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AMA feedback on GP Training Draft Outcomes Framework

The AMA welcomes the opportunity to provide feedback on the Draft Outcomes Framework for GP training following transition to the Colleges in 2021.

The AMA's vision for general practice training is to develop an appropriately trained and sustainable general practice workforce that meets individual and community needs, serves the most disadvantaged, achieves health equity, attracts high-quality and committed registrars and supports general practice to be viewed as the specialist training of choice. This requires a flexible and integrated national general practice training pipeline, with strong collegial links to the profession.

As such, the AMA broadly supports the five Outcomes outlined in the Draft GP Training Draft Outcomes Framework (Attachment 1), with any concerns or suggestions outlined below.

It is critical to acknowledge that in addition to attractive, high-quality and cost-effective GP training, there are several other factors that can have significant long-term impacts on the GP registrar workforce. This includes poorer remuneration, fewer benefits and less flexible training for GP registrars compared with their hospital counterparts, a lack of prominence and exposure to general practice in prevocational years, and a lack of adequate support for general practice by government.

The impacts of these long-standing issues are clear, with the declining interest general practice training and unfilled GP training places for the third consecutive year. These issues need to be considered alongside the delivery of all GP training programs to ensure sustainability of the GP workforce, and are discussed where relevant to each Outcome below.

Outcome 1: A quality GP training program that educates GPs to provide appropriate healthcare to address the needs of all population groups across Australian communities.

Objective 1.1: To ensure all training undertaken provides quality education to registrars with appropriate support.

The AMA supports innovative, responsive and evidence-based general practice training that is well-resourced, flexible, and integrated within the community and broader health care system.

Flexibility of training is paramount, including options for part-time training and training that allows movement of GP registrars across different settings. The ability of GP registrars to train between hospitals, community health centres, non-GP specialist services and general practice would provide trainees with a diverse training experience and broaden their clinical skillsets. This is of particular importance in rural and remote settings, where services like GP-led maternity care are needed, but are currently in acute decline.

Under current GP registrar employment arrangements, this kind of flexibility is difficult to achieve. The widespread implementation of a single employer model for GP registrars, similar to the model being trialled by the Murrumbidgee Local Health District, would enable such flexibility. The AMA notes that the trial of the single employer model is only planned for GP registrars in rural areas. This should be expanded to include all GP registrars to improve to the appeal of GP training more broadly, and to create unity rather than division within the profession.

There should also be flexibility in supervision models, with the option for remote supervision of GP registrars where needed. This is important to support rural and remote placements, where face-to-face supervision arrangements can sometimes be difficult. It is also particularly relevant in the current climate, with the widespread use and support of telehealth consultations in general practice. With telehealth use likely to increase over time, flexible supervision will be vital to ensure sustainable GP training.

To ensure GP registrars are sufficiently supervised and supported, consideration should be given to implementing in-practice assessments and education of supervisors to complement existing supervisor training and CPD models. This would help to foster ongoing improvements in the delivery of supervision and ensure remediation and education can be provided for supervisors in a non-threatening way.

The AMA is aware that many registrars opt to pay high fees to private education providers to cover real or perceived gaps in the delivery of the curriculum currently provided by some Regional Training Organisations (RTOs). Any changes to the current GP training landscape should seek to understand and address the issues that contribute to registrars making this choice.

Objective 1.2: To ensure that the education and training provided to registrars prepares them to provide holistic patient centred healthcare for vulnerable populations groups.

A measured approach to ensuing GP registrars experience caring for vulnerable populations will ensure a well-rounded training experience. It is critical that GP registrars are appropriately supervised when working with vulnerable patient groups, including when conducting home visits, visiting aged care facilities, after hours care shifts and palliative care.

GP registrars in both metropolitan and rural locations can experience suboptimal supervision arrangements, and pressure to see increasing patient numbers when providing care for vulnerable populations groups, including visits to residential aged care facilities. Adoption of flexible supervision models, including remote supervision by telephone is a potential solution for this issue, if the GP registrar and supervisor are both comfortable with the arrangement.

The relatively short duration of placements within general practice can also create barriers for GP registrars working with vulnerable patient groups that require ongoing treatment, including patients

with chronic disease. These patients typically see the same GP[1], which can limit opportunities for GP registrars to have ongoing exposure to these patient groups. Supervisors will need to ensure that GP registrars training in their practice have access to vulnerable patients, while preserving the patients' right to choose their doctor and maintaining their continuity of care.

Objective 1.3: To ensure that education and training is effective and leads to the attainment of fellowship.

The AMA supports that appropriate and timely remediation be provided to registrars to ensure they remain on-track to progress through their training program.

Flexibility is a central tenant to setting fellowship targets that are tied to grant agreements. GP registrars should have the flexibility to pursue training in other areas (e.g. obstetrics, anaesthetics etc) if they wish, and should not be financially penalised if there are disruptions to their training (for personal or professional reasons). Targets should also recognise that not all trainees will progress at the same pace, but should be stringent enough to produce high-quality GP workforce.

Existing AGPT solutions for registrars that have exhausted their training time that provide registrars opportunities to seek further support to attain fellowship should be maintained. The AGPT programs new approach to this issue commenced on 1 October 2019. Other GP training pathways should have similar policies in place to ensure consistency between training programs.

Better access to, and recognition of, part time training as an option, rather than an exception, along with other flexible training plans will help to ensure the maximum number of registrars entering the program will attain fellowship and make general practice training attractive to a wider audience. Additionally, this will help to attract well-rounded doctors to the profession as they bring their experience from other areas of medicine and of life to their work in the GP setting.

Objective 1.4: Registrars are adequately supported and experience quality training.

The AMA agrees that registrars should receive continued support throughout their training program. This support should be culturally sensitive, and flexible for doctors that require additional assistance in their training, or modifications to the standard training pathway for cultural or religious reasons.

Anonymous or deidentified avenues for seeking assistance should be in place with greater ability for RTOs to intervene on a registrar's behalf. Registrars report difficulties in raising concerns in several areas, including workplace relations and employment issues, difficulties with supervisory arrangements, MBS billing practices, and practice policies. This is due to a fear of negative ramifications within their current workplace, and on their reputation and career prospects going forward. Registrars may also feel pressured to remain in difficult work circumstances in order to continue with their training. Prior to a formal complaint to their RTO, there are few opportunities to address such difficulties for both practices and registrars. The AMA supports a move to the single employer model for all GP registrars to remove this significant issue of having a supervisor/assessor that is also an employer. This would provide registrars with alternative options for escalating complains with the issues raised above or the provision of inadequate training.

[1] AIWH 2018. Coordination of health care: experiences of GP care among patients aged 45 and over, 2016.

Practices require better access to HR resources and supports to ensure they can navigate relevant workplace agreements, the National Terms and Conditions for the Employment of Registrars (NTCER) and industrial relations law, as employers. This would help to relieve pressure and distress often associated with navigating these issues and allow both parties to focus on training as a priority. Practices should have access to this support as a benefit of employing a registrar, since this employment arrangement is significantly different to the contract-based appointment of fellowed doctors.

A lack of exposure to general practice in prevocational years continues to be of concern (see 2.1 for further comments). Additionally, due to the relatively short training program, registrars are required to map out the entirety of their training early on. This commonly occurs only 5 or 6 months into their practice-based placements which, for many, is the first time they have been exposed to general practice medicine. These factors combined mean there is little opportunity for registrars to explore the diversity of general practice and tailor their training to particular interest areas that they may not identify until they have commence community-based training, or make up for lack of exposure or diversity experienced during pre-planned placements. Better access to part time training and more flexible practice matching arrangements would help to overcome this issue.

Outcome 2: A well distributed GP workforce to service all communities across Australia.

Objective 2.1: To ensure that registrars are exposed to quality training in regional, rural and remote areas.

The AMA supports exposure to quality training in regional, rural and remote areas, and feels that some rural exposure is beneficial to trainees whether they intend to remain rural or not. Rural medicine is often perceived as a second-class option—a positive rural training experience is a good way to show trainees that rural medicine can offer them fulfilling and challenging careers.

However, registrars should not be forced into long-term rural placements. As shown with bonded medical places, forced service in rural areas only increases the negative perception of rural careers and cause angst for trainees, and does not promote retention of the rural medical workforce[2]. Instead, policy should be focused on building a rural training pipeline that offers high levels of support and a rewarding training experience.

A positive culture surrounding rural training and careers should begin in medical school. While there are policies in place to ensure at least 25 per cent of new medical student enrolments come from a rural background (the AMA would like this to be increased to one-third), this needs to be coupled with strong rural leadership and mentoring, and investment into rural and regional training infrastructure. Establishing regional training networks would bolster rural training opportunities, and provide valuable and meaningful career pathways for doctors in training who want to work in rural Australia[3]. This is important as many medical students have positive training experiences in rural areas but prevocational and specialist medical training often requires a return to metropolitan centres. Regional training networks would enable more training in rural areas, with city training required only for specific skills.

[2] AMA Position Statement Geographic Allocation of Medicare Provider Numbers 2002. Revised 2019
[3] AMA Position Statement Regional Training Networks 2014.

A rural term should be considered favourably for doctors in training and given prestige when applying for a specialty training program. Rural specialists and GP proceduralists should also have fully funded access to centres of excellence to regularly enhance and broaden their skill base.

Inadequate remuneration has been identified as an ongoing issue for doctors working in rural and remote areas[4]. Financial incentives such as rural loadings for GP trainees will ensure competitive remuneration and encourage rural placements.

Flexible options for rural placements that suits family/living circumstances like FIFO work (similar to the model used in NT for doctors visiting remote communities) should be available where there are critical workforce shortages. More broadly, there needs to be flexibility to support individual family/spouse employment situations that would make extended rural placement difficult.

There is a notable absence of prevocational exposure to general practice and other forms of community-based medical care. This was previously accessible via the Prevocational General Practice Placements Program (PGPPP). The flow on effect is a decreased interest in GP training more broadly, and a difficulty for the sector in attracting high-quality trainees to the GP speciality training programs. Government initiatives like the Rural Primary Care Stream of the Stronger Rural Health Strategy (that includes the existing Rural Junior Doctor Training Innovation Fund) are designed to expose rurally based interns to rural general practice. These programs should continue to be evaluated for their effectiveness. Other options like the AMA's Community Residency Program, which is designed to provide the same high-quality general practice experience, but delivered more cost effectively than the former PGPPP, should also be considered.

As mentioned in section 1.1, the ability for GP trainees to train between hospitals, community health centres, non-GP specialist services and general practice under a single employer model would allow for a broader range of generalist training that is necessary for rural general practice. This blended model makes rural practice attractive and more interesting for younger doctors.

Objective 2.2: To enable registrars who have a proven interest in rural practice to be provided with opportunities to continue their training in those regions as they progress through the medical pathway.

The AMA agrees that fostering existing interests in rural practice is an effective way to grow and retain a rural workforce.

GP registrars that do most of their training in rural areas should be financially supported to travel to metropolitan areas to further their training in specific skills where needed. The AMA has previously advocated that financial assistance be available to support rural doctors training in metropolitan areas, as already exists for metropolitan doctors training rurally[4].

The formation of support networks for rural and remote registrars post-fellowship is a critical part of maintaining a rural workforce. The AMA's regional training networks[3] are designed to achieve this goal. This would require a collaborative approach to GP training, and rural training in general between individual practices, local hospitals, and government. This infrastructure combined with an employment model like the single employer model for GP registrars would promote flexibility in training and

[4] AMA Position Statement Rural Workforce Initiatives 2017

movement between community and hospital settings—as would be required for rural generalist training.

Objective 2.3: To encourage registrars to practice in AMSs and rural and remote regions post fellowship.

The AMA encourages additional support for GP registrars that would like to practice in rural and remote regions or AMSs post-fellowship.

For this to be successful, the factors underlying the current lack of GP registrars interested in remaining in rural and remote practice after fellowship need to be addressed. Issues including a lack of peer support and professional networks, opportunities for partners/family, access to locums for holiday/sick relief, fewer professional development and training opportunities and disparities in earning potential, are commonly cited as reasons for returning to cities after achieving fellowship.

The provision of opportunities for GPs in rural areas to undertake dual training would be a great incentive to remain in rural areas where they can work in the hospital and within general practice, for example, dual GP and anaesthetics training.

Opportunities should be made available for increased access to rural and remote placements for metro-contracted GP registrars who may find, during their training, they wish to have exposure to rural or remote general practice. Due to the current split of metro and rural pathways, opportunities for this are limited or not accessible at all.

Objective 2.4: To ensure that GP training continues to have a regional delivery.

RTOs provide a suitable framework for this coordinated approach to GP training and have been doing so for many years.

The current model of GP training combined with the AMA's regional training networks will provide the infrastructure for flexible training options to develop high-quality and flexible generalist and specialist rural training pathways targeted at the regional level.

Outcome 3: GP training program that aims to address the Australian Government's Closing the Gap health targets on Aboriginal and Torres Strait Islander child mortality and life expectancy.

Objective 3.1: To expose all registrars to Aboriginal and Torres Strait Islander health training and support culturally safe care for Aboriginal and Torres Strait Islander People.

The AMA supports the focus on creating a culturally sensitive GP workforce that is specifically trained in Aboriginal and Torres Strait Islander health issues.

Colleges should review the effectiveness of their Reconciliation Action Plans in creating culturally sensitive GP registrars and supervisors in collaboration with existing Aboriginal and Torres Strait Islander medical workforce and organisations such as the Australian Indigenous Doctors' Association (AIDA).

Notably, since the needs and resources within specific communities and regions differ, local partnerships should be established between training organisations and Aboriginal and Torres Strait Islander community leaders to ensure that appropriate cultural education and support is being provided to both registrars and supervisors.

Objective 3.2: To increase the number of Aboriginal and Torres Strait Islander doctors gaining GP fellowship.

The AMA supports Aboriginal and Torres Strait Islander people have a leading role in identifying and responding to the nature and challenges of Aboriginal and Torres Strait Islander health, and that the medical profession has a responsibility to partner and support these efforts[5].

While efforts have been made to increase the number of Aboriginal and Torres Strait Islander doctors within the medical workforce, there are still significant barriers for the recruitment and retention of Aboriginal and Torres Strait Islander medical students through to college training and fellowship.

Research from AIDA and James Cook University[6] identified that barriers to gaining fellowship were cultural and structural, and effective support networks were crucial for success. An example of specific issues that were identified include fellowship exam design suited to urban practice, rather than tailored to meet the needs of Aboriginal and Torres Strait Islander trainees and Indigenous health. Assessment methods need to be accommodating to cultural needs while maintaining the integrity of training standards.

These barriers need to be addressed by the Colleges in collaboration with the existing Aboriginal and Torres Strait Islander medical workforce and organisations like AIDA and the Indigenous General Practice Registrars Network (IGPRN) for any meaningful progress to be achieved in supporting Aboriginal and Torres Strait Islander GP trainees through to fellowship.

Outcome 4: Commonwealth investment in GP training is effective and efficient.

Objective 4.1: To ensure Commonwealth funds are expended in a transparent manner.

The AMA agrees that regional training partners should have adequate governance arrangements to support GP training and feels a blended funding model will be useful to appropriately fund the different aspects of GP training. Any changes in the funding structure for GP training must involve further investment and ensure that practices, supervisors and GP trainees are not disadvantaged.

A blended funding model where activity-based funding could support direct training costs (including practice and supervisor remuneration), and block funding could support indirect training costs and overheads, would improve the transparency of funding allocated to GP training. However, care must be taken to ensure that activity-based funding does not result in undue pressure on trainees to see large volumes of patients, or work faster than they are comfortable to do.

This is important, as significant conflicts of interest currently exist as the role of supervisor, employer and business owner are often held by the same person. A reduction in activity-based remuneration to supervisors potentially incentivises this conflict of interest. As mentioned throughout this submission, a single employer model, that separates the roles of supervisor and employer, would help to address this.

[5] AMA Position Statement Aboriginal and Torres Strait Islander Health Revised 2015.
[6] Australian Indigenous Doctors' Association and James Cook University Joint Research, 2019. Strong Futures: Strengthening the Path to Fellowship for Aboriginal and Torres Strait Islander Medical Graduates.

Moreover, Commonwealth funding should continue to recognise differences in geographical area of practice and community need, with incentives offered to trainees practicing in areas of workforce need and increasing rurality.

The framework implies through the point *"regional training partners are selected through a clear and transparent process"* that there may be changes in the existing regional training organisation structure. The future role of RTOs in GP training in 2022 is still uncertain. Clarification on the issue would be welcomed.

Objective 4.2: To ensure that registrars transitioning between training programs are managed effectively.

The AMA strongly supports flexibility in the training program that enables registrars to transition between programs, as this enhances attractiveness of GP training programs, allows training to be tailored to the particular needs and interests of registrars, and encourages registrars from a variety of backgrounds.

As mentioned in section 2.3, current training pathways can be inflexible, with metro-contracted GP registrars unable to gain exposure to rural or remote general practice due to the current split of metro and rural pathways. Ensuring flexibility will help support GP registrars to train in a program that best suits their needs and the needs of the community.

Outcome 5: High quality Rural Generalist Training is provided in coordination with jurisdictions.

Objective 5.1: To ensure that training meets the needs of the community.

The AMA supports collaborative partnerships between general practice, education providers, the profession, hospitals, health sector, local, state and federal governments, and the community to support and resource rural generalist training.

As mentioned in previous sections, the AMA's regional training networks model can provide the infrastructure to enable these collaborations and provide high-quality, flexible training options to for regional and rural generalist and specialist training pathways.

Objective 5.2: To ensure that rural generalist training prepares GPs to work in rural and remote areas.

Community general practice in rural and remote areas is facing significant workforce shortages. In some rural areas, there are no hospitals and communities rely on general practice alone. The minimum amount of time that rural generalists are training in community general practice should reflect this critical role of general practice in these communities, and the ongoing issues of workforce shortages.

Rural generalist trainees should not be forced to give up their accrued leave (sick, personal, and maternity), or their professional networks to undertake community-based general practice training. Rural generalism relies on the ability of doctors to move between the hospital and community settings to best serve the needs of rural and remote communities. The single employer model for rural generalists/general practice in the Murrumbidgee Local Health District removes significant barriers to pursuing general practice training, and enables the seamless transition between hospital and community-based general practice training environments required for training.

Upon achieving fellowship, rural generalists should be supported as per the measures discussed in section 2.3. Adequate personal and professional support, including access to peer support and professional networks, opportunities for partners/family, access to locums for holiday/sick relief, professional development and training opportunities and appropriate remuneration, is essential to retain this specialised rural workforce.

Should you require any further information or clarification on the AMA's response to the Recommendations, please contact Kristen Farrell at kfarrell@ama.com.au.

Yours Sincerely,

Dr Tony Bartone
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