The diagnosis: Why integrated regional General Practice training is vital for a strong and sustainable Australian health care system

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A surplus of city doctors is undermining the health care system and this relates in part to a lack of focus on rural General Practice: five key points

1 Doctors shape health care systems, especially where funding is based on services that doctors provide. The number, profile and distribution of Australia's medical workforce is a major determinant of the structure, effectiveness, accessibility and cost of the health care system as a whole. With spending largely driven by clinical activity in public and private hospitals and in community settings and in the context of population ageing, there is ample scope for what economists call 'supplier-led demand' that will keep any number of doctors busily occupied.

2 Training more doctors in the city and hoping they will 'trickle-out' to the regions has been in vain. Australia's very high level of domestic medical workforce production remains overwhelmingly geared to produce more metropolitan consultant specialists. The various factors contributing to this include a predominantly metropolitan base of medical education and training at all levels and an over-reliance on trainees to service the rosters of busy, increasingly subspecialised, units in activity-funded metropolitan hospitals. The excess in the number of city doctors is in turn contributing to subspecialisation and fragmentation of care, undermining quality comprehensive primary care and driving unsustainable growth in health expenditure.

3 Importing overseas-trained doctors as a temporary fix for the regions is making the metropolitan oversupply of doctors much worse. Australia continues to rely heavily on international medical labour to prop up health services in regional areas, as junior and hospital doctors, GPs and consultant specialists. Those doctors do a great job. However, the importation of medical labour is a major contributor to the oversupply of medical workforce in capital cities, because that tends to be where overseas-trained doctors gravitate once initial visa and Medicare billing restrictions lapse.

4 Strong comprehensive primary care should be the cornerstone of the Australian health care system but is being undermined by the medical and GP training arrangements and the funding of general practice. Australia needs to strengthen comprehensive, high quality primary care but this is being undermined by burgeoning acute hospital activity, medical sub-specialisation, a lack of outcomes-focus for GP training, an excess of GP labour supply in the cities, and GP funding that rewards high throughput, low value care. The situation is further complicated by the rise of corporate medicine and commercial business models in the cities that generate demand for more GP labour, notably international medical graduates and GP trainees.

5 Building a substantial pipeline of domestic medical graduates who willingly pursue remote and regional careers in General Practice and consultant medical practice is the single most important national medical workforce reform. Successful models of domestic 'pipeline' production of medical graduates, GPs, Rural Generalists and consultant specialists for regional practice need to be identified and expanded, at scale. This requires joined-up thinking and alignment across Commonwealth and state/territory government programs.

The Australian Government's General Practice training scheme is in need of review

The Australian Government's GP training scheme, the Australian General Practice Training program (AGPT), is a $310m annual investment by the taxpayer to produce the next generation of GPs to meet community needs.

> *Established in 2001, AGPT lacks intended outcomes or outcome-oriented program performance measures and has never been externally evaluated for value and impact.*

The core design of the AGPT program is largely unreformed since inception: a national provider network of training organisations is contracted by government to deliver GP training for a specified number of trainees, with half of the nationally aggregated training time to be undertaken outside of major cities. Training is delivered in accordance with the curriculum and training standards set by the accredited GP training colleges, those being the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACCRM).

Not surprisingly, the GP and medical workforce landscape in Australia has changed considerably since 2001. Capital cities are now oversupplied with GPs (and doctors in general) while rural communities still rely on bringing in doctors from overseas. Those international doctors tend to move on to metropolitan locations when visa and Medicare billing restrictions lapse, illustrated by the fact that international graduates working as GPs are now providing the majority of GP services in the city as well as the country.

Meanwhile, the numbers of applicants to the AGPT program is in decline, mirrored by historically low and waning interest in General Practice as a career from medical graduate surveys.

The main structural changes to detail of the AGPT program since 2001 have been:

- Tripling of the number of funded GP training places
- A ten-fold increase in the level of government funding
- Progressive consolidation of most regional training organisations back into capital cities
- The Commonwealth Department of Health taking over the functions of its commissioning body, General Practice Education and Training Ltd (GPET Ltd) when it was scrapped in 2014

As a consequence of the GPET Ltd closure, the Department inherited operational roles that include decision-making and data collection at the level of individual GP trainees as well as a more usual function for government in contracting with providers (Regional Training Organisations) and overall policy and program administration. There are many other perverse aspects of the legacy design of the Australian General Practice Training Program, some of which are detailed below.

The legacy Australian General Practice Training program is out of step with workforce priorities and good public sector program design in a number of ways

The most obvious problem with the Australian General Practice Training program as a Commonwealth health workforce initiative is that there are no overarching program objectives nor program logic leading to the desired outcomes..

Beyond this fundamental point, there are many perverse features of the legacy AGPT program design that have been inherited from GPET Ltd. These include the following:

Rural sticks without carrots

- Metropolitan-based GP training is subsidised by the taxpayer on the same basis as rurally-based training, be it Balmain or Burketown, Brighton or Benalla. There is no positive gradient of incentives and supports for trainees and training practices in more remote locations.

- Instead, a 'conscription' mechanism is used to achieve the longstanding 50% national target for non-metropolitan training time.

- For those doctors intending to train to a RACGP Fellowship, this is done by requiring applicants to pay to sit a national test, out of which lower-ranking candidates and international medical graduates are allocated an unpopular and inflexible 'Rural Pathway' GP training place. Consequently, the very trainees who are more likely to require additional training support tend to be assigned to more isolated and under-resourced locations, without a commensurate increase in funding and support.

- Those applicants with higher test scores are more likely to win the choice pick of flexible 'General Pathway' training place. While in theory those doctors can train regionally, the great majority do not (and some are prevented from doing so by their training provider).

- Meanwhile, all the doctors training towards an ACRRM Fellowship are obliged by the Department to accept a restrictive 'Rural Pathway' training place.

- This 'rural is for losers' aspect of the candidate selection design in AGPT tends to make rural GP training unpopular among domestic medical graduates and junior doctors. This is in contrast to the popularity and impact of rural training for medical students (under the Rural Health Multidisciplinary Training program) and among junior doctors (in the now defunct Prevocational General Practice Placement Program, PGPPP).

- The required contribution to the national 50% non-metropolitan training target varies widely among contracted training providers. Perversely, those providers serving larger regional populations are allocated a disproportionate share of the unpopular 'Rural Pathway' places to fill, a turn-off for prospective GP trainees who might have considered applying to train in those regions. This includes regional Queensland and western New South Wales and the whole of the Northern Territory and Tasmania.

Red tape without flexibility

- In spite of shortages of trainees in rural locations, training providers are not permitted to flexibly fill vacant rural GP training opportunities outside of the Department's annual AGPT recruitment round, no matter how obvious the community need, nor how suitable the prospective GP trainee.

- A complex set of Departmental 'AGPT Policies' impose red-tape, inflexibility and rules to be applied at the level of the individual trainee – much of which would be better managed by local training providers according to program objectives.

Data without purpose

- There are burdensome data reporting requirements whereby identified individual trainee information must be synchronised to the Department's data system (RIDE) on a daily basis, detailing the hours worked by each trainee, their location of practice, the type of training term, the educational activities that they have undertaken, teaching visits, assessments that they have sat, the exam results, personal leave and other matters - for no apparent reason.

- No such identified client-level information is required in other Commonwealth health workforce program contracts. Contracted organisations in other programs provide the Department with aggregated performance data and qualitative reports that relate to explicit objectives for programs, for example under the Rural Health Multidisciplinary Training program (RHMT) and the Specialist Training Program (STP).

Roads without destinations

- In the main, performance measures for contracted GP training providers are about process and structure, not outcomes or impacts. For instance, measures of

achievement in Indigenous health include a count of 'accredited Aboriginal and Torres Strait Islander health training facilities' and 'the number of registrars undertaking training' in them. Not only are these measures unrelated to what one might wish to achieve as an outcome (eg: filling jobs in Indigenous healthcare settings with well-trained GP Fellows), those measures and associated rules that restrict time spent, set up an expectation that trainees are cycled rapidly through Indigenous health care settings, rather than stay on, complete their training and hopefully gain permanent employment.

Silos without synergy

Finally, and importantly from a program design perspective, AGPT operates largely in isolation of other Commonwealth investments in rural medical workforce training and support, thereby missing opportunities for synergy in public investments. These include:

- Rural Clinical Schools, Regional Medical Schools and their associated Regional Training Hubs (the RHMT program)
- University Departments of Rural Health (RHMT)
- Regional Primary Health Networks
- Rural Workforce Agencies
- Rural scholarship and bonded medical places schemes
- General Practice Procedural Training Support Program
- The Rural Junior Doctor Training Innovation Fund
- The More Doctors for Rural Australia Program

What the Department is considering in AGPT reform goes beyond the Ministerial commitment

In October 2017, the Commonwealth Minister for Health made a commitment that GP colleges would have a leadership role in GP training from 2022.

It is indeed entirely appropriate for the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine to take on full and unambiguous leadership of curriculum, standards, quality assurance of training, management of trainees in difficulty, professional conferences, collection of identified information on trainee progress and award of Fellowships – areas in which the Department (and GPET Ltd previously) have been much too operationally involved.

However, Commonwealth program design to achieve rural GP workforce outcomes is a different matter from the technical quality and very integrity of accredited GP training.

It remains uncertain what the Department is intending with the planned 'transition' of the AGPT to a college-led model in 2022. From the information provided to date, it appears that the AGPT program is likely to be contracted out to the GP colleges in a largely unreformed state, including the various problematic aspects of the legacy AGPT program design outlined above. The Department's core role of applying health workforce program funds to achieve health workforce policy objectives would therefore also be outsourced to colleges.

Given that there are no outcome-orientated policy objectives for AGPT - and particularly given its historical failings in rural GP workforce – wholesale outsourcing of the program is a high-risk move for the Commonwealth Government and, more particularly, for regional communities.

The lack of critical review of the AGPT program ahead of such a change is especially glaring given the various audits underway or planned that will impact on future GP workforce. These include the Minister's 10 Year Primary Care Plan, a Medical Workforce Reform Advisory Committee analysis of GP workforce needs, the external review of the Rural Health Multidisciplinary Training program (RHMT) and the National Medical Workforce Plan. The last national review of GP training was back in 1998. It is time for another.

Meanwhile, the Commonwealth commitment to establishing a National Rural Generalist Training Pathway is welcome

In a separate and important development for rural stakeholders, the Minister committed to establishing a National Rural Generalist Training Pathway by 2021, to train a special cadre of broadly-skilled rural GPs who can work in community primary care as well as provide emergency and hospital care and other services. This is a very welcome development, but regional and rural communities need both Rural Generalists services (Rural Generalist Medicine) and well-trained GPs who choose to focus on community practice. Well designed regional pathways to rural practice are important for both.

JCU is Australia's most successful university in producing medical graduates and GPs who go on to work in regional and remote locations

James Cook University is demonstrating what can be achieved if the 'training pipeline' from regional medical school to a rural GP or Rural Generalist career is aligned. JCU is one of a handful of universities worldwide that are achieving such outstanding rural medical workforce outcomes:

- Seventy-five percent of the almost 1800 JCU medical graduates since 2005 have gone on to work in regional and remote locations for periods of 12 months or more
- Just under half of JCU's graduates pursue careers in General Practice, one third of those in Rural Generalist Medicine
- Graduate tracking research shows that over 1000 JCU graduates are currently serving rural, remote and regional communities (around 62%)
- Of the 424 GP Fellows who completed training with JCU in the first three years, four out of five were working in regional and remote locations six months post-Fellowship
- Those GP Fellows trained by JCU who were also graduates of the JCU medical program are even more likely go rural, with 95% working in regional and remote locations at Fellowship

To achieve these results, JCU has systematically applied the evidence for what it takes to produce rural GPs and regional consultant specialists:

- Around 70% of domestic students admitted to JCU's medical school have regional and remote backgrounds
- JCU's medical program is an entirely regionally located 'end-to-end' medical program
- In addition to clinical training in regional hospitals and general practice, every student undertakes at least 20 weeks of clinical placement in small rural and remote communities, and some considerably more time in long 'integrated' rural terms
- JCU works with junior doctors and hospitals across the region to promote and facilitate regionally based post-graduate training in General Practice and consultant specialties
- Since 2016, JCU has directly provided 'joined-up' General Practice training for medical graduates, with a distributed delivery model covering 90% of Queensland, as a provider in the Australian General Practice Training program

Recommended actions

The immediate concern for James Cook University is that its successful model of integrated medical and General Practice training, which has been established across regional Queensland, is under threat with the outsourcing of AGPT by the Department. The transition to College-led training is an opportunity to implement urgently needed changes to address the GP workforce maldistribution that the AGPT program was originally established to address.

This is not only important for regional Queensland communities but also for wider national reforms, because JCU's unique 'joined-up' regional training model may well be an exemplar to inform national program design.

In relation to the broader AGPT program, JCU offers the following recommendations:

In the short term

Policy

1. Proceed without delay with the full establishment of a National Rural Generalist Training Pathway as announced in the 2019 Budget, including an allocation of training places and resources that currently reside within AGPT

2. Defer Departmental decisions on the detail of the 2022 transition of mainstream AGPT training to colleges, pending consideration of outcomes of the RHMT review, Medical Workforce Reform Advisory Committee analysis of GP workforce needs, progress with the National Medical Workforce Plan, considerations arising from the 10 Year Primary Care Plan and further consultation with regional stakeholders about the best operational model to achieve the program objective*

3. Commission a comprehensive external review of AGPT against its stated program objective* and related rural health and health workforce policy priorities

AGPT Program reform

4. Provide Regional Training Organisations with the option of achieving GP trainee geographic distribution targets, by means other than doctors having to apply for and be allocated a conscripted 'Rural Pathway' training place within an AGPT region

5. Deliver on the Minister's promise of College-led GP training by removing the Department from direct involvement in decision-making and data-collection at the level of individual GP trainees, and at the same time:

6. Strengthen RACGP and ACRRM leadership roles in curriculum, standards, accreditation, quality assurance, tracking trainee progress, management of trainees in difficulty, appeals, completion of training and hosting of GP training conferences

7. Redesign training provider funding agreements to specify explicit and measurable objectives, meaningful outcome indicators and reporting on management of exceptions

8. Consider harmonising the Department's approach to training provider contract management within AGPT to that applied in RHMT

In the medium term

9. Redesign AGPT as informed by an external review and other health and medical workforce policy priorities

10. Develop clear AGPT program objectives and intended outcomes, establish baseline data and performance indicators and an ongoing monitoring and evaluation strategy

11. Align Commonwealth investments in rural medical and General Practice workforce to achieve better coordination and continuity (ie: a 'rural pipeline')

12. Consider how government investment in a reformed AGPT might align with and support a national 10 Year Primary Care Plan and a stronger health system built on high quality primary care.

** 'Provide training programs to develop a workforce that will provide high quality services and meet community need, through programs such as the Australian General Practice Training Program' (Budget 2017-18. Portfolio Budget Statements)*