

Changes to training for General Practice in Australia

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The Australian context

Australia is an enormous continent with a small, mainly coastal population of approximately 20 million. A total of 84% of the population live in large cities and surrounding areas, which constitutes only 1% of the continent's area.¹ Nevertheless, Australians living in rural areas need to access services in their local community, and general practice is one such service. The difficulties encountered in ensuring an adequate supply of appropriately trained general practitioners (GP) to rural areas have been prime drivers behind the Australian government's radical reforms of general practice training in 2001.

The Family Medicine Program and the Royal Australian College of General Practitioners Training Program

More than one quarter of a century after formal training for general practice was established in this country, Australian GP training has gone through its most significant change process. The national Training Program of the Royal Australian College of General Practitioners (RACGP) has been discontinued and the government has established its own funding company, which in turn distributes funds to 22 regional training providers. In the light of this radical change it is timely to briefly examine the history of GP training in Australia.

The first training scheme

The RACGP was formed as a national organization in 1958, building on a structure of Australian state-based

Faculties of the British Royal College of General Practitioners.² Small scale training programs were organized by College fellows through their state Faculties during the 1960s, culminating in the first federally funded scheme in 1973. Named the 'Family Medicine Programme' (FMP), this scheme was part of the federal government's strategy to increase the number of GPs and to enhance the role of community health.

The FMP annual report of 1974^{2,3} stated its aims as being:

- 1 To upgrade the standard of primary health care by increasing the number of graduates entering general/family practice
- 2 To improve the standards of training for, and consequently the job satisfaction to be derived from, family medicine
- 3 To involve family physicians and other members of the health team with community health care and reduction of professional isolation.
- 4 To train teachers and assure adequate accredited training posts in general/family practice of a suitably high standard.
- 5 To develop comprehensive training programs and materials for all phases of graduate education for general/family practice
- 6 To provide retraining for women and other graduates who have had an extended period away from practice.

Many of these aims remain relevant today. Family Medicine Programme training continued as a voluntary activity over the next 20 years and in spite of an increasingly restrictive policy framework, developed innovative models of supervision and teaching. Using an apprenticeship model, enhanced by educational activities both within general practice and externally, FMP enrollments peaked at 830 in 1993, shortly before the federal government took steps to limit enrollments to 400 per year, in order to control the number of graduating GPs.

Vocational registration

In 1989, the RACGP negotiated with the federal government over the introduction of a system of

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vocational registration for GPs, with the relevant legislation amended in 1996 requiring completion of the renamed RACGP Training Program by all new doctors who wished to become GPs. Thus, formal training for general practice became mandatory, and the RACGP Training Program was the only pathway to that career. The Fellowship of the RACGP (FRACGP), by examination, became the endpoint of GP training and remains so today.

The establishment of the Australian College of Rural and Remote Medicine

Making any program compulsory and removing alternative pathways inevitably raises the stakes for those involved. Many have commented on the political 'heat' that surrounded the RACGP Training Program throughout its existence.² This heat gradually increased throughout the 1990s to the point of combustion at the end of that decade. A number of factors contributed to this, perhaps the greatest being growing dissatisfaction among some rural doctors with the Program's failure to resolve the shortage of GPs in rural areas. The RACGP Training Program had established a rural stream in 1992 and began offering Graduate Diplomas in Rural General Practice from 1996, but there was neither the will nor the way to force GPs to remain in rural areas after they completed their training. A variety of conflicts both within the RACGP and between the College and the Rural Doctors Association of Australia in the mid 1990s led to the formation of the Australian College of Rural and Remote Medicine (ACRRM) in 1996, a group that wished to become responsible for rural GP training.

Strategies to bring the RACGP and ACRRM together into a cooperative training venture at the end of the 1990s were largely unsuccessful, except for the establishment of Joint Consultative Committees (tripartite groupings with the relevant specialist College) and a small Pilot Remote Vocational Training Stream (PRVTS). The organization of ACRRM now declares itself to be 'the peak professional association for rural medical education and training in Australia' and states that its core function is 'to determine and uphold the standards that define and govern competent unsupervised rural and remote medical practice.'⁴ The RACGP declares itself as 'the national leader in setting and maintaining the standards for quality practice, education and research in Australian General Practice' and states that its core responsibilities are general practice standards, education and training in Australia.⁵

Tensions between the two organizations existed in the context of repeated government reviews of the RACGP Training Program. The 1996 'Holsgrove Report' recommended the creation of alternative pathways to a career in general practice, including Masters

degrees as an alternative to the FRACGP.⁶ It recommended the establishment of a Board of Studies for General Practice Vocational Training, a theme that also emerged from the 1998's Ministerial Review of General Practice Training.⁷

Ministerial review of general practice training, and the creation of GPET

The then Minister for Health commissioned a major review of general practice training in 1997 in order to provide recommendations on the best possible future vocational education system for general practice into the next century.⁸ One of the key recommendations of this review was the establishment of a 'National Council of General Practice Education and Training'. This council was proposed to have one of four alternative roles: an advisory role, an advisory and limited funding role, an advisory and moderate funding role, or a full funding role.⁷ The review group recommended the third option, but in 2000 the Minister for Health, reportedly frustrated by continuing tensions within the profession and the collapse of collaborative structures, implemented the fourth and most extreme option. This led to the creation of General Practice Education and Training Limited (GPET) in 2001, a commonwealth owned company that took responsibility for GP training from the RACGP from the beginning of 2002.

The loss of its training program has had a significant effect on the College, both in a financial sense and in terms of fulfilling its commitment to registrars. The RACGP responded to the creation of GPET by creating its own company, General Practice Education Australia (GPEA), to carry forward the skills, experience and resources of the former training program. Staff of the RACGP Training Program were able to transfer to the College's new company in order to complete the training of those registrars who were already enrolled. This arrangement terminates at the end of 2003, and GPEA is busily developing new areas of business, while the College focuses on standard setting and assessment. A recent review by the Australian Medical Council endorsed this role for the College.

Although GPET is owned by the Commonwealth of Australia, it has a board consisting of medical practitioners and a non-medical Chair who is appointed by the Minister. A board member is nominated by each of:

- RACGP
- ACRRM
- General Practice Registrars Association
- Australian Divisions of General Practice
- Committee of Deans of Australian Medical Schools.

The Minister has appointed three additional board members. In 2001, GPET called for tenders from regional consortia to provide vocational training for general practice for 3 years from 2002. Twenty-two consortia (covering urban, rural and mixed regions) are now providing training across Australia (Fig. 1). Consortia partners commonly comprise educational institutions such as universities, professional organizations such as colleges, divisions of general practice, hospitals, community controlled organizations and other relevant bodies. The GP supervisors and registrars are active members of most consortia.

The Australian General Practice Training Program: the way forward?

General Practice Education and Training Limited requires consortia to deliver the new Australian General Practice Training Program according to the RACGP's Vocational Training Standards and Requirements⁹ and to ensure that registrars are ade-

quately prepared for assessment by the RACGP at the completion of training. Both the RACGP Curriculum¹⁰ and the ACRRM Curriculum are recommended. All training, whether in hospital posts, general practice, or other locations, must be accredited by the RACGP.

Within these limits, however, there are plenty of opportunities for training providers to be innovative. Most are continuing to deliver the old training program in this developmental phase, although some are introducing local initiatives such as portfolio based training, in-training assessment and vertically integrated activities. Many of the key staff members of regional training providers are former members of the RACGP Training Program and have transferred their expertise to the new system. However, a great deal of experience has been lost in the transition.

Unavoidably, the creation of a regionalized training program has proven to be an expensive exercise for the funding body. The GPET's Canberra office is larger than the RACGP's Melbourne office it replaced, and there are now 22 regional infrastructures to support rather than the previous nine RACGP state offices. Activities such as curriculum development, educa-

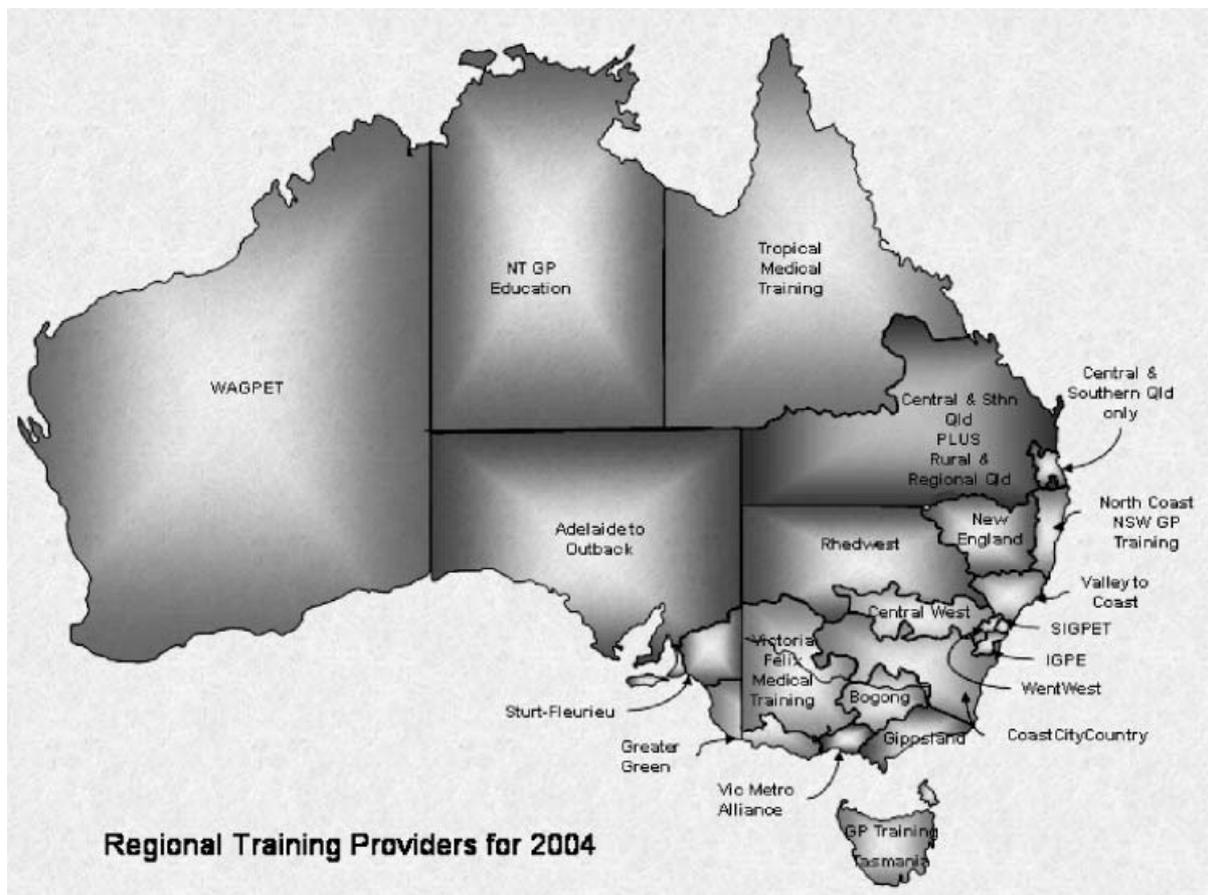


Figure 1 Regional training providers for 2003.

tional resource production and national policy workshopping are not occurring to the same extent.

The greatest challenge for the new training program, however, will be to resolve the medical workforce problems that bedeviled its predecessor. The uneasy tension between education and workforce continues under the new regime, with the federal government requiring GPET to institute a compulsory 6 month term in outer metropolitan areas for all new entrants to the program in 2003 and beyond, in addition to the longstanding 6 months minimum rural commitment.

The upheaval caused by these changes appears to have combined with other problems such as a medical indemnity crisis and lagging GP incomes to make a

career in general practice less popular. Application rates have diminished since the new arrangements were instituted to the point where some rural regional quotas are unlikely to be filled in 2004. The number of training places is being increased from 450 to 600 per year from 2004.

The success of the new program will be measured in terms of the supply of a comprehensively trained, well distributed workforce of new GPs who have experienced a satisfying educational experience in the practices of motivated, skilled supervisors, who in turn are supported by organizations such as universities, divisions and Colleges. With political will, collegiate cooperation and adequate funding wisely spent, such an outcome is entirely possible.

References

- 1 Australian Bureau of Statistics. *Year Book Australia*. Canberra: ABS; 2002.
- 2 Wilde S. *25 Years Under the Microscope . . . a History of the RACGP Training Program*. South Melbourne: RACGP; 1998, 56.
- 3 Programme FM. *Annual Report*. Melbourne: RACGP; 1974.
- 4 Australian College of Rural and Remote Medicine [Internet]. Kelvin Grove: ACCRM; [updated 7 January 2003; cited 18 June 2003]. Available from: <http://www.accrm.org/>.
- 5 Royal Australian College of General Practitioners [Internet]. Melbourne: RACGP; [updated 13 February 2003; cited 18 June 2003]. Available from: <http://www.racgp.org.au/folder.asp?id=226/>.
- 6 Holsgrove GJB, Jones A, Southgate L. *Alternative Approaches to Vocational Training for General Practice*. Canberra: Commonwealth Department of Human Services and Health, 1996.
- 7 Phillips B. *General Practice Education: The Way Forward*. Canberra: Commonwealth Department of Health and Family Services, 1998; 87–93.
- 8 Wooldridge M [Internet]. *Media Release – Review of General Practice Training*. [updated 29 May 1997; cited 18 June 2003]. Available from: <http://http://www.health.gov.au/archive/mediarel/1997/mw0197.htm/>.
- 9 Meumann FWR. *General Practice Vocational Training Standards and Requirements*. Melbourne: RACGP, 2001.
- 10 Royal Australian College of General Practitioners (Wellar R ed). *Training Program Curriculum*, 2nd edn. South Melbourne: RACGP, 1999.