The prescription: better General Practice training that is aligned to Australian community needs

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The why, the what and the how of future GP training arrangements

This is the second paper in a series that seeks to chart a stronger future for general practice (GP) training arrangements in Australia.

The first paper (*'The diagnosis: why integrated regional General Practice training is vital for a strong and sustainable Australian health care system'*) described Australia's medical and GP workforce policy context, the various limitations of the legacy design of the Australian General Practice Training program (AGPT) and set out a case for review and reform.

This paper offers a prescription for features of a quality Australian GP training system that is aligned to priority community needs and that represents value for public investment.

For context, Australia's current and future specialist GP workforce is mainly produced through the AGPT, funded by the Commonwealth Department of Health.

The AGPT has two broad aims :

1. To support a national training program that produces a qualified GP workforce able to provide high quality services (a training quality/capacity issue)

2. To improve the geographic distribution of Australia's GP workforce, with a focus on regional and remote locations (a rural community access issue).[1]

There are no outcome-oriented performance measures for either of these aims and the AGPT program has not been externally reviewed for impact or value since inception.

The suggested 'prescription' for GP training is in three parts: 'the why, the what and the how'.

Firstly, we offer a set of foundation propositions to set the context for a GP training system ('the why'). Secondly, we propose a set of idealised characteristics of the system from the perspective of communities, learners and supervisors ('the what'). Thirdly, we outline a set of design options that would deliver on those propositions ('the how').

National Rural Generalist Pathway

The Australian government committed to establishment of a National Rural Generalist 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. Rural Generalist Medicine is also to be recognised as a 'field of specialty practice' within the specialty of General Practice. The Australian College of Rural and Remote Medicine has been allocated a specific tranche of 100 training places per year for a National Rural Generalist Pathway and $62m has been committed to improve training and coordination for aspiring rural generalists in each jurisdiction.

While related, this distinctive national program is out of scope for this paper, the focus of which is on options for reform of the mainstream Australian General Practice Program.

[1] The two statements distill elements of Australian Government policy from relevant Budget documents. For details on the health workforce measures relating to GP training, see Budget 2017-18: Portfolio Budget Statements 2017-18 Budget Related Paper No. 1.10 Health Portfolio, Program 2.3 'Health Workforce'. Available at: https://www.health.gov.au/sites/default/files/health-portfolio-budget-statements-2017-18.pdf

Why: GP training arrangements should be aligned with other reforms to help make comprehensive primary health care the cornerstone of Australia's future health care system

The following statements describe broad aspirations as considerations for GP training within the Australian healthcare system:

- First and most importantly, comprehensive primary health care should be the cornerstone of a future person- and community-centred Australian health care system
- General Practitioners (GPs) will remain the principal medical workforce in a future comprehensive primary care system, working in expanded teams alongside other health professionals and community workers, integrating health care with community services and operating in partnership with and for the benefit of local communities
- Future healthcare models should emphasise a continuum of health care grounded in trusting relationships – be that in the home, a community clinic, the residential aged-care setting, an emergency department, the local hospital, in tertiary care settings and by electronic means
- Medical and communication technologies, health informatics and artificial intelligence can help break down the barriers to continuity of person-centred, relationship-based and team-delivered healthcare that is informed by the best evidence
- Operating within this model, the scope of GP practice and related competencies will expand to reflect greater GP involvement across the continuum of person-centred health care and population health
- Aboriginal and Torres Strait Islander community-controlled health services and numbers of existing comprehensive GP practices (particularly but not exclusively in rural locations) represent existing models of comprehensive primary care that might be adapted more broadly
- While out of scope for this paper, it is generally accepted that reform of general practice financing is necessary and that the most likely direction of development will be towards voluntary patient enrolment in primary care practices ('health care homes') and a blended payment funding system (a mix based on service activity, weighted capitation for enrolled patients and performance in meeting targets)

And in wider medical workforce context:

- Training more doctors in the city and hoping they will 'trickle-out' to the regions has instead contributed to metropolitan oversupply and sub-specialisation (see Paper 1: The diagnosis)
- Therefore, achieving a substantial pipeline of domestic medical graduates who willingly pursue careers in General Practice and Rural General Practice is a first order health workforce policy priority
- International medical graduates (IMGs) provide important services in regional and remote locations - but reliance on overseas labour as an ongoing 'fix' for the regions contributes to GP workforce oversupply in the city once initial visa or Medicare restrictions lapse (Paper 3: GP workforce data (pending))
- Domestic medical graduate interest in GP careers (in the city and the regions) is best advanced by coordinated action across medical education and training, ranging from policies on selection into medical school, the focus of medical curricula, the composition of teaching faculty, the settings where clinical learning occurs, scholarships and bursaries, early graduate engagement in general practice, clear GP training pathways aligned to community needs and continuing professional development
- It is also important that GP work be inherently fulfilling and impactful, with appropriate financial remuneration and strong professional and community standing
- Similarly, domestic graduate interest in rural GP careers (GP and Rural Generalist) is advanced by coordinated action in education, training and career attractiveness, with the added interventions of locating medical schools and clinical training opportunities away from major urban centres and aligning those with regionally-based GP training pathways after graduation

What: Specify the desired characteristics of an idealised GP training system from the community, learner and supervisor perspectives

Taking the above statements as foundation aspirations there are still many options that might be considered for the re-design of a national GP training system. Consideration of idealised characteristics of a system from different 'user' perspectives can help refine these options.

GP training from the perspective of communities

- *Local accessibility and partnerships.* There are local points of presence and opportunities to develop relationships with the agencies and individuals who are responsible for developing the next generation of GPs to serve local community needs
- *Aboriginal and Torres Strait Islander communities.* Indigenous Australian communities and particularly Aboriginal community-controlled health services are a priority in any GP training system. Authentic partnerships (local, state and national), reciprocity and a focus on meaningful outcomes from a community perspectives are high priorities.
- *Continuity and return.* Communities can feel confident that their involvement with learners at any stage of medical education and training can facilitate the later return of those individuals as qualified GPs who will benefit from having established relationships and a sense of belonging
- *Community co-investment and reciprocity.* Communities can co-invest in the development of their future GP workforce in a spirit of partnership and reciprocity with providers of training, through activities such as formal welcoming, facilitation of social networks for professionals and their spouses, support with accommodation, guidance regarding employment for a spouse, childcare and other family support
- *Agency collaboration.* The agencies responsible for medical education and training across the continuum and those with GP workforce responsibilities (e.g. Rural Workforce Agencies, Primary Health Networks and regional hospital networks) work collaboratively and in partnership with communities to solve current and future GP workforce needs

GP training from the perspective of GP training candidates

- *Clear view to a GP career.* There is a clear and compelling pathway to a fulfilling GP or Rural Generalist career that is visible from the earliest stages of medical education
- *A continuum of positive exposure and learning in general practice*. Medical students, junior doctors and GP trainees have ample positive exposure to high quality models of General Practice and Rural Generalist Medicine as teachers, clinical placement supervisors and mentors
- *An end-to-end system of incentives that is aligned to community needs.* There is a transparent, graduated system of incentives and support that is aligned to priority workforce needs - for primary care generally and particularly in relation to geographic remoteness and in the Aboriginal and Torres Strait Islander community context
- *Community and professional relationships.* The program should maximise opportunities for students, junior doctors and GP trainees to establish and maintain connections within local communities and local professional networks, particularly in rural and high-needs communities
- *Flexible training.* Within a national system of training incentives and overarching quality standards, GP trainees enjoy a high degree of autonomy in relation to the location of training, movements around the country, their preferred sequence of training experiences, opportunities to undertake international electives and choices to train part time, job-share or take a leave of absence from training for family or other purposes
- *High quality clinical supervision*. Trainees benefit from high quality supervision that is adaptive to the local context and the competence and confidence of individual trainees and that is not unduly compromised by service delivery demands
- W*ell-designed education programs.* High quality, learner-centred, engaging and adaptive pedagogies are technologically enabled and widely accessible
- *Strong peer networks and mentors.* Learners enjoy supportive and career-affirming peer networks and ample opportunities to establish mentor-mentee relationships, with the particular needs of Indigenous learners also being met

GP training from the perspective of GP training supervisors

- *GP supervisor status and recognition.* GP supervisors enjoy a place as central participants in the GP and primary care training system and are recognised and rewarded accordingly
- *Professional development.* GP supervisors are supported to maintain and extend skills in health professional education, clinical practice, scholarship, research and professional leadership
- *Satisfaction in meeting community needs.* GP supervisors see a tangible return on investment through their involvement in developing the next generation of GPs and other health professionals who go on to serve their own and other communities
- *Participation across the continuum of learning.* GP supervisors seamlessly engage in the teaching of medical students, junior doctors, GP trainees and other health professional learners in 'teaching practices', many of which are recognised as centres of teaching and research excellence in comprehensive primary health care
- *Relationships in a supportive regional network.* GP supervisors are an integral part of a regional and self-sustaining network of people who are involved in GP, medical and primary care professional training, where individuals come to know and trust one another and are able to rely upon others for advice and support
- *Ready administrative support.* GP supervisors are supported to manage compliance, reporting, forms and paperwork in a system where red-tape is minimised and where there is ready access to local administrative support, whatever the stage of medical or health professional training
- *GP supervisors, cultural mentors and cultural educators in the Indigenous health context.* Supervisors and mentors in Indigenous health care settings have particular perspectives on training that develops both technical and cultural competence in a supported environment and that has positive community impact

How: Define functions, roles and options for the structure of GP training that best align with the 'why' and the 'what'

This section explores roles for agencies that are or might be involved in GP education and training in various capacities, consistent with 'the why' and 'the what' above.

Assumptions for this analysis:

- The Federal, State and Territory governments' roles are substantially unaltered with respect to health care policy, financing, planning and delivery
- The focus on regionalised health care will continue (through Local Hospital Networks/ Hospital and Health Services and Primary Health Networks)
- There will be a stronger emphasis on service integration across the continuum of care including more community-based care and delivery of health care by electronic means
- Financing reforms for public hospitals will place a greater emphasis on population health outcomes, avoidable hospital admissions and value-based health care
- Similarly, financing reforms in primary care will continue to moves toward voluntary patient enrolment and blended payment arrangements
- The roles of the Australian Medical Council and the accreditation of specialist medical colleges (including in general practice) will be unchanged
- Rural Generalist Medicine will be recognised as a 'field of specialty practice' within the specialty of general practice
- The Federal government will continue to curtail access to international medical labour and place greater emphasis on satisfying the medical workforce needs with domestic graduate supply
- For professional entry medical education, there will be a minimal increase in medical school places overall but more regionally-based delivery of medical education

Options for program structure and agency roles

An effective national GP training program requires coordinated action across a range of agencies and functional areas of work. Table 1 illustrates a selection of the range of tasks that might be considered and the agencies that might be involved.

Table 1. Functional tasks in GP training and some of the agencies involved

Functional tasks	Agencies
• Promotion of GP careers to students and junior doctors • Promotion of rural careers to students and junior doctors • Career guidance and pathway navigation (students and junior doctors) • Career guidance and pathways (GP trainees) • GP curriculum and summative assessment • GP training provider accreditation • Delivery of GP education program and formative assessment • Management of individual GP trainee learning plans • Brokering allocation of GP trainees to available training posts/terms • Identifying and supporting registrars at risk • GP training post quality enhancement • GP training post development and accreditation in areas of need • Hospital term access and support • GP supervisor engagement and development • GP practice contracting and performance • GP practice administrative support • System of incentives aligned to priority workforce needs • Local application of trainee/ supervisor/practice incentives aligned to workforce needs • Terms and conditions of employment of trainees • Engagement with community stakeholders in the delivery of the program • GP workforce solution collaboration (system/ jurisdiction level) • GP workforce solution collaboration (region/town level) • Evaluation of outcomes • Assessment of program impact and values • Partnership with ACCHSs at the local, state and national levels	• Australian Government Department of Health • State/Territory Departments of Health • Australian Medical Council • Royal Australian College of General Practitioners • Australian College of Rural and Remote Medicine • Other specialist colleges that offer training/ credentialing for GPs • Not-for-profit GP training companies • Medical schools (metropolitan) • University Departments of General Practice • Regional Medical Schools and Rural Clinical Schools (including Regional Training Hubs) • University Departments of Rural Health • Rural Workforce Agencies • Primary Health Networks • GP Supervisors Association • GP Registrars Association • Australian Medical Students Association • National Rural Health Student Network • Individual teaching GP practices • Public Teaching Hospitals (large) • District and local public hospitals • Aboriginal and Torres Strait Islander Community Controlled Health Services and peak bodies • Rural local governments and community agencies • Australian Rural Doctors Association • Australian Medical Association

GP Colleges should have a lead role in GP education and training across all options

The Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine share a mandate as the Australian Medical Council-accredited colleges in the specialty of General Practice. As such, they are responsible for ensuring that their respective specialist Fellows are 'able to practice unsupervised in … providing comprehensive, safe and high quality medical care that meets the needs of the Australian … community' and 'are prepared to assess and maintain their competence and performance through continuing professional education, the maintenance of skills and the development of new skills'.

In relation to training towards the Fellowship credentials, the GP colleges are responsible for overseeing and assuring: programs of training and education; curriculum development and renewal; the system of assessment for Fellowship; training program evaluation; trainee reviews and appeals; trainee selection policy; trainee engagement and welfare; remediation; and accreditation of training sites and training providers.

Colleges should be unambiguously responsible for: accreditation of training providers; summative assessment; award of Fellowship; development of core learning resources; and tracking trainee progress to achieving their Fellowship. In addition, colleges make direct contributions to support for individual trainees at risk; GP supervisor and medical educator professional development; and promotion of General Practice as a career.

This role for colleges in the GP training system needs funding support. Given the importance of primary care, the quality and capacity of Australia's General Practice training system is a public good, that warrants government investment for the core educational activities of GP colleges.

But achieving regional GP workforce outcomes through GP training requires an integrated regional approach to the delivery of training, partnerships and incentives

Building a substantial pipeline of domestic medical graduates who willingly pursue remote and regional careers is arguably the single most important national medical workforce reform. This is best achieved by a program design that: favours selection of students and trainees with rural connections; bases entry-level medical education in regional locations; aligns regional medical education with regionally-based internships, RMO and GP training pathways; and provides contextually-relevant financial and other incentives.

Regional incentives for GP trainees may take many forms: salary subsidies; transferable employment entitlements; retention bonuses; education debt relief; provision of accommodation and transport; subsidised attendance at courses; priority access to key skills formation opportunities; options for attractive elective training experiences; and family assistance packages and support networks for spouse and children. Evidence also suggests that ensuring that GPs and GP trainees can maintain a broad scope of practice is an important factor in rural attraction and retention. Regional stakeholders can usefully contribute to trainee attraction and retention, including community agencies and local government, local and district hospitals, regional university campuses, rural clinical schools, Primary Health Networks, Rural Workforce Agencies and others.

It will be important to ensure that terms and conditions of employment for GP trainees are no less attractive than what is on offer for trainees in hospital-based specialty training.

Regional teaching practices, GP supervisors and rural hospitals should also be supported to help achieve workforce outcomes in a national GP training system. Again, financial incentives are required and practical measures are important too, including access to capital infrastructure grants, information and communication technologies, educational inventories, learning aids, professional networks and continuing professional development. ACCHSs are a particularly important setting of learning with distinctive support requirements.

The Options

Option 1. *Government-contracted accredited GP training entities operating within a national system of workforce incentives to deliver both training and workforce outcomes*

In this 'minimum change' option, the Australian Government sets the macro workforce policy objectives and a panel of College-accredited GP training providers operate within state/territory boundaries, much as occurs at present.

As it does now, the Department of Health would contract with GP training providers to deliver outcomes around the quality and capacity of GP training. However, the Department would also require GP training providers to deliver negotiated regional GP workforce outcomes, with the emphasis on domestic medical graduates who go on to practice in rural areas (and other priority workforce locations) as GP Fellows.

To drive this, a national system of scaled geographic incentives for trainees, supervisors and training practices would be administered by the panel of training providers. The degree to which this might be locally adapted (as opposed to, for instance, incentives being based only on a geographic classification system) would need to be determined.

As with the other options below, the GP colleges would receive government funds for core education-related activities. Again, as with the other options, GP trainees would retain a degree of flexibly in their training and would be able to transfer between locations (and training providers and jurisdictions) within a national system of geographic workforce incentives.

Option 1. Advantages and Disadvantages

Advantages

1. Minimum change option
2. Nationally-consistent workforce training incentives framework
3. Alignment with jurisdictional-level policy and programs
4. Explicit delineation of GP training quality/capacity from GP workforce distribution outcomes

Disadvantages

1. Limited traction, presence and accountability in the regions if training providers are city-based
2. Limited scope for local flexibility and collaboration around incentives to deliver GP workforce outcomes without local presence
3. Little opportunity for vertical integration (medical schools, rural clinical schools, university Departments of GP, hospital medical education units)
4. Limited scope for development of research and scholarship

Option 2. *Vertically-integrated GP training in regional Australia delivered by regional medical schools and rural clinical schools, flexible local application of training/workforce incentives and Colleges auspicing training in major cities in concert with Departments of General Practice* ***(preferred option)***

Under Option 2, the Federal Government would again set the macro workforce policy objectives and a framework for the application of incentives for GP trainees, supervisors and training practices.

The policy emphasis in this option is to establish vertically-integrated regional medical education and training pathways for domestic medical graduates to regional General Practice careers. Domestic graduates from regional medical schools and rural clinical schools (RMS/RCSs) are supported to pursue regional hospital options as junior doctors and to proceed to regionally-based GP training in seamless and locally-adapted pathways. The pathways would be flexible to allow entry at any level and movements in from any other region. It would also accommodate international medical graduates looking to achieve Australian GP Fellowship.

As with option 1, suitable regionally-based education entities (RMS/RCSs) would be contracted by the Department of Health and required to meet accreditation standards set by colleges to deliver GP training. GP training would then be integrated with existing program activities in professional entry medical education and the support of graduate pathways to regional careers (through the Regional Training Hubs component of the Rural Health Multidisciplinary Training program).

The RMS/RCSs would have scope to flexibly broker incentives and support for trainees, supervisors and training practices to achieve workforce outcomes, for which they also would be accountable. This would be within broad parameters of a national incentives framework. Regional and local partnerships would be brokered with hospitals, PHNs, local governments, community agencies and others, including on a town-by-town basis.

Again, Colleges would be funded by the Department of Health for core education-related activities and obligations as AMC-accredited specialist colleges and trainees would enjoy flexibility of movement within a national framework of incentives.

In major cities, Colleges would be directly responsible for delivery of GP training, possibly supported in part by trainee financial contributions in well-served locations. Education and training would ideally be delivered in partnership with University Departments of General Practice, and this could be a required program feature.

Metropolitan links of GP training with universities would help assure continuity across the domestic education and training continuum and may afford efficiencies in delivery. It would help to raise the profile and appeal of general practice among domestic students and graduates and enhance the development of GP scholarships and research.

Option 2. Advantages and Disadvantages

Advantages

1. Public investment is scaled and aligned to GP workforce needs
2. Contextually relevant local application of incentives, partnerships and co-investments
3. A regionally-integrated student-to-RMO-to-GP training pathway is best evidence for rural retention
4. Simplified administrative and partnership arrangements for practices/hospitals in regions
5. More scope for regional GP teaching, research and scholarship ('GP portfolio careers') that enhance attraction and retention
6. Established provider network with existing infrastructure and efficiencies

Disadvantages

1. Not all existing regional education entities have established GP training capacity
2. Vertical integration in urban locations (medical schools, hospital medical education units, GP Colleges) would need considerable development
3. Scope for GP research and scholarships in urban locations would also depend on partnerships

Option 3. *A voucher system for GP trainees scaled by community need and operating in a market of College-accredited GP training providers*

This option applies a training voucher mechanism for achieving GP training workforce distribution within an open market of accredited GP training providers.

The Australian Government would set the macro workforce policy objectives and a framework for the application of incentives to subsidise the costs of GP training. The incentives are made available to trainees as 'training vouchers', which would be competitively awarded to a defined number of candidates in a process overseen by GP Colleges. The financial value of the training voucher would be scaled by workforce need in the individual trainee's training location.

Any training entity (existing providers, universities and other organisations) that can meet GP College accreditation requirements would be able to enrol, place and train GP trainees. The trainee vouchers deliver government revenue for training providers. Trainees holding training vouchers may also contribute to the costs of delivering training in non-priority locations, over and above voucher revenues. Training providers would also be able to train candidates who are not voucher-holders on a cost-recovery basis.

Colleges would again receive government funds for core activities (including accreditation and oversight of the national provider network). As with other options, GP trainees would be able to transfer between locations (including jurisdictions) within a national system of incentives that attach to the voucher.

Option 3. Advantages and Disadvantages

Advantages

1. Public investment is aligned to GP workforce needs
2. Government responsible only for design and oversight of GP training voucher system and core funding for Colleges
3. Other than accreditation, training provider performance is disciplined within a market of trainees and training practices

Disadvantages

1. Areas of market failure likely in remote and regional locations
2. Potentially large and overlapping training provider network with confusion for trainees and training practices
3. Likely to be an unstable training environment over time and within and across regions
4. Opportunities for vertical integration in medical education are patchy, as is the scope for research and scholarship research and scholarship

Option 4. *College-managed training with GP workforce incentives administered by region workforce entities*

This option represents a separation between College-managed oversight/delivery of GP training and the provision of government GP workforce incentives for trainees, supervisors and practices in regional and underserved locations.

Once more, the Federal Government would set the macro workforce policy objectives and a framework for the application of incentives for GP trainees, supervisors and training practices, based on geographic location. GP trainees would again be able to transfer between locations (including jurisdictions) within the national system.

Colleges would be funded by Department of Health for core education-related activities and obligations as AMC-accredited specialist colleges. Colleges would also directly deliver training and/or engage accredited training providers on a regional basis and would levy training fees.

However, GP training fees would be offset by subsidies and incentives. Regionally-based workforce entities (for instance Primary Health Networks or Health Workforce Agencies) would broker the application of training subsidies (trainees, supervisors and practices) within a national framework. The Department of Health would contract with regional workforce entities to administer incentives and would hold the provider accountable to the Department for working with the Colleges, training providers and other stakeholders to achieve specified workforce outcomes.

Option 4. Advantages and Disadvantages

Advantages

1. Public investment is scaled and aligned to reflect GP workforce needs
2. Informed regional application of incentives, partnerships and co-investments
3. Clear delineation of GP training quality/capacity from GP workforce distribution outcomes

Disadvantages

1. Many regional workforce entities have limited regional infrastructure
2. Colleges have little established regional delivery capacity
3. Limited opportunity for vertical integration of medical education and training
4. Limited research and scholarship
5. Potentially complex and unstable arrangements for trainees, practices and hospitals in regions to navigate

Recommended actions

In the short term

Policy

1. Proceed 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 transfer of mainstream AGPT training contracts to colleges pending consideration of outcomes of the RHMT review, MWRAC analysis of GP workforce needs, further developments with the National Medical Workforce Plan, a decision on the development of a Primary Care Plan and further consultation with regional stakeholders about the best operational model to achieve the program objective*

3. Commission an external review of AGPT comparing its stated program objectives* to related rural health and health workforce policy priorities.

AGPT Program reform

4. Provide RTOs with the option of achieving GP registrar 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 registrars, and at the same time:

6. Strengthen RACGP and ACRRM leadership roles in curriculum, standards, quality assurance of training, management of trainees in difficulty, collection of data on trainee progress and award of Fellowships

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

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

In the medium term, and considering the issues explored in this paper

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 establish 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 Primary Care Plan and a stronger health system based on 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)*