Getting governance right for a sustainable regionalised business model

Caroline O Laurence, Linda E Black, Mark Rowe and Rod Pearce

The current regionalised model of delivery of the Australian General Practice Training (AGPT) program has been in place now for nearly a decade. Through this period, the governance of general practice has changed, with new partnerships developed and changed decision-making processes implemented.

Although some improvements, arising out of the recommendations of the 1998 Ministerial Review of General Practice Training, have been made, there are still ongoing challenges that will test the sustainability of the current regionalised business model of general practice training.

These deliberations include the cost and quality of training, the structural outcomes and training governance issues. Due to the lack of reliable measures and the lack of public access to comprehensive data and robust evidence, this article focuses on governance of general practice education and training at the macro level. It outlines how the decision-making processes have changed, and how they may need to change further if the current regionalised training model is to be sustainable.

Changing governance of general practice education and training

The changing governance of general practice education and training from the 1970s to present is illustrated in Box 1, which summarises the key organisations involved, the changing focus of training and the decision-making model used by the key organisations involved. There has been an increase from two key organisations in the 1970s to six in 2011, with the training focus expanding from a national to a regionalised perspective and incorporating vertical integration of medical training.

Due to the limitations relating to measurement, data access and availability challenges noted above, our examples, with acknowledged limitations, are based on the results of reviews, evaluations and personal observations.

A college-focused model — 1970s to 2001

From the 1970s through the 1990s, all decision-making responsibility rested with the federal government (ie, the previous incarnations of the Australian Government Department of Health and Ageing) and the Royal Australian College of General Practitioners (RACGP). They exercised direct decision-making powers over funding and training delivery, respectively — the federal government provided funding and the RACGP managed funds, delivered training and developed the curriculum. During this period, the federal government extended its role when it linked training with quality by making changes to sections 19AA and 19AB of the Health Insurance Act 1973 (Cwlth) and by establishing vocational registration.

A third player entered the general practice education and training environment in 1997 with the establishment of the Australian College of Rural and Remote Medicine (ACRRM). The ACRRM arose from a belief by some that rural and remote medicine was a broad but discrete form of general practice, and from a dissatisfaction with the way the RACGP related to its Rural Faculty members. The ACRRM adopted a similar governance and decision-making role to the RACGP, but without the legislative recognition as a training program that is required for granting independent vocational registration status as a general practitioner.

This model of general practice training had several successes during this period, with the increased recognition of quality general practice through vocational registration, the recognition of the wider scope of general practice with the establishment of ACRRM, and recognition and support of general practice as a vocational specialty with changes to the Health Insurance Act in 1996.

A regionally focused model — 2002 to 2011

The 1998 review of general practice training led to the introduction of a regionalised model of general practice education and training using regional training providers (RTPs). In 2001, the Commonwealth Department of Health and Aged Care established a Commonwealth-owned company, General Practice Education and Training (GPET), to establish the new training environment for general practice vocational training.

ABSTRACT

- The 1998 Ministerial Review of General Practice Training identified several areas for improvement that led to major changes in the provision of general practice training, including the establishment of General Practice Education and Training (GPET) and the regionalisation of training.
- The regionalised training business model has been in place for nearly 10 years, and several key organisations have been involved in its evolution, including the Australian Government, speciality colleges, GPET and regionalised training providers.
- The future holds challenges for the regionalised training business model as the general practice education and training landscape becomes more complex. The framework in the current model will provide a base to help meet these challenges and allow for further sustainable expansion.
In 2002, the newly established GPET and the RTPs significantly changed the business model of general practice vocational training. The regionalised model now included additional organisations in the governance of general practice education and training, and shifted decision-making responsibilities so that they involved direct, delegated and consultative processes (Box 2). For example, funds management, as a key decision-making responsibility, was delegated to GPET, which in turn delegated aspects of this role to the RTPs. This new model also shifted decision making related to education and training development and delivery — previously held predominantly by the RACGP — to the RTPs.

During the establishment phase of the new model, there was confusion and mistrust regarding the demarcation and devolution of governance and decision-making roles for both new and old organisations, but most notably the colleges, GPET and RTPs. The roles of the new organisations (GPET and RTPs) were evolving and the roles of the old organisations (RACGP and ACRRM) were in a state of flux. With the establishment of the AGPT program, the RACGP vocational training program that had been in place for nearly 30 years was deemed to be at risk, particularly by those who perceived they were losing governance and decision-making roles and responsibilities to new players.5 However, nearly 10 years on, each organisation’s role is becoming better defined and delineated. Box 2 provides a matrix of the current integrated distribution of governance and decision-making roles across the key organisations — from an RTP perspective.

The current regionalised model for general practice education and training has achieved a number of successes. These include regionalisation of training, general practice exposure during hospital training years, increased rural training, the formal inclusion of Aboriginal and Torres Strait Islander health training in education and training syllabi, and, most recently, the introduction of a streamlined training post/supervisor accreditation process.

The decision to regionalise the general practice vocational training program in 2002 resulted in the creation of 22 RTPs, which were charged with delivering general practice training throughout Australia. In 2011, the number of RTPs was reduced to 17 but still had the same coverage responsibility. Recent reviews indicated that the current training model provides optimal benefits to the Australian community and demonstrated that the current distribution of registrar training is a good match to the distribution of the population (in contrast to the distribution of GPs).

Since 2005, there have been expanded opportunities for junior doctors to be exposed to general practice during their hospital years of general training, through the introduction of the Prevocational General Practice Placements Program (PGPPP). This has built on its much smaller but successful predecessor program, the ACRRM’s Rural and Remote Area Placement Program. As an example, in South Australia, the PGPPP annually allows over 110 interns and residents to undertake at least one of their junior rotations in general practice. Further, supervision and teaching in general practice rotations were deemed to be of high value to hospital-based rotations. Further, supervision and teaching in general practice rotations were deemed to be of high value to hospital-based rotations.
superior quality. In 2010, the opportunities through PGPPP were expanding significantly across the nation, at equivalent and higher levels than those in SA.13

Available data indicate that the current training model has increased the number of registrars training in rural regions (Box 3).9 The rural pathway is now a distinct path that registrars can select from entry, regardless of their fellowship intent, and is available through most RTPs. In 2006, the ACRRM successfully gained recognition of its fellowship as a legislative end point for independent status as a specialist GP. At the same time, the RACGP strengthened its approach and support of rural-oriented registrars.

The formal inclusion of Aboriginal and Torres Strait Islander Health training in RTP education and training syllabi continues to be a work in progress, but some achievements have occurred as part of the new regionalised model. During this period, GPET developed a Framework for general practice training in Aboriginal and Torres Strait Islander health10 and, more recently, a draft guide to general practice training in Aboriginal and Torres Strait Islander health, which will act as a regional component to the framework. GPET also established the Aboriginal and Torres Strait Islander Health Training Advisory Group14 as a subcommittee to its Board, and, in 2008, created an ongoing professional support network for Aboriginal and Torres Strait Islander GP registrars. Additionally, the number of registrars undertaking training in accredited Aboriginal and Torres Strait Islander medical services has increased from 65 in 2003 to 141 in 2009.9

Most recently, the RACGP and the ACRRM have been working in a tripartite relationship with RTPs to introduce a streamlined and delegated training post/supervisor accreditation process. This process replaces the previous college-directed and -controlled process of assessing and accrediting practices and supervisors for the colleges’ training standards. The governance bodies of both colleges have approved an accreditation framework whereby this assessment and accreditation process has been streamlined and delegated to the RTPs. The colleges’ responsibility has shifted to endorsement of the RTPs’ recommendations, with a bolstered responsibility for the accreditation of RTPs that includes reviewing the methodology used to conduct this delegated work. This arrangement allows for a more straightforward and ongoing quality assurance process conducted by RTPs to determine the accreditation eligibility of training posts and supervisors — an innovation that came from on-the-ground supervisor feedback.

Implementation is a work in progress, but the decision by the colleges to delegate this important decision making to RTPs, while retaining overall governance responsibility for this area of work, is an important achievement. It also forms a possible template for how future changes can be determined and implemented.
Ongoing challenges as future possibilities

Although we have outlined the changes in the governance model for education and training in general practice and some of the successes that have resulted from clearer roles and lines of decision making, there are a number of ongoing challenges that will continue to test the sustainability of this model. These challenges include:

- the outcomes of the primary care reforms, which may see changes in GPs’ roles and an emphasis on team care;
- the role of generalism within medicine and how training supports this;
- the competition for clinical training places for health students and the impact this will have on teaching practices and access to hospital training positions for GP registrars;
- the issue of the cost of general practice vocational training and the link between funding with outcomes; and
- the expansion of the type and level of education and training that is expected to occur within general practice in the near future.

For example, as shown in Box 1, the future is likely to include more organisations across a broader range of health disciplines that will need to be part of the governance and decision-making framework. Necessarily, the model will need to expand its focus to include vertically and horizontally integrated education and training.

Further, the competing demands of cost, quality and structural perspectives (particularly with regards to retention) will continue into the future. The use of nationally agreed benchmark measures that have been consultatively determined by the key organisations, and monitored over a set period, may assist future debates and inform how to better adapt the regionalised model for the future.

In the interim, we suggest that a significant contributor to the ongoing viability of the regionalised training model would be the continued evolution and development of an integrated governance and decision-making matrix that is better suited to the evolving regionalised business model of general practice vocational training. This requires that the key organisations currently involved in education and training in general practice continue to genuinely and willingly evolve their governance models and decision-making processes to ensure maximum benefit is gained by trainees, trainers, the community and individuals. Equally, it requires incoming organisations to show a similar willingness to discuss and determine governance and decision-making models that will complement regionalised education and training, with a view to achieving the same outcome.

Regardless of the type and level of education and training required in general practice, decision-making responsibilities will continue across fund management, curriculum development, training standards development, education development and delivery, trainee examinations, RTP accreditation, training post/supervisor accreditation, workforce distribution and strategic training policy. Over the past decade, some lessons have been learned about how to more effectively allocate these responsibilities across all parties involved in education and training in general practice. In a more complex environment with more organisations involved, the most significant challenge remains to continuously improve this governance and decision-making framework so that it remains integrated, and strengthens the regionalised model of education and training in general practice.

Conclusion

In the past three decades we have seen an expansion in the number of players involved in education and training in general practice. Throughout this period some hard lessons have been learned, but some clearly identifiable successes have been achieved for general practice vocational training, both before and after the current regionalised training business model. We are of the view that over the past decade, a more integrated matrix of governance and decision making has ensured that many of the objectives specified in the 1998 Ministerial Review of General Practice Training are being met, or at the very least are on target. However, significant challenges remain. The one highlighted in this article is the genuine willingness of all key organisations to continue this integrated model of governance and decision making as the type and level of education and training expands in general practice over the next decade.

If we are able to demonstrate a collective level of maturity that allows for this genuine and respectful collaborative approach, then this model will not only be sustainable, but grow in status as a best-practice regionalised training provider model. It will also allow the development of interdisciplinary teaching, interprofessional education and most importantly collaborative practice that will benefit local patients in local communities. We are of the strong view that this outcome is worthy of pursuit — a sentiment that is being increasingly echoed by international colleagues.

Competing interests

None identified.

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