) and horizontally (across medical and other health disciplines) integrated, seamless and efficient manner which will also rely on wider health system reforms
- community and private sector, public hospitals, not for profit settings, as well as indigenous health, chronic disease, aged care and other special purpose settings
- inter professional learning environments
- coordinated, flexible and efficient delivery processes
- innovative and quality managed environments
- training settings that embrace the changing needs of education and training while retaining the master/apprenticeship model
- evolving team-based training environments
- evolving roles in the general practice and primary care setting
- evolving technologies in clinical practice and medical education
- changing workforce participation patterns.

With these outcomes in mind, and given the future health and general practice context, a number of challenges for the future are identified for consideration.

Challenges

There are a number of obvious challenges for the future that need to be considered urgently and where new solutions will need to be found by the profession working hand in hand with government, training providers and the community.

Key Issue 1: General Practitioner training numbers, distribution and teaching capacity

Training Numbers

An adequate general practitioner workforce will be dependent on an adequate supply of trainees into the education and training programs designed to equip them for the general practitioner role of the future.

Graduating numbers of Australian medical students will reach capacity by 2012 with input of domestic students of 2,945 p.a. and international students at approximately 455 p.a. overall.²⁵ There are a declining number of Australian graduates choosing general practice as a career option. The entry into the Australian General Practice Training (AGPT) program represented 27% of Australian graduates in 2007 and 29% in 2008. International medical graduates have formed about a third of entrants into the program particularly into the rural pathway of training. Prior to 1996 the percentage of Australian graduates choosing general practice was close to 50%, one of the reasons that GP training entry numbers were capped. The number of entry training places for general practice in 2008 was 600 per annum. The entry numbers were recently increased by the Commonwealth government to 675 in 2009, 700 in 2010 and to 812 annually from 2011 onwards. The number of places in the Rural Vocational Training Scheme (RVTS) was also be increased from 15 to 22 starting in 2011.

The Australian Medical Workforce Advisory Committee (AMWAC) in 2005 projected that 1100-1200 new entrants from 2007 would be needed to ensure a stable number of GPs.²⁶ GPET has also undertaken some modelling regarding the number of AGPT entrants needed into the future and has set a target of attracting 35% of Australian graduates into the workforce by 2012, mostly through marketing strategies to the prevocational doctors. This is a figure of 1100 per annum in real terms.

The number of entrants required is largely projected assuming that general practice work patterns and demand for services will remain at similar levels. Changes within the primary care workforce as a whole may influence the number of GPs required in the future. It could be argued that increasing the role of other primary care workers will reduce the need for general practitioner services. On the other hand, the increasing chronic disease burden and ageing population and a trend to more standard working hours for GPs will increase demand for medical services. It has been shown in the USA context that increasing a generalist primary care physician workforce does reduce costs and improve health outcomes.^{27 28}

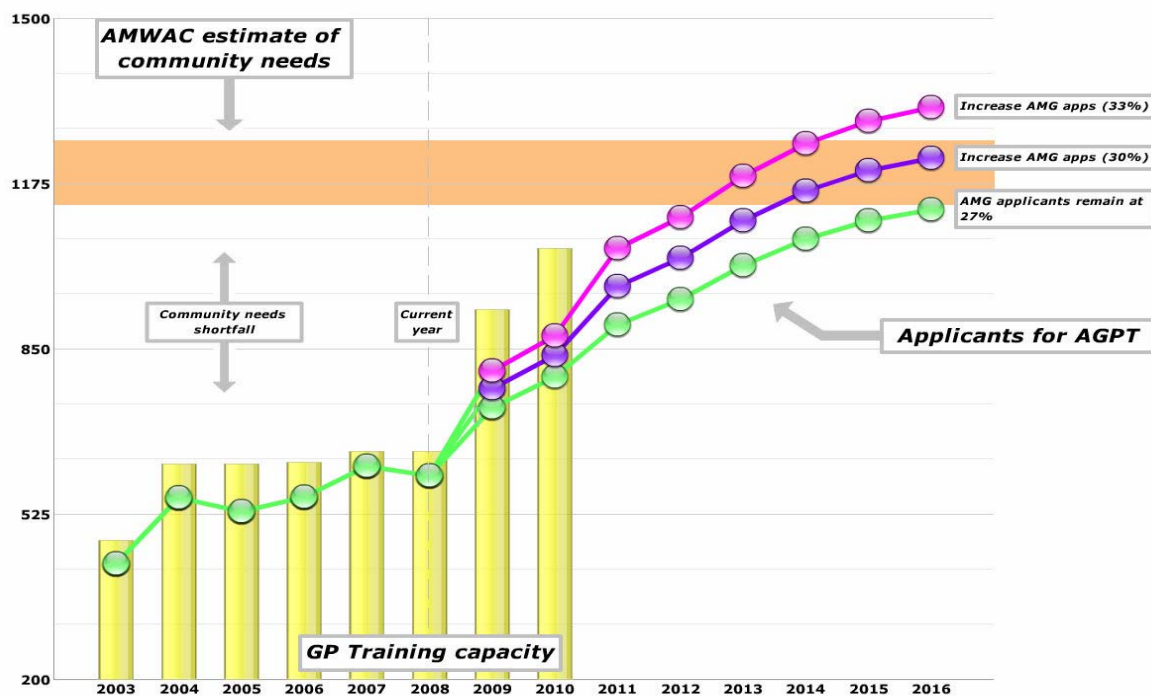
²⁵ Medical Training Review Panel *11th Report*. (Dec 2007). Department of Health and Ageing. pg 22,23

²⁶ Australian Medical Workforce Advisory Committee (2005), *The General Practice Workforce in Australia: Supply and Requirements to 2013*, AMWAC Report 2005.2, Sydney

²⁷ Ferrante J M et al. (2000). Effects of physician supply on early detection of breast cancer. *J Am Board Fam Pract*; **13**(6):408-414

²⁸ Greenfield S et al. (1992). Variations in Resource Utilisation among medical specialties and systems of care. *JAMA*; **267** (12):1624-1630

Figure 2: AGPT Program Entrants, Training Capacity and Community Needs
(copied from GPET submission to NHRC May 2008 pg 5²⁹)



While the recent increase in training places by the Australian Government is welcome, further increases will need to occur if supply is to match current predicted demand. It will be essential to undertake constant updated modelling to further clarify and refine real general practitioner workforce needs of the future. The workforce data that may be collected under the proposed new national registration system as well as the proposed national health workforce agency³⁰ could assist this process.³¹ However, it is essential that governments continue to work collaboratively with the profession to ensure a supply of general practitioners that matches demand and satisfies requirements for standards and quality.

Recommendation 1: That the Australian Government ensure that appropriate number of GP training places are funded and allocated to meet the current and future workforce requirements for the primary health care needs of Australia, taking due consideration of the demographics of current workforce (i.e. ageing and non-procedural)

Recommendation 2: That the Colleges, GPET & GPRA are included in any workforce planning related to the general practice workforce. Such workforce planning should take particular note of changing demographics and expectations in the Generation X and Generation Y training cohorts

²⁹ General Practice Education and Training (May 2008). *Submission: National Health and Hospitals Reform Commission*. (Accessed October 2008). [http://www.nhrc.org.au/internet/nhrc/publishing.nsf/Content/083-gpet1/\\$FILE/083%20General%20Practice%20Education%20and%20Training%20Limited%20Submission.pdf](http://www.nhrc.org.au/internet/nhrc/publishing.nsf/Content/083-gpet1/$FILE/083%20General%20Practice%20Education%20and%20Training%20Limited%20Submission.pdf)

³⁰ Council of Australian Governments meeting 28 November 2008. http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta (Accessed December 2008)

³¹ Council of Australian Governments meeting 28 November 2008. http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta (Accessed December 2008)

Training distribution

We must stem the workforce shortage and future decline in areas of general practice workforce shortage in Australia. Priority must be given to support for training that will encourage general practitioners to work in such areas, and there must be flexibility in the funding and governance to address the regional and local reasons for those shortages.

Training Distribution - Rural

Over the last fifteen years there has been a concerted effort to train future doctors in rural, remote and outer metropolitan environments, particularly those training for general practice. Currently the AGPT fills 600 training places a year of which 250 are designated as places in RRMA 3 to 7 regions. The remaining 350 Registrars also undertake at least 6 months of training in a rural or remote area. Maintaining these rural training strategies is an important way to ensure the distribution of General Practice Registrars (GPRs) across the population of Australia.

There is now increasing evidence particularly from the tracking of the rural clinical school cohort that the place of training influences subsequent place of practice. The regionalization of GP training, with 20 regional training providers (RTPs) delivering training, and distribution of training places to those RTPs, has been an reasonable attempt to achieve training spread and workforce supply to regional and rural areas.

Rural exposure in medical schools has increased with most students experiencing at least a short term rural attachment. Most medical schools now have 25% of their HECS funded medical students undertaking a rural stream of training with a minimum one year placement in a rural environment, as part of a Commonwealth funded initiative to promote rural experiences. Various forms of rural scholarships, some with rural bonding requirements, have also been important strategies to attract student commitment to rural training and practice.

There is also a small program for training remote single practice doctors, the Remote Vocational Training Scheme (RVTS), and a new program of rural generalist training being developed with Queensland Health. GP Registrars who train in a rural setting are offered substantial remuneration incentives by government to do so through the Registrar Rural Incentive Payment Scheme (RRIPS).

Maintaining such strategies will not be enough to stem the workforce shortage and future decline in rural and remote Australia. There must be a continued priority on support and training that will encourage general practitioners to work in remote and rural practice.

Training Distribution - Outer metropolitan

Outer metropolitan areas have also been targeted as needing increased workforce supply, and GP Registrars in the general training stream are required to undertake a mandatory 6 months of training in an outer metropolitan area as well as the mandatory 6 month of training in a rural area. Again, incentive payments are available from government.

Maintaining such strategies is important. As well, there have been a range of suggestions to increase the diversity in the geographic distribution of training. These have included the suggested establishment of community clinical schools in outer metropolitan regions and potentially in other metropolitan areas of high community need (see Urban and Inner Metropolitan, below) along similar lines to rural clinical schools.

Training Distribution - Urban and Inner Metropolitan

While the strategies currently in place focus on important areas of workforce shortage, they fail to address other issues of need, such as the metropolitan, urban and inner urban areas of high community socio-economic and health need. Figures on poorer health outcomes from such areas are subsumed into averaged metropolitan health statistics. The RACGP has policies that seek to address such issues by broadening the strategies around registrar placements and the enhancement of registrars' interest in practicing in such settings.³²

Likewise, the needs of special groups must not be overlooked. The number of GP training places in Indigenous health locations has also increased substantially over the last 5 years, and at least maintaining if not augmenting these levels will be important.

***Recommendation 3:** That the distribution of funded GP training places should reflect geographic access, workforce shortage, health and socio-economic needs of the community*

Teaching Capacity

With the current projected increase in training numbers and if the number of GP training positions is increased further as recommended, teaching general practices will need to accommodate an increased number of Registrars. With the doubling of medical student numbers and the increasing emphasis on community based medicine, general practices will be teaching double the number of medical students and often for longer periods.

As well, the new teaching role being developed with prevocational training with the Prevocational General Practice Placement Program (PGPPP) has also added additional demands, as has the expectation that other health professionals such as nurses and allied health workers may be undertaking some training in a general practice environment.

There is a need for overall and coordinated investment in the GP teaching sector to ensure high quality and appropriate community based experiences for the doctors and GPs of the future.

***Recommendation 4:** That the capacity of the GP education and training system be examined at a macro level to ensure the full continuum is adequately supported to deliver coordinated and high quality teaching. This includes adequate numbers of appropriately skilled teachers and recognition of teaching as a vital component of service delivery within the health system, and financial and other recognition where additional duties and responsibilities are assumed in the private and community setting*

³² Royal Australian College of General Practitioners. <http://www.racgp.org.au/policy/healthsystems>
http://www.racgp.org.au/scriptcontent/policy/policydocs/Relationships_between_General_Practitioners_and_Community_Health_Services.pdf
http://www.racgp.org.au/scriptcontent/policy/policydocs/GP_and_patient_research_Policy.pdf

Capacity of teachers

There are decreasing numbers of full time general practitioners per head of population and increasing service loads. Therefore, new approaches to teaching need to be considered. Potential strategies, many of which are in operation within specific regional training providers, include the following:

- encouraging General Practice Registrars (GPRs) to undertake a teaching role as a normal part of their learning cycle, as currently happens in the hospital sector. This will require teacher training of GPRs and recognition and remuneration of that teaching effort
- enhanced professional and financial incentives to encourage retention and a higher proportion of general practitioners to become supervisors and teachers
- sharing of teaching responsibilities between General Practice supervisors and utilization of senior College Travelling Fellows/Mentors
- incentives to attract senior, retiring or semi retired GPs into a teaching role with appropriate remuneration and conditions, i.e. the development of a multi-tasking senior teacher, supervisor, mentor role
- enhancement of distance supervision and teaching through video-teleconferencing, interactive learning, structured simulation sessions, hotlines and other strategies
- utilising other teachers in the general practice setting including nurses and allied health professionals also needs to be considered in selected curriculum areas as appropriate.

In addition, supporting general practice teachers via enhanced information management and information technology systems, team structures, teaching infrastructure, professional development opportunities, and career pathways, will be critical to increasing the proportion of practitioners and practices involved in teaching.

Recommendation 5: *That the number of general practice clinical supervisors is increased to reflect increasing trainee numbers whilst ensuring quality teaching is maintained*

Recommendation 6: *That the role of teaching in general practice be recognised and that appropriate funding mechanisms are further developed to support this role*

Recommendation 7: *That models continue to be developed where registrars and other practice team members are encouraged, supported and remunerated for teaching*

Capacity of training practices

There are currently about 6300 general practices across Australia but only about 2000 of these are currently accredited for GP training. Participation rates are considerably higher amongst rural practitioners. With only 30% of general practices currently accredited, there is clearly some capacity to bring other practices on board to increase training capacity.

There are many conflicting demands on the current infrastructure available to support quality teaching activities in general practice, and there is little opportunity or support to increase the number of medical surgery consulting rooms, teaching areas, accommodation for visiting students registrars and allied health team trainees.

General practices are essentially private businesses that have historically not built premises to include training rooms because of poor return on investment for building infrastructure that does not generate income.

Mechanisms for increasing training infrastructure have included state-territory funded integrated primary health care initiatives (eg, GP Plus SA, Community Partnerships in Victoria, HealthOne NSW) and more recently, the 31 GP Super Clinics development as well as some Rural Clinical School infrastructure payments to practices. New models to support and develop investment in training infrastructure in existing practices are a priority - first and foremost in areas of greatest community need regardless of geography.

There needs to be much more detailed and specific development, for example:

- extension of the National Rural and Remote Medical Infrastructure Fund into urban areas of high community need
- development of practice enhancement grants linked to a quality framework
- further development of hub and spoke education and training networks
- “business development” support to encourage practices to invest in teaching infrastructure.

Accommodation

Part of clinical training infrastructure requirement is suitable and affordable accommodation for the increased numbers of students, junior doctors and registrars training in community settings. This is a vital issue in remote and rural contexts.

Access to appropriate information technology infrastructure for learning is essential, particularly in a rural and remote environment, as is access to travel opportunities both for learning and to reduce professional and personal isolation.

Achieving access to both elements in rural and remote environments within a short timeframe is critical to workforce strategies.

Recommendation 8: *That additional funds to support increased levels of teaching infrastructure and accommodation facilities for training posts be distributed **urgently** to enable expansion of capital and facilities to be commenced as medical graduate numbers increase. Recent COAG announcements could support such initiatives*

Recommendation 9: *That the developments in internet and e-health delivery be harnessed to support general practice training. Recent COAG announcements could support such initiatives*

Training in regional and rural hospitals

Regional and rural hospitals provide an important training experience and opportunity for general practitioners, particularly those that intend to work outside of metropolitan areas at various stages in their career. These facilities provide an opportunity for generalists to undertake a rich and challenging variety of primary and secondary care and to gain competency in managing the varied clinical, professional and management interfaces between these models of care. Encouraging extended or advanced training in hospital settings may also address particular care needs such as the management of chronic disease and complex co-morbidity.

It is vital to the future rural medical workforce that general practitioner registrars have significant and well organised access to hospital training opportunities, and that such training posts are appropriately accredited to ensure they are able to provide an appropriate scope for skills development and a quality experience for registrars.

Recommendation 10: *That appropriate support be given to extend training opportunities within accredited hospital training posts or other relevant workplaces.*

Key Issue 2: General practice as a preferred career option

Recognition of general practice as a specialty

The general practitioner role is acknowledged as a specialty area of practice by its recognition as a specialty by the AMC. However, in Australia, there is still a way to go before it receives full recognition by governments and the medical fraternity. Unless there is such recognition with remuneration structures which create wage parity, it will always be difficult to foster interest from Australian graduates. This is a significant issue that requires attention and falls outside the scope of this paper but the following proposals will go some way to improve the profile of general practice as a specialty area of practice.

Recommendation 11: *That marketing and recruitment strategies are collaboratively developed and implemented by the profession to increase awareness of general practice as a high status, diverse and rewarding career*

Recommendation 12: *That remuneration and incentives structures are defined that will make a GP career and GP training attractive options*

Promoting the role of the general practitioner

The reasons for the declining entry of Australian medical graduates into general practice needs further exploration. There is evidence that early exposure to positive career experiences and mentors increases the likelihood of that career being chosen.³³ General practitioner role model exposure and celebrating the contribution of the well trained generalist is important whether it be GP Registrar talks at high school level in a small rural town, or in a GP led teaching grand rounds at a major city hospital. Reinforcing the role of the general practitioner in the wider community context is important.

Further information on factors that influence career choices and locations of practice is still important. Longitudinal tracking of medical students is now occurring. However, we need more information immediately to influence current trends where pre-vocational doctors are following career paths away from general practice. There is a need to determine the drivers for rural or urban practice and apply a full range of diverse recruitment strategies.

Recommendation 13: *That the factors that influence career choice and location continue to be actively monitored and reported*

A number of unique marketing strategies aimed at promoting general practice³⁴ are currently in place such as:

- General Practice Students Network (GPSN) which is built on some of the same principles as the successful Rural Clubs
- GP Compass, a new initiative designed to connect with new graduates during the prevocational period
- GPSN Schwartz First Wave Scholarship Program, which offers an opportunity for medical students in their first or second year to experience General Practice under the guidance of a dedicated General Practice Preceptor.

³³ General Practice Education and Training (2007). *If the job fits. The complexity of medical career decision making, A review 2007*. GPET. Canberra. <http://www.agpt.com.au/policiespublications/research>

³⁴ Jill E Thistlethwaite J E, Kidd M Rand Hudson J N. (2007). General practice: a leading provider of medical student education in the 21st century? *MJA*; **187** (2): 124-128

While these initiatives particularly around mentoring roles are in early stages of operation they appear to be having some impact and it is therefore important to ensure that they not only continue but are strengthened.³⁵

Recommendation 14: *That evidence-based, appropriate recruitment and remuneration strategies which include but are not limited to role modelling, peer to peer support, early positive exposure, social marketing and professional networking are implemented*

Recruitment strategies

Increasing general practice exposure in medical school as well as in prevocational training should be maximized as a means to increasing the number of students choosing general practice as a career path.

Current models of education and training within the university and hospital environments offer limited exposure to general practice for students and pre-vocational doctors. Whilst universities differ on their GP placements, a large proportion only offer a 10 week rotation typically in the 3rd or 4th years of their degree. There are real concerns around the quality of this exposure and student feedback indicates that there is much room for improvement.³⁶ The hospital environment provides very limited exposure to general practice, particularly in metropolitan areas where GPs are not routinely involved in planning and delivery of inpatient care. By contrast, hospitals provide a significant exposure for other specialties. It is critical that strategies are implemented to provide targeted exposure in these environments. GPSN, GP COMPASS, PGPPP, and First Wave Scholarship program are important first steps in this direction and should be supported, built upon and expanded in the future.

Recommendation 15: *That General Practice organisations work with the Medical Deans of Australia and New Zealand (MDANZ) to increase early ongoing and positive exposure to general practice during medical school programs*

³⁵.

Fried, Toni (2006). *Influence of role models and mentors on female graduate students' choice of science as a career*. 2006 Mount Saint Vincent University
 Hensler-McGinnis, Nancy Felicity (2004). *A qualitative study of changes in career orientation: Exploring the contributions of life meaning and role modeling/mentoring to women's life/career paths*. University of Maryland, College Park
 Dingus, Jeannine E. (2003). *Let the circle be unbroken: Professional socialization of African American teachers from intergenerational families*. University of Washington, 2003
 Wickham, Sara. *Midwifery Today with International Midwife*. Eugene: Dec 31, 2001. , Iss. 60; pg. 9
 Michelle S Horner, Susan Milam Miller, David C Rettew, Robert Althoff, et al (Sept-Oct 2008). Mentoring Increases Connectedness and Knowledge: A Cross-Sectional Evaluation of Two Programs in Child and Adolescent Psychiatry. *Academic Psychiatry*. Vol. 32, Iss. 5; pg. 420
 Kerry Priest (2008). Career Decision-Making for Agriculture Students' Sustainability. *The Agricultural Education Magazine* Jan/Feb 2008. Vol. 80, Iss. 4; pg. 23

³⁶ General Practice Students Network (2007). *Briefing paper: Optimising General Practice Rotations*. GPSN. Melbourne

Expansion of Rural Clinical schools and establishment of Community clinical schools

Rural clinical schools, while still focussed on other medical specialist training programs, do provide placements of up to one year in rural general practices for up to 25% of students. However, Rural Clinical Schools are variable in terms of their exposure to General Practice and GP role models. The Prevocational General Practice Placement Program (PGPPP) has also provided some junior doctors (about 280 per annum) with general practice term rotations at a time when career choices are being made.

Rural clinical schools have been a key strategy to promote rural general practice as a career choice. There is emerging evidence that this strategy has been important in influencing career choice for rural general practice.³⁷ Expanding the same concept to community clinical schools in outer metropolitan urban settings is recommended for all Australian capital cities.

The establishment of community clinical schools in outer metropolitan regions along similar lines to rural clinical schools would allow for increased placement of medical students into general practices in such areas during their early training. This would enhance the diversity of the training experience for students and hopefully increase interest in general practice as a career option.

***Recommendation 16:** That opportunities to create new community based academic centres of excellence (e.g. Community Clinical Schools) in areas of high health and socio-economic need be explored. At the same time the capacity of current rural clinical schools and regional training providers will need to be increased. Recent COAG announcements could support such initiatives*

Expansion of Prevocational General Practice Placement Program (PGPPP)

This program has been established successfully for more than 3 years and is now operating in all States. The PGPPP provides prevocational doctors with exposure to general practice for clinical learning purposes but also provides exposure to a potential career pathway at the time when 60% of junior doctors are making their final career choice. This is a key recruitment strategy as well as an important strategy for increasing clinical training opportunity and the GP workforce. A key recommendation is to increase the overall number of PGPPP sites, as well as the proportionate opportunities available in each State and Territory.

***Recommendation 17:** That government invest in initiatives that will increase opportunities for expanded community based prevocational positions, eg PGPPP, so that interest and exposure to general practice is maintained and opportunities to shorten training times are maximised*

Increasing number of applicants into GP training

There are a range of suggestions to increase effective recruitment which include:

- Continued strong marketing of GP training to universities and junior doctors
- Review policy relevance and requirements for the rural pathway and requirement for registrars to undertake both a rural *and* an outer metropolitan term
- flexible incentives for ‘Area of Need’ placements – rural and urban
- further development of training and professional development pathways and career options
- greater mobility between all college pathways and disciplines

³⁷ Eley D S. Baker P G. (2007). Will Australian rural clinical schools be an effective workforce strategy? Early indications of their positive effect on intern choice and rural career interest. *MJA*; **187** (3): 166

- greater recognition of general practice as a specialty in career structures will be essential to foster interest in the discipline
- promoting the role of general practitioner to include special interest areas and qualifications with access to hospital practice is a key strategy to develop broader career pathways for generalist doctors that will need further work and development at all levels.
- promotion of Indigenous health training as a potential career pathway

Recommendation 18: That strategies to support and facilitate increased levels of training, education and support for Indigenous doctors and doctors wishing to work in Indigenous health are identified and implemented

Review of selection and entry into AGPT

The selection of future GPs into training is currently receiving some scrutiny by GPET with a Recruitment Working Party. This group is looking at reliability and rigor of the process. It is acknowledged that the Australian Medical Council has a significant role to play in setting the principles and standards for selection. This working group's finding will need to inform future selection processes.

Some issues that may need further consideration regarding the specifics of the merit-based selection of registrars could include:

- the criteria used for assessment for entry
- the use of reliable tools to assess applicant suitability
- timing of selection
- application process
- mechanisms for distribution of training places to RTPs
- the effect of the rural and general pathway systems on selection and entry numbers.

Attractive training posts

It is arguable that greater fairness and a more seamless distribution of junior doctors would be introduced if GP registrars were salaried by the training program commensurate with their postgraduate level and within industrial agreements.

The total financial package to the general practice employing and training the registrar also needs to be taken into account so that there is an overall gain for the general practice.

This would remove the potential conflict between supervision and employment responsibilities within training practices that has been an uncomfortable component of the current system. It would also allow for a more flexible training experience for Registrars over the duration of training as well as within practice-based placements. Such a remuneration methodology should not undermine the positive aspects of the learning experience.

Key Issue 3: Role of the Colleges and Professional Standards

Role of the colleges

General Practice has a long and respected role in the delivery of high quality primary health care, and its continuing improvement, in Australia. Improvement in the primary care environment in Australia is dependent on the strong core of general practice. Australian General Practice benefits from:

- high quality training supported by a range of comprehensive future-oriented curricula
- accreditation of its training and practices by RACGP and ACRRM standards programs
- general practices located across Australia in most urban and rural communities.

Core to the provision of general practice healthcare is quality education and training. The colleges are responsible for:

- defining the nature of the discipline
- setting the standards and curriculum for education and training and assessment
- setting the standards for quality clinical practice and supporting general practitioners in their pursuit of excellence in patient care and community service
- continuing professional development standards

The Australian Medical Council (AMC) has provided accreditation as appropriate to the RACGP and to ACRRM to set standards for various training responsibilities, including:

- prevocational training
- selection requirements for registrars
- accreditation of training posts and training supervisors
- program providers
- assessment and Fellowship requirements.

In relation to international medical graduates, the AMC performs the initial credentialing for international medical graduates, and sets the standards for the processes for specialist assessment by the accredited colleges.

The role of the Colleges in setting standards for selection, vocational training, and assessment are vital to ensure the ongoing quality of Australian general practice vocational training.

When developing standards, the colleges draw together the educational understanding, expertise and evidence of the profession, both nationally and internationally, through wide consultation and feedback. This ensures that Registrars in Australian general practice vocational training continue to be trained to a high standard which is also appropriate to community needs.

Furthermore, due to the collegiate nature of the colleges, including the large amount of pro bono work provided by college members and Fellows, education, training, supervision, assessment, and standards development are delivered at a fraction of the actual cost.

Standards

The standards for prevocational and vocational training are based on the principles and standards for postgraduate medical education, that ensure the practitioner is able to practice competently and with compassion.

The underpinning principles of general practice vocational training are that the registrar:

- learns principally from quality practising general practitioners
- has sufficient one-on-one learning, including direct observation
- learns principally in the workplace, with carefully controlled clinical exposure
- is exposed to a full range of general practice clientele and works in various settings
- receives regular feedback on performance
- learns across all the domains of the curriculum
- has opportunities for reflection with peers
- has the opportunity to learn the non-clinical workings of general practice.

The standards for vocational training reflect the need for patient safety, registrar safety, and quality in education and training.

Curricula

The RACGP and ACRRM have developed frameworks and curricula upon which education, training, and assessment for General Practice is developed, delivered and assessed in Australia. These curricula include core/primary requirements as well as options for advanced or extended training and development.

Accreditation and quality improvement

Fundamental to setting standards are:

- accreditation
- monitoring
- quality improvement.

To ensure training is being delivered to the standards set by the colleges, the colleges must continue to have a role in the accreditation of:

- supervisors and trainers
- training posts
- training providers.

Key to any accreditation model is the need for a quality improvement cycle, where standards, processes, and requirements are continually reviewed and assessed by the profession, for the profession, to inform ongoing quality improvement.

For a full list of the colleges' accreditation functions, please see Appendix 2.

Assessment

The need for accurate formative and summative registrar assessment (both during training and at the end of training) is an important aspect of vocational training.

The Assessment requirements, and Fellowship standards, are designed to ensure that general practice training meets high standards, and prepares registrars for unsupervised general practice anywhere in Australia.

It is vital that assessment processes, and Fellowship requirements, continue to reflect contemporary general practice, drawing on the breadth of experience and knowledge from college members, Fellows, and other stakeholders.

Role of the Australian Medical Council

The group advocates for the continued role of the Australian Medical Council (AMC)³⁸ to ensure that the standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

The system has worked well for decades, and the risks of changing are likely to outweigh any potential benefits. The group would not support an alternative model.

Specifically, the AMC should continue to:

- assess medical courses and training programs, for both medical school courses and training for medical specialties, and accredit programs which meet the AMC accreditation standards
- assess overseas training doctors, or international medical graduates, who wish to practice medicine in Australia
- advise the Health Ministers on uniform approaches to the registration of medical practitioners and the maintenance of professional standards in the medical profession
- advise the Commonwealth and the states on the recognition of medical specialties.

In relation to accreditation, the AMC processes entail both accreditation and peer review to promote high standards of medical education, stimulate self-analysis and assist the training organisation under review to achieve its objectives. AMC standards define the knowledge, skills and professional attributes expected at the end of basic medical training and specialist medical training, and good practice in the delivery of medical education and training. Training organisations that meet AMC standards are granted accreditation.

Recommendation 19: *That the AMC be authorised and supported to act as the body to govern the role of and performances of the Colleges in General Practice vocational education and training*

Recommendation 20: *That general practice standards for education and training continue to be set and arbitrated by the profession's relevant colleges, ACRRM and RACGP. This includes a key role in setting and monitoring training standards, curriculum development, accreditation of sites and training organisations, assessment processes and selection for training programs*

Recommendation 21: *That the RACGP and ACRRM are appropriately acknowledged and supported in the form of policy, process and (where appropriate) resources to undertake the role outlined in recommendation 20 across the continuum of medical education and training*

³⁸ Australian Medical Council Accreditation and Recognition, accessed 10 February 2009, <http://www.amc.org.au>

Key Issue 4: Vertical Integration of Education and Training

Providing a seamless, efficient and effective pathway of training for the GP learner from medical school through to vocationally trained practice is the aim of a vertically integrated system. One of the outcomes expected of the new system established under GPET was 'to promote vertical and horizontal integration of education and training at a regional level'.³⁹ A framework for vertical integration was developed⁴⁰ and this highlighted the need to approach vertical integration at the level of the learner, the teachers, the teaching practices as well as the teaching organisations.

While vertical integration is already occurring in the GP education and training sector, further development should be considered in the context of recent changes, including for example the advent of the PGPPP and the increasing numbers of medical graduates.

Recommendation 22: *That improvements be made in coordination and communication of clinical training provision to most efficiently use existing resources and better support vertical integration of teaching and education within practices*

Recommendation 23: *That opportunities are identified to evaluate and to increase vertical integration through undergraduate to vocational training*

Regional organisation partnerships

Presently there are a range of organisations involved in delivery of GP education and training at the regional level. The two principal organisations that mostly deal with teaching practices for education and training purposes are universities and regional training providers. However, Colleges, Divisions of General Practice and Rural Workforce Agencies also have a role. Reducing complexity for the end-user in relating to these organisations is a key challenge for these organisations.

Regions have not integrated the delivery of medical student teaching, PGPPP delivery and GP registrar training into the one organisation with the exception of perhaps the Northern Territory and Australian Capital Territory. In these instances one organisation is responsible for all placements, workshops, teacher training and practice support and payment. The one group of medical educators delivers all the educational input across all levels and at times through combined workshops.

Integrating Accreditation of teaching posts

Initial accreditation of a teaching posts and practices must be undertaken by relevant accreditation bodies such as RACGP and ACRRM. However, there may be opportunities to streamline accreditation processes. Examples include the potential for a cross representative panel to undertake accreditation against the College (RACGP and ACRRM), Postgraduate Medical Council and University standards for GP education and training at the same time as accrediting for general practice standards, assuming that there have been no indications that the practice requires specific review.

³⁹ GPET. (2004) *General practice Education and Training*. GPET. Canberra

⁴⁰ Thomson J. (2004). *A Framework for Vertical Integration in GP Education and Training*. GPET. Canberra

This could involve one set of paperwork and one survey visit to a practice, which would significantly streamline the approval stages for standards organisations as well as reduce red tape and disruption for practices and their staff.

Recommendation 24: *That opportunities to streamline accreditation processes across the continuum be identified and implemented in order to facilitate integrated teaching practices and reduce red tape*

Integrating curriculum delivery

It would assist practices to have some mapping across curricula for medical students, prevocational doctors, and GP Registrars, with clear information to teachers on how joint vertically integrated teaching might occur at the practice level, which components of a curriculum are to be delivered in a practice and clear and simple processes for assessment.

Integrating Teacher training and certification

Teacher training is often but not always delivered jointly through one regional training body that approves courses with appropriate certification and recognition processes for all levels of training. There are currently discrepancies in remuneration available for teacher training and this requires some streamlining. With GPRs increasingly taking on a role of teaching medical students and junior doctors, they will also need training, recognition and remuneration, as teachers.

Integrating Payments to practices and teachers

There could be capacity to develop both a single continuous stream of payment to practices for both teaching services and a one-off infrastructure payment for rooms to train GP learners. These payments could be tiered depending on level of commitment to training. It may be that a fully integrated training practice receives a “bonus” payment in recognition of increased investment in teaching. New models for streamlined and consistent payment processes warrant development.

Again, GP teacher remuneration is complex. It comes from various sources at different rates with different administration and reporting requirements. Some teachers, especially GP employees and GPRs, are not receiving payments at all. Developing a single stream of funding to the individual with a tiered system depending on teaching commitment could be explored.

Recommendation 25: *That governments introduce and coordinate incentive payments to encourage integrated teaching practices*

Seamless regional training pathway for GP training

While there has been an emphasis in the last 5 years on delivering training in a regional setting, it is still not possible for a medical student to be guaranteed a regional pathway of training into general practice. Development of regional pathways of training with Universities, regional hospitals and regional training provider endorsement will be critical to retaining graduates of Universities in their region. Such retention will ultimately be a measure of the success of regionalised training at both undergraduate and postgraduate levels. Nationally determined selection processes will need to be examined to enable regional career development for the GP learner.

There have been a number of initiatives to have quotas for medical student selection from RRMA 3 to 7, and for indigenous students. GPET does have a quota of 5 places per annum for self identified Indigenous registrars.

Career pathways for medical education

Creating career pathways for general practice teaching has developed over recent years. There are now increasing numbers of academics in University Departments of General Practice or Rural Health, city and regional clinical schools holding conjoint appointments with regional training providers. GP supervisors are also taking up clinical academic appointments and part time medical educator roles. Continuing to develop such career opportunities in medical education from the GP registrar onward will be important in further developing the standing and the standards of the discipline of general practice.

Key Issue 5: Stream lined and flexible training pathways

With workforce shortages and limits in training capacity, there is a need to ensure that the future workforce is trained in the most efficient manner. Streamlining training to enable a career pathway to be achieved in one geographic location has already been mentioned.

Other components of training could be streamlined as well.

Recognition of prior learning (RPL)

Increasing pressures on clinical training placements and experiences, will make it even more important to ensure that there is no wastage in the system, and that prior learning with established competencies is recognised at entry.

Where appropriate, the delivery of training, the assessment of learning outcomes, and the award of Fellowship, need to be competency-based. Competency-based assessment may either shorten or lengthen the duration of the training and assessment processes for individual candidates.

Key from Registrars perspective is RPL, and the flexibility to choose and transfer between the RACGP and ACRRM programs. Simplification, transparency and portability between the two programs such that Registrars can map training to work towards one or the other or both needs to occur. An important point to consider is that portability between the two programs occurs seamlessly without extending length of training.

This will also create more choices to future entrants and make the training program more flexible and attractive, without ‘forcing’ entrants to pick one end point over the other early in their training when they may not fully appreciate their own learning needs or career aspirations. There is an interest amongst Registrars wanting to do both training programs, but are potentially made to make a “forced choice” towards one college or the other.

Having in place systems for recognition of prior learning will assist with shortening the duration of training, provided it is found that the prior learning contributed to the specific competencies required. In the interests of shortening training times and maximising efficiency, there is a need to encourage greater RPL across the qualifications, particularly in relation to previous, relevant experience in prevocational training, e.g. PGPPP experience. Training requirements are often based on time-based experiences rather than competencies or case load experience. Review of RPL principles and practices by Colleges to streamline and condense training pathways will continue to be important.

Recognition of prior learning of international medical graduates (IMGs) entering the Australian general practice workforce has been complex and is continuing to evolve with the new pathways to registration recently introduced. There is however, still no mechanism to recognize overseas prior learning of GP Registrar entrants into AGPT. This may need some further attention.

Mutual recognition

Given the numbers that will require training and the workforce service pressures, there is a need to achieve Fellowship in the most efficient and cost effective way. Agreements to develop dual Fellowship pathways between the two generalist Colleges (RACGP and ACRRM) may be one mechanism to attract graduates into a general practice career, particularly rural practice.

As well there is some demand indicated for dual fellowships between the two generalist fellowships as well as generalist and specialist fellowship qualifications. These opportunities are being explored by the Colleges.

Registrars and RTPs are seeking greater clarity about which components could be mutually recognised in the RACGP and ACRRM pathways of training. The RACGP's Censor in Chief and ACRRM's Censor have agreed on the wording of a memorandum of understanding that will minimize registrar disadvantage in this area. The main issue that prevents recognition is the candidate's ability to demonstrate that they have undertaken adequately supervised training in a properly resourced and organised health care centre where they have undertaken an appropriate scope, volume and quality of practice.

Resolving some of the complexities in achieving concurrent College training requirements and joint recognition is key to ensuring an attractive training pathway for potential rural doctors.

Recommendation 26: *That the RACGP and ACRRM continue to work toward the development of a framework to maximise opportunities for Recognition of Prior Learning and Mutual Recognition processes between the two General Practice qualifications and between General Practice and other Specialty training programs*

Recommendation 27: *That a documentation system be developed that will capture learning across the GP Education and training continuum and align with the Recognition of Prior Learning and Mutual Recognition frameworks*

Key Issue 6: Interdisciplinary learning

Inter-disciplinary learning is emerging as key to the development of team skills in clinical practice. Increasingly the general practice teaching setting could be developed as an inter-disciplinary learning environment for GPs, nurses and other allied health professionals.

There is a need to expand training both across the medical specialties for the medical pathways of training and also across the different health professionals particularly at the University level. As competency based training is becoming more accepted in the health arena including the medical arena, it should be possible to train health professionals collaboratively in any core or equivalent competencies. Such initiatives will require some commitment and change in professional training cultures.

There are already some key initiatives in the Australian health education environment in this area. The University Departments of Rural Health are centres where some training is occurring across health disciplines for some components of University degrees in nursing and allied health areas particularly.

Medical Colleges are sharing some learning and curriculum modules and running some joint workshops. In the mental health arena there have been some continuing professional development activities in Divisions of General Practice across primary care mental health professionals particularly in the Medicare *Better Access* initiative.

Existing state and territory IPHC initiatives and the new Australian government *GP Super Clinic* initiative presents a critical opportunity for the development of general practice infrastructure that will also provide opportunity for clinical inter-disciplinary training across all primary care professionals.

This emerging field will be important in the future. A recent consultation document launched in 2008 entitled *Interprofessional Health Education in Australia*⁴¹ poses important questions about the future training of our health professionals and how we might most effectively equip them to work in their roles in the future. Some of the current best exemplars are often in rural areas and include both practice based and campus based inter professional learning. Cultural constraints as well as regulatory constraints will need attention and there will need to be incentives to change current practices. Future development and research will be needed in this area.

Recommendation 28: *That there is support provided for increased focus on opportunities for cross-profession training for health care professionals*

⁴¹ Learning and Teaching for Interprofessional practice Australia. (Dec 2008). *Interprofessional Health Education in Australia* . <http://www.education.uts.edu.au/research2/projects/ltipp.html> (accessed February 2009).

Key Issue 7: Training for future general practitioner roles

Training being delivered now must be equipping GPRs with skills for their future roles. Some of the areas highlighted as needing particular attention are:

- rural specific skills – recognising that rural medicine requires specific competencies
- enhanced generalist skills – recognising the increasing complexity of primary generalist medical care
- procedural skills – recognising the increased need for such competencies particularly in the rural and remote context
- expanded sub specialist skills – recognising the increasing interest and demand for such services within the primary medical care context
- increased management of chronic disease, complex co-morbidities, and preventative health
- Team and organisational leadership skills in relation to clinical governance.
- population health and the capacity to work in partnership with Community Health Services in planning for local community needs (critical in areas of significant community disadvantage)

The role of the professional Colleges

The professional Colleges have been developing frameworks that define GP specific skills and also determine specific curriculum requirements for education and training at all levels of the training continuum. For example, the RACGP's emerging three-level RACGP GP Special Skills Framework works well for areas of specific interest, both within general practice and between general practitioners and other medical disciplines. Such work, being led by the Colleges, will be important to ensure that GPs are competent and credentialed for their level of practice.

Increasing the number and roles of GP proceduralists

The number of rural GP proceduralists is declining and with an ageing GP population this decline is likely to accelerate unless steps are taken to reverse this trend. At the same time numbers of rural specialists in general medicine and surgery are also declining.^{42 43 44} There is currently provision for procedural training in rural practice in AGPT. Advanced skills posts include training in procedural medical areas such as obstetrics, surgery, anaesthetics, emergency medicine, Aboriginal and Torres Strait Islander health, and paediatrics. Undertaking a twelve month period of such advanced training is a compulsory component of the award of FACRRM and FARGP. Opportunities to develop advanced skills in one of 10 disciplines are offered, including non-procedural and procedural disciplines.

The number of procedural training posts are limited by the availability of suitable hospital based positions. Creation and accreditation of such training posts requires negotiation with individual hospitals and supervisors as well as jurisdictions at state and territory level. In some hospitals the provision of such training is not continuous and places are competitive with training from other specialist medical colleges. This needs concerted effort by all parties to provide better certainty, focus and marketing of opportunities.

⁴² Australian Institute of health and Welfare. (2007). *Medical Labour Force 2005*. AIHW National Health Labour Force Series No 40 pg 20 to 23

⁴³ Australian Institute of Health and Welfare (2005). *Rural, regional and remote health—Indicators of health*. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5); 2005.

⁴⁴ Royal Australasian College of Surgeons Activities Report for the period 1 January 2007 to 31 December 2007. (Accessed February 2009).
<http://www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/Activityreports/default.htm>

Emergency medicine is emerging as an area that could benefit from GPs trained specifically in this field as commonly occurs in some other countries e.g. Canada. NSW Health has developed and funds a successful Procedural Training Program in partnership with RTPs.

Another example of a model that has increased access to procedural training is the rural generalist pathway in Queensland Health. Negotiation with State and Territory governments to develop such pathways of employment with training positions is an option for the future. The private hospital sector has not been considered as a possible clinical training ground for GPs in extended roles and needs further exploration, possibly along the lines of the Expanded Specialist Training Places (ESTP).

Increasing other GP expanded skills training and recognition

GPs are increasingly undertaking additional training, often with no formal qualification to reflect the advanced or expanded skills required for their practice context. This may include expanded skills training in academic general practice, women's health, dermatology, psychological medicine, sports medicine, etc. This may happen during training or at any time subsequently in response to the demands of the clinical context or personal interest. Making provision for the recognition and accreditation of such roles in key areas and further incorporating relevant training with appropriate certification into AGPT by the Colleges warrants exploration.

Development of diploma courses has been discussed by various Colleges. Mutual recognition of training across various College training programs would be a key, with blended training programs that allow concurrent training without necessarily adding increased training time. Flexible training arrangements will need to be developed to allow for blended models of training.

While not suggesting a move away from the current model of direct patient learning, opportunities to develop, within 10 years from now, modules of learning that could be recognised across different general practice College qualifications (and other specialty fields) warrant investigation. Assessment could be competency-based rather than time- and experience based.²⁹ These and a wide range of related issues were explored previously.⁴⁵

The centrality of clinical experience with a General Practitioner teacher who is able to give feedback on performance as expertise is built must not be lost.⁴⁶ Sound educational theory and practice should underpin changes to training with learning outcomes prevailing over shortening course length for expediency's sake and as a response to workforce pressures.

Preparing the GP as the leader of the multidisciplinary team

The way to alleviate workforce shortages is to develop and support properly constituted general practice teams, which include members properly remunerated for the services they provide under the management and supervision (delegation) of the patient's general practitioner. There are many successful examples of expanded practice nurse roles and

⁴⁵ Royal Australian College of General Practitioners (2007). *General practice and primary health care in 2015*. (Accessed August 2008). <http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/vocationaltraining/GeneralPracticein2015/GENERALPRACTICEIN2015.pdf>

⁴⁶ Norman, G, Eva, K, Brooks L & Hamstra, S (2006). Chapter 19: Expertise in Medicine and Surgery. In K. A. Ericsson, N. Charness, P. J. Feltovich & R. R. Hoffman (Eds.), *The Cambridge Handbook of Expertise* (1st ed., pp. 901). Cambridge: Cambridge University Press.

efficient team function in private, not for profit and public settings, with quality and safety aspects maintained.⁴⁷

One of the key challenges for the future is preparing GPs to be part of the increasing team environments in the primary care sector. As nurses and others take an increasing role in this sector, GPs will need to define for other professions in the team the GP scope of practice, unique competencies and contributions to the management of patients. While GPs must remain central to patients care, the GPs may also be acting in different roles in different teams; as clinical coordinator, as team leader, or GP consultant. Setting agreed standards for the competencies, training programs, standards and assessments for this diverse range of functions will be important to future integrated primary health care delivery.

***Recommendation 29:** That there is ongoing and increased levels of support, focus on opportunities, and recognition for procedural skills and other expanded scopes of training for GPs, GP Registrars and practice nurses*

⁴⁷ Kidd MR, Watts IT, Saltman DC. (2008). Primary health care reform: equity is the key. *MJA*; 189 (4): 221-222.

Key Issue 8: International Medical Graduates

IMGs are a significant and growing part of the general practice workforce, but many have not received any formal training in the Australian context. While the proposed national registration arrangements may provide a consistent and stream lined approach for registration of IMGs, they fail to provide any national and consistent approach to IMG education and support towards achieving vocational qualification.

The IMGs entering general practice fall into two broad streams: those that have permanent residency and enter via the AGPT system; or those that have temporary residency and enter with limited recognition of prior overseas general practice vocational training.

There are a plethora of organisations that are currently providing various forms of education and support for temporary resident doctors at different career levels and stages, but they are not coordinated and often not evaluated for their effectiveness. The options for improvement in the proposed new registration environment would see integrating the efforts of the various groups. RTPs for example could take a lead in this process. The various RTPs make specific provision for tailored training for IMGs within their GP training program, and have developed many resources and educational expertise in this area, although not consistently.

Mentorship

One of the key features in a successful Tasmanian model for support and education of IMGs, apart from the organisational integration, is the appointment of a mentor to the IMG to assist and support the IMG through both the registration and education processes. In discussions with Dr Samantha Egan of the ANU who has undertaken recent qualitative research with IMGs, this is one of the key interventions that IMGs consider would make a difference. The Colleges have also instituted IMG mentoring processes where mentors are drawn from IMG Fellows of the relevant College.

Education program designed for appropriate level

There have been a number of programs developed to support IMGs entering general practice, both at the prevocational and vocational levels. Evaluating these programs and mainstreaming such schemes will be important in developing and maintaining a well trained IMG workforce.

The ROVE (Rural Outreach Vocational Training) program was delivered by RTPs and integrated with the AGPT. Funding for the program has currently lapsed, but the program was well evaluated and could be redeveloped to provide some RPL towards AGPT training, if that is the appropriate pathway, or Fellowship exam preparation only, if that is the appropriate pathway.

A number of Colleges, RTPs and other education providers are likely to become AMC accredited workplace assessment agencies in the future. As such there will be an opportunity for these organisations to be important in both facilitation of the medical registration process while at the same time providing education and support towards full vocational qualification.

Given the limited research and data on IMG education and support systems, an initial step in progressing any further on IMG education and support could be a national conference or some other process to:

- share current research
- develop some recommendations for further research and streamlining of pathways and education and training in light of proposed new registration arrangements.

Recommendation 30: *That government ensure that appropriate programs are available and accessible to improve the support, orientation and ongoing skills development of International Medical Graduates working in Australian general practice*

Recommendation 31: *That funding be made available to allow stakeholder engagement to discuss and develop International Medical Graduate education and training frameworks in GP and community based settings*

Key Issue 9: Governance and management of the future system

Governance of general practitioner education and training, i.e. strategy setting, policy development and funding control of the general education and training continuum, is currently dispersed across multiple jurisdictions and organisations, leading to silos of education and training delivery.

The Australian Government funds university training places both through the education sector and also through the Department of Health and Ageing (DoHA) for Rural Clinical Schools. State governments also fund infrastructure and teachers for clinical training in public hospital and community health environments. Policy around medical student training programs and exposure to general practice during student years rests with individual Universities and Australian Medical Council (AMC) accreditation processes.

Prevocational training is largely funded by State governments, with scant emphasis on community based training, given the state health jurisdictional emphasis on provision of acute in-hospital services. The Australian Government has recently started to fund a small number of positions in general practice through the PGPPP. PGPPP funds are held by ACRRM and the RACGP before being distributed to PGPPP consortia. Policy around training for this prevocational period is largely determined by Postgraduate Medical Councils in each State although RACGP, ACRRM, and the PGPPP National Advisory Committee have also set policy for the general practice context. Hospitals will have difficulty accommodating the expanded workforce of new graduates that will result from additional undergraduate training positions, and it will be both logical and practical to expand community based prevocational positions.

College governance and management roles

Standards for vocational GP education and training are set by the ACRRM and RACGP. Each College has developed a set of standards for training providers and teaching practices and teachers and each College accredits against their respective standards. The AMC accredits the professional Colleges. (See also Key Issue 3, and Appendix 2.)

GPET governance and management roles

The Australian Government funds GPET to oversee and manage a national network of regional training providers. The GPET board comprises key stakeholders, including both colleges, registrars and additional independent directors. GPET therefore has a substantial role in providing leadership and operational policy for the delivery of GP training and education.

The current system of GP training has achieved some of the objectives set at the time of formation of GPET.

The objectives of GPET⁴⁸ stated at the time of establishment were 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

⁴⁸ General Practice Education and Training (Accessed February 2009).
<http://www.agpt.com.au/GPETtheCompany/AboutGPET/>

- 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 Ageing regarding undergraduate and postgraduate training issues.

Many of these objectives have been fully or partially met but it is appropriate to review both the objectives and the progression towards them at this time. The current environment provides an opportunity to re-evaluate these objectives and the degree of progress that has been made toward them.

Governance into the future

Professional Colleges will continue to have the key role in shaping and defining the future professional roles and responsibilities for general practitioners and rural doctors. Colleges, Universities and postgraduate medical councils will still be determining policies that relate to standards of education and training, including curriculum requirements and assessment processes.

The Australian Medical Council will continue to accredit these bodies.

All agencies delivering any education and training will continue to be required to be accredited against the standards set by these professional bodies, thus ensuring high quality and consistent delivery of training.

Collaborative planning for the future health workforce

Some new structures have been set up at a national cross-jurisdictional level recently which will contribute to workforce planning and policy processes. The new national health workforce agency mentioned in the recent COAG announcements, if implemented, will have some planning role for university education for future health workforce needs and these functions will be clarified over time. Likewise the proposed new national registration system for health professionals may administer registration requirements for these professionals and has the capacity to capture data that can inform education and training needs and workforce planning.

While professional groups continue to lead in policy and standards for education and training, governments have an interest in open, evidence-based processes, in close collaboration with professional and educational bodies, to define:

- current and future health professional workforce needs
- appropriate workforce distribution patterns
- number and nature of discipline-based training places required

- the nature of possible role flexibility between disciplines
- strategies to ensure an appropriate match between education, training and workforce requirements
- integrated strategies to deliver the health workforce to areas of need.

National general practice training and education need to dovetail with national primary health care policy frameworks, with common principles that also enable appropriate local decision making, diversity and flexibility. Such a “top down-bottom up” system makes the most of central coordinating roles, while also factoring in critically important local knowledge and contexts.⁴⁹

Central coordinating agencies not only ensure consistency of standards but also bring significant capacity to allocate resources when and where they are needed. General practice is by its nature linked very closely to local communities. The local knowledge derived from the special place of general practice in local communities is essential for the planning of every aspect of general practice training. The capacity of general practices to couple training with the delivery of primary health care is unique, based as it is at the coalface of what the community wants and expects.

A “top down-bottom up” approach is the only way to ensure that general practice education and training remains patient-centred, and deliverable in the community context.

Management

Many organisations are involved in managing the delivery of GP education and training. Each level of education is a separate silo of management with limited vertical integration occurring. Governments are funding a range of management organisations at each level, while significant funding is provided by private organizations such as the RACGP and ACRRM.

At the medical student level, the Department of Education, Employment and Workplace Relations (DEEWR) funds universities to operate medical schools, and DoHA funds universities to operate rural clinical schools. Often the rural clinical schools are the only University infrastructure in that region.

At the prevocational level, State owned public teaching hospitals largely manage prevocational training including the hospital based experience required for GP training. They fund infrastructure and staff in directorates of clinical training who deliver training. Staff specialists contribute to teaching activity.

The PGPPP is separately funded by DoHA and is managed by two managing organisations namely the RACGP and ACRRM. PGPPP has clear costing for teaching, infrastructure and trainee salary arrangements. The managing organisations subcontract with individual organisations that act as fund holders for the onsite delivery of the PGPPP sites. Many of these local fund holders are currently RTPs. A PGPPP National Advisory Committee is responsible for approving all PGPPP post applications.

⁴⁹ Royal Australian College of General Practitioners (2007). *General practice and primary health care in 2015*. (Accessed August 2008).
<http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/vocationaltraining/GeneralPracticein2015/GENERALPRACTICEIN2015.pdf>

At the vocational level in general practice, GPET is the national managing organisation for some processes such as selection and indigenous health placements, but the 20 regional training providers largely directly manage operational delivery of the program.

The Colleges manage professionally based processes on a cost recovery basis such as:

- recognition of prior learning
- accreditation of training posts
- accreditation of training supervisors
- assessment
- support and advice to registrars, supervisors and medical educators through the Censors, senior college teachers, and mentor networks.

The Colleges manage the accreditation of RTPs (including accreditation of posts and supervisors), the educational curriculum and assessment, and certification processes.

The Colleges will always have a role in Recognition of Prior Learning processes, because the standards overseas need to be constantly scrutinized to ensure that standards in Australia remain high. Accreditation of teaching posts should also include the professionally-based bodies to ensure that standards of patient care, service to the community, and professional teaching standards are maintained. The Colleges are also vitally involved with assessment, the outcomes of which again are determined based on professional standards.

It is timely to consider how some efficiency could be obtained in this complex and multilayered management system.

Consolidation of regional management structure

The regional training infrastructure that was further developed for GP vocational training through the establishment of regional training providers, and for rural medical school education through the establishment of rural clinical schools, appears to have had a positive impact on the GP workforce entry in regional areas. There is opportunity to increase the regional management of delivery of GP education at all stages of training through these organisations.

While core RTP responsibilities have been to manage delivery of vocational training, many have expanded that function to include management of pre-vocational, professional development or allied health education activities. This has included management of PGPPP in their region, as well as education and training of IMGs through programs such as Rural Outreach Vocational Education (ROVE).

The new IMG registration pathways add a further potential training stream. This integrated RTP management of a number of training streams for regional delivery could lead to significant gains in efficiency of GP training and assessment systems.

It could also assist non-registrar college examination candidates prepare for examinations, with resultant improvements in pass rates and standards.

At the very least, it is important that regional organisations are encouraged to create partnerships around delivery of education to ensure seamless pathways for the learners, as well as efficient and streamlined administrative and funding processes for training general practices and GP Supervisors. Effective partnerships and even amalgamations between RTPs, Universities and Rural Clinical Schools, Divisions and Rural Workforce Agencies should be further encouraged where appropriate.

It is equally important to build up the capacity of local structures like community hubs, and potentially GP super clinics, to achieve practical vertical and horizontal integration within training and assessment systems, from practice to local government levels.

Importantly, the current Australian Government's wider reform environment creates an opportunity to review the jurisdictional responsibilities described above, and create efficiencies and beneficial local reforms.

Recommendation 32: *That coordination and management systems be improved, at a regional level particularly, to reduce duplication of processes and resources directed to training delivery*

Key Issue 10: Innovation, evaluation and research

The current workforce environment is placing considerable stress on the general practice training system, so it is an important time to research innovative training models that maximise teaching effort while minimising disruption of clinical service to the community.

Two of the original objectives of GPET were to:

- promote Australia as a world leader in establishing innovative and effective mechanisms for general practice education and training, and
- establish a national framework for the evaluation of general practice education and training outcomes.

These objectives are still relevant today and into the future.

Innovation

Increased pressure on teaching delivery in practices has highlighted the need for innovative teaching methods. Methods such as “Teaching on the Run” and “Wave consulting” are some examples of methods that are being used and may need to be further implemented. Exploring other simulated teaching methodologies that are applicable to general practice, and providing access to such teaching, is another priority. Involving GP Registrars and others in teaching has already been mentioned.

Tried and true teaching methods

The continuation of the apprenticeship model for general practice education and training, and the necessity for good professional roles models, are fundamentally important for the continuation of general practice training, while recognising the registrar’s right to have the structure and focus of their general practice rotations based on learning rather than being used as workforce.

The apprentice masters are the GP supervisors, and they are the most important teachers in vocational training. The apprenticeship model enables good teachers to care about their registrars and to both teach them and learn from them. The apprenticeship model therefore provides many efficient and effective means to convey modern teaching, thought, skills, knowledge and experience, both vertically and horizontally through the general practice training system. This will happen provided systems are also in place to enable the registrar to question and challenge.

Advocacy for keeping the apprenticeship model for training does not preclude further innovative ways to improve teaching.

Simulated learning

Simulated learning is one of the education innovations that will have increasing applicability in the stretched clinical training environment of the future. Significant regional and practice based investment will be needed into such learning.

Recommendation 33: *That a significant proportion of the recently announced funding by COAG for Simulated Learning Environments (SLE) be directed to providing increased access to and use of SLE for GP training and education*

Evaluation

An essential component of any planning is the evaluation process. Evaluation of past successes and areas for improvement is essential, but is often overlooked or taken for granted.

Effective evaluation strategies should be in place as a requirement for:

- any externally funded training initiative
- any externally funded research initiative
- Australian Medical Council accreditation of programs, policies and processes for selection, training and assessment
- all internal training and assessment processes, particularly regular events like selection, examinations, and policy reviews.

Funding for any general practice training program should only be provided on the basis that evaluation strategies have been included in the funding proposals.

***Recommendation 34:** That the Australian Government invest in the development of a framework for a comprehensive evaluation of the current training system across the GP training continuum (i.e. undergraduate, Pre-vocational, and Vocational components)*

***Recommendation 35:** That there is investment to implement the framework proposed in recommendation 34 with capacity for ongoing external evaluation of the current training system and its objectives*

Research

Traditionally, research endeavours into medical education and training have not received substantial attention or funding in Australia. Research is needed because, as established in this document, the contexts of general practice education and training in Australia are unique and changing.

Grey literature

Finding innovative ways to communicate will help improve GP training initiatives.

GPRA has always focussed on providing grassroots driven innovative solutions to drive policy and research. With this in mind GPRA has recently launched a new online portal called GREYMATTER. GREYMATTER is an online, open-access, repository of grey literature in the primary health care sector. Grey literature comprises newsletters, reports, working papers, theses, government documents, fact sheets, conference proceedings and other documents that are free of charge but difficult to find. GREYMATTER allows users to share this grey literature within the sector allowing users instant access to the latest trends and data within the sector.

A few recent studies have evaluated the usefulness of grey literature. Studies have indicated that researchers conducting meta-analyses should make an effort to include both grey and published material in order to limit bias.⁵⁰ They also conclude that exclusion of grey literature from a meta-analysis could lead to exaggerated estimates of intervention effectiveness. Other research has attempted to measure the impact of grey literature on

⁵⁰ McAuley L, Pham B, Tugwell P, Moher D. (2000). Does the inclusion of grey literature influence estimates of intervention effectiveness reported in meta-analyses? *Lancet*; 356(9237):1228-31.

physical sciences using bibliometric indicators.⁵¹ They conclude that grey literature is an important source of information despite the variability of its use. One study conducted an expanded search, including a search for the grey literature, in order to identify material for their systematic reviews.⁵² The conclusion of their study demonstrated that expanding the search beyond MEDLINE and other conventional databases did identify additional relevant information for the systematic review. We are in the middle of a fundamental shift in the paradigm of scientific communication.^{53 54} This shift has culminated in substantial impacts on the grey literature. Publishing trends continue to influence developments for accessing grey literature, and have also contributed to the growth and emergence of new types of grey literature.

Possible Research priorities

Some of the priorities for research into general practice education and training could be to:

- evaluate the reasons registrars choose general practice as a career choice
- market general practice as a career choice
- enhance general practice as a career choice
- establish agreed standards and requirements for evaluation of training programs
- strengthen the technical and professional competencies in general practice
- investigate the most effective means to ‘train the trainers’
- implement effective supervision
- explore effective mentoring models
- contribute to the literature on adult learning
- maximise delivery of high quality training, given resource and workforce restraints
- develop innovative teaching methods for general practice teaching sites
- create networks for general practice training
- discover inventive solutions at the local level that could be applied more widely across Australia
- determine reliable and valid assessment methods for Australian contexts, to be used for selection into training, recognition of prior learning, formative assessment of progress through training, and summative assessments of suitability for independent practice.

Governance of research

There is currently no systematic approach to research into general practice education. Establishing a clear research agenda for the sector is important.

Research collaborations between all of the stakeholders in general practice training will be needed, as corporate knowledge and expertise is spread throughout the sector, in tandem with the various training governance and implementation roles.

⁵¹ Di Cesare R. (1994). The evaluation of grey literature impact using bibliometric indicators: the case of the physical sciences. *Online information 94: 18th International Online Information Meeting proceedings* Dec 6-8 1994; London. Oxford, UK: Learned Information; 405-13.

⁵² Helmer D, Savoie I, Green CJ, Kazanjian A. (2001). Evidence-based practice: extending the search to find material for the systematic review. *Bull Med Libr Assoc*; 89(4):346-52. Available at: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=11837256>

⁵³ Egger M, Juni P, Bartlett C, Holenstein F, Sterne J. (2003). How important are comprehensive literature searches and the assessment of trial quality in systematic reviews? Empirical study. *Health Technol Assess*; 7(1).

⁵⁴ Lawrence S. (2001). Online or invisible? *Nature*; 411(6837):521.

A separate source of funding could be established, such as an NHMRC priority area of funding, or a separate program. Funding should be provided on a competitive basis against usual research funding criteria, such as relevance and potential impact, track record of investigators, and with the requirement to collaborate across the sector.

Recommendation 36: *That research be commissioned on options to improve perceptions of general practice as a specialty area of practice*

Recommendation 37: *That continuing longitudinal research into GP workforce patterns be commissioned to inform future workforce planning, ensuring that assumptions, data, analysis and modelling adequately account for the diversity of the general practice workforce. Such research should at a minimum include consultation with ACRRM, RACGP, GPET, GPRA, Rural Doctors' Association of Australia, and Australian Medical Association*

Recommendation 38: *That funding is provided to undertake research and evaluation of innovative teaching and supervisory models in the general practice training environment*

Appendix 1. History of GP Education & Training in Australia

A brief chronology of the significant events in GP education and training are listed.

- 1958 – Royal Australian College of General Practitioners (RACGP) established
- 1973 – Australian government provides funding to allow RACGP to conduct vocational training for general practice, known as the Family Medicine Programme
- 1974 – Formation of the National Trainee Association (NTA)
- 1993 – Family Medicine Programme renamed RACGP Training Program
- 1993 – Formation of the National Registrar Association (NRA)
- 1996 – All new general practitioners must pass RACGP assessment processes before they can gain access to vocational registration
- 1996 – Pilot for pre-vocational placements with rotations in Cleve, South Australia, of four interns from Flinders Medical Centre
- 1996 – RACGP institutes a regionalisation policy, compulsory rural terms and the voluntary Rural Training Stream
- 1997 – Australian College of Rural and Remote Medicine (ACRRM) is established
- 1999 – ACRRM develops the Rural and Remote Area Placement Program (the pilot program later known as PGPPP)
- 2000 – RACGP has 15 regional training nodes and 3 regional programs fully managed by other organisations
- 2001 – General Practice Education and Training (GPET) is created to implement a regionalised training program
- 2001 General Practice Registrars Australia Ltd. (GPRA) formed (from NTA)
- 2002 – Regional Training Providers (RTPs) are established to deliver general practice vocational training
- 2002 – GPET commences regionalised training program
- 2002 – RACGP establishes General Practice Education Australia for pre-2002 general practice registrars without consortia
- 2003 – Remote Vocational Training Scheme established
- 2003 – RACGP receives initial Australian Medical Council (AMC) accreditation for setting general practice education standards
- 2004 – All registrars receive training through RTPs
- 2005 – Prevocational General Practice Placements Program (PGPPP) established
- 2006 – RACGP receives re-accreditation from the AMC
- 2007 – GPRA establishes the General Practice Student Network (GPSN)
- 2007 – GPSN Schwartz First Wave Scholarships established
- 2007 – ACRRM receives initial AMC accreditation for setting general practice education standards

Appendix 2. College Accreditation Responsibilities

A1. Curricula

The RACGP and ACRRM curricula both set standards for the knowledge, skills and attitudes necessary for a competent, unsupervised general practitioner to care for our patients and support the current and future goals of the Australian health care system.

<http://www.racgp.org.au/curriculum>

<http://www.acrrm.org.au> > education > vocational training

A2. Standards for GP Education and Training: Trainers and Training Posts

The standards for trainers and training posts set the standards required in general practice training posts, and extended skills posts.

The standards apply to the general practitioners who take responsibility for training the registrar within the primary healthcare and general practice setting. The trainers and training posts standards specify the education and experience required of the supervisors, supervision and training, registrar support, registrar experience and workload, and registrar feedback.

Accreditation of supervisors and training posts is essential to ensure that the standard of training is uniformly high throughout Australia with suitable role models, experience, supervision, teaching and access to proper resources and facilities.

<http://www.racgp.org.au/vocationaltraining/standards>

<http://www.acrrm.org.au> > education > vocational training

A3. Standards for GP Education and Training: Program and Providers

The standards for programs and providers set the requirements for the education providers responsible for vocational training.

The programs and providers standards cover the standards for training programs, program education and training, selection and enrolment, support for registrars, support for trainers, and registrar performance and monitoring.

<http://www.racgp.org.au/vocationaltraining/standards>

<http://www.acrrm.org.au> > education > vocational training

A4. Requirements for Fellowship of ACRRM and RACGP

Fellowship of ACRRM or RACGP are the recognised standards for practising as an unsupervised general practitioner in Australia. To attain Fellowship, applicants must have

undertaken suitable training/experience in general practice, and demonstrated their competence by successfully completing the respective College assessment processes. Each College has a number of pathway options for candidates to achieve Fellowship depending on their individual experience and circumstances.

<http://acrrm.org.au> > education > fellowship

<http://www.racgp.org.au/fellowship>

A5. Requirements for Rural Fellowship in RACGP

Fellowship in Advanced Rural General Practice (FARGP) aims to assist candidates to become competent and confident to work anywhere in unsupervised rural and remote general practice. The flexible program consists of core and optional education activities, which have a strong practice based focus.

Candidates must complete the advanced rural skills post curriculum requirements, a rural general practice module, an emergency skills module, elective educational activities, and a final portfolio.

Advanced rural skills training is available in, Anaesthetics, Obstetrics, Surgery, Aboriginal Health, Mental Health, Paediatrics, Emergency Medicine, Adult Internal Medicine, Small Town General Practice, and other individually designed programs.

<http://www.racgp.org.au/rural/fargp>

A6. Continuing Professional Development

ACRRM and RACGP set standards for ongoing professional development and quality assurance. Both programs require GPs to accrue a number of points which are awarded for undertaking education activity that has been accredited against standards aimed to improve competence to practise and patient safety.

There are also a number of standards that relate to administration and reporting of education activity by providers, including human resources, feedback, activity reports, and sponsorship.

<http://www.racgp.org.au/qacpd/20082010triennium/providerforms>

<http://www.acrrm.org.au> > education > PDP

A7. Standards for General Practices

The standards for general practices form one of the benchmarks of quality and safety in Australian general practice and provide future directions for quality improvement. The standards are developed by the profession, for the profession, with both experts and in the profession and consumers involved in the development of the standards.

The standards outline the aspects of general practice that support high quality and safe comprehensive care, including attention to the services practices provide, the rights and needs of patients, quality improvement in education processes, practice management, the physical aspects of practice, general practice teams, and general practice systems and processes.

<http://www.racgp.org.au/standards>

A8. RACGP Standards for the Supervision of Prevocational Doctors in General Practice

The RACGP has set standards for programs and providers set the standards for prevocational education, selection, enrolment, support, and performance during training.

The education and training of prevocational training is based on the principles and standards of postgraduate medical education that ensure the practitioner is able to practice competently and with compassion.

<http://www.racgp.org.au/prevocational/supervision>