

The Auditor-General  
Audit Report No.34 2010–11  
Performance Audit

## **General Practice Education and Training**

**General Practice Education and Training Limited**

Australian National Audit Office

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of Australia 2011

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19 National Circuit  
BARTON ACT 2600

Or via email:  
[webmaster@anao.gov.au](mailto:webmaster@anao.gov.au)



Canberra ACT  
24 March 2011

Dear Mr President  
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in General Practice Education and Training Limited in accordance with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit, and the accompanying brochure, to the Parliament. The report is titled *General Practice Education and Training*.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—<http://www.anao.gov.au>.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ian McPhee', is positioned above the printed name.

Ian McPhee  
Auditor-General

The Honourable the President of the Senate  
The Honourable the Speaker of the House of Representatives  
Parliament House  
Canberra ACT

## AUDITING FOR AUSTRALIA

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For further information contact:  
**The Publications Manager**  
**Australian National Audit Office**  
**GPO Box 707**  
**Canberra ACT 2601**

**Telephone:** (02) 6203 7505  
**Fax:** (02) 6203 7519  
**Email:** [webmaster@anao.gov.au](mailto:webmaster@anao.gov.au)

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### Audit Team

Chloe Andrew  
Anne Cronin  
David Hokin  
Liz Wedgwood

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# Abbreviations

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|       |   |
|-------|---|
| ACRRM | Australian College of Rural and Remote Medicine   |
| AGPT  | Australian General Practice Training Program      |
| DoHA  | Department of Health and Ageing                   |
| FWE   | full-time workload equivalent                     |
| GPET  | General Practice Education and Training Limited   |
| GP    | general practitioner                              |
| IHT   | Indigenous health training                        |
| IRIS  | Interactive Registrar Information System          |
| KPI   | key performance indicator                         |
| PBS   | Portfolio Budget Statements                       |
| PGPPP | Prevocational General Practice Placements Program |
| RACGP | Royal Australian College of General Practitioners |
| RIDE  | Registrar Information Data Exchange               |
| RTP   | regional training provider                        |
| SAMS  | Selection Application Management System           |
| SIMS  | Selection Information Management System           |
| SoE   | Statement of Expectations                         |
| SoI   | Statement of Intent                               |



## **Summary and Recommendations**



# Summary

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## Introduction

1. General Practice Education and Training Limited (GPET), a wholly owned Commonwealth company, manages general practice<sup>1</sup> training programs funded by the Australian Government.
2. GPET's major training program, Australian General Practice Training (AGPT), is the most common method of vocational training undertaken by registered medical practitioners seeking to become general practitioners (GPs).<sup>2</sup> GPET's other training program, the Prevocational General Practice Placements Program (PGPPP), provides prevocational 'work experience' in general practice to less experienced medical trainees.<sup>3</sup>

## General Practice Education and Training Limited

3. GPET was founded in 2001, significantly changing the way general practice vocational education and training had been organised and delivered in Australia. Until then, general practice vocational education and training had been delivered by the Royal Australian College of General Practitioners (RACGP), with Australian Government funding.
4. Important features of the vocational training model instituted by the Government was that it be run on a regional basis, be responsive to local

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<sup>1</sup> General practice is the first point of contact for the majority of people seeking health care. General practice training broadly follows an apprenticeship model, with the 'trainee' undertaking structured education as well as supervised practical (clinical) training over the course of their learning time.

<sup>2</sup> General practice is a medical specialisation for medical practitioners, recognised by fellowship of the relevant professional colleges. The relevant professional colleges are the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM). Fellowship requires successful completion of college assessment processes.

Fellowship of the relevant professional colleges is a mandatory requirement to become a qualified GP, able to consult with patients unsupervised and unrestricted, and provide a Medicare rebate to those patients for the cost of medical services delivered. The structured vocational training managed by GPET is one way that medical practitioners seeking to become GPs work to gain the skills and knowledge required for vocational recognition as GPs.

Based on Medicare claims data, there were 25 726 vocationally recognised GPs and other medical practitioners billing Medicare in Australia in 2008–09. Medicare is Australia's universal health insurance scheme, providing free or subsidised treatment by medical practitioners.

<sup>3</sup> That is, graduates from medical school who are still undertaking their intern training in hospitals to become registered medical practitioners.

community and health care needs, and that it foster community-based education, with teaching practices that encourage best practice and reward teaching in the community. GPET launched AGPT in 2002 and it took over responsibility for PGPPP in January 2010, to provide more efficient and integrated general practice training.

5. GPET is a Commonwealth company limited by guarantee. Its scope and operations are framed by the Company Constitution which specifies the company 'objects' (that is, objectives or purposes) regarding general practice training, the *Corporations Act 2001* (Corporations Act) and the *Commonwealth Authorities and Companies Act 1997*. GPET does not have specific enabling legislation.

6. The sole member of GPET is the Commonwealth, represented by the Minister for Health and Ageing. The company is governed by a board of directors which is directly accountable to the member (the Minister) for its performance in meeting the objects of the company and addressing government priorities. Consistent with the duties of directors under the Corporations Act, the Board is independent in its capacity to determine GPET's strategies and the work program required to achieve these outcomes.

7. Based in Canberra, GPET's expenses in 2009–10 totalled \$106.7 million, with an average staffing level of 35 people.<sup>4</sup>

## **Scheme design for general practice education**

8. The Australian Government places a quota on the number of new general practice training places it funds through GPET each year. In broad terms, GPET's role is essentially one of managing and supporting the delivery of outsourced training within a global budget for places and funding

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<sup>4</sup> GPET's revenue in 2009–10 totalled \$124.8 million, of which the majority was revenue from government (\$118.6 million in 2009–10). GPET did not receive fees.

In 2010–11, GPET's revenue from government is expected to increase to \$150.4 million and average staffing is expected to increase to 38 people.

In addition to general practice policy and promotion functions, GPET's program delivery activities broadly involve selecting and accrediting training providers, allocating training places to training providers, attracting and selecting trainees, and managing funding and provider contracts. See Appendix 3 for GPET's organisational structure.

determined by government, to meet training quality standards specified by relevant, separate authorities.<sup>5</sup> GPET is not a regulator.

9. GPET receives funding from the Australian Government, represented by the Department of Health and Ageing (DoHA), under three-year Funding Agreements. GPET's role is to allocate the government-funded training places and associated funding to the organisations it contracts to deliver the education and training across Australia, and to contract-manage those training providers.

10. In early 2010, there were 17 Regional Training Providers (RTPs) throughout Australia delivering AGPT. PGPPP was also delivered by these RTPs, and some additional providers such as universities and divisions of general practice.<sup>6</sup>

11. RTPs are not-for-profit organisations created to deliver education and training within a specific geographical location. RTPs deliver general practice training in local general practices using networks of GPs who are able to provide experience and support to the trainees (that is, to the GP registrars and junior doctors undertaking training).<sup>7</sup>

12. Once GPET allocates training places to RTPs or other training providers, these bodies determine the placement of participants in particular geographic locations within their regions, in collaboration with relevant hospitals and general practices.

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<sup>5</sup> GPET manages general practice training and education. It is not responsible for the registration of doctors; this is a function of the medical boards in the states and territories. Nor is GPET responsible for the assessment of international medical graduates who may wish to practise in Australia; this is one of the functions of the Australian Medical Council.

Regarding the setting of training quality standards, training quality standards for AGPT are set by the professional colleges. The training quality standards for PGPPP are set by the Post Graduate Medical Education Councils in each state and territory in respect of interns and by the professional colleges in respect of junior doctors who have completed their intern year.

<sup>6</sup> Divisions of general practice are professionally led and regionally based voluntary associations of GPs that seek to provide professional support for GPs and to coordinate and improve local primary care services.

<sup>7</sup> A GP registrar is a registered medical practitioner taking vocational training in the speciality of general practice (undertaking AGPT). A junior doctor is a medical graduate still undertaking medical training as an intern in the hospital system. The junior doctor may participate, as part of their formal hospital intern training, in a placement in a general practice situation, via PGPPP. This general practice placement complements the junior doctor's other intern training in fields such as accident and emergency, obstetrics, gynaecology or surgery, which are based in the hospital.

13. Trainees do not pay fees for their education and training; these costs are met from government funding. Based on 2009 figures for GPET, in broad terms, the education and training cost per GP registrar is \$45 000 per year.

## **GPET's training programs**

14. The distinctive nature and context of GPET's general practice training programs and associated administrative arrangements bear on GPET's administrative effectiveness in managing the programs. These matters are highlighted in this section as context.

### *Australian General Practice Training*

15. AGPT is a competitive, three to four-year full-time vocational education and training program for medical graduates wanting to pursue general practice as their medical specialisation. Selections for AGPT are done by GPET and RTPs. Training of these trainees (GP registrars) is conducted within accredited medical practices and hospitals, and is supervised and assessed by experienced medical educators.<sup>8</sup>

16. GPET accredits RTPs against college standards, and RTPs in turn accredit their networks of training practices against college standards. The systems of accreditation provide GPET with assurance that the education and training from training providers is in accordance with required standards.

17. As well as being a training program, AGPT has a workforce dimension because GP registrars provide primary care services while participating in AGPT. GP registrars undertaking a recognised training placement can access the GP items in the Medicare Benefits Schedule.<sup>9</sup> Community access to general practice medical services is further enhanced by AGPT's requirement that GP registrars complete training placements in outer metropolitan, rural and remote areas, areas often defined as ones of medical workforce need.

18. AGPT is a growing program; the government increased the number of new intake training places on several occasions from 2008 onwards in order to

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<sup>8</sup> AGPT is successfully completed when the GP registrar meets the requirements for fellowship set by the professional colleges (for example, completion of relevant training, assessments and examinations).

<sup>9</sup> The Medicare payments attached to services provided by GP registrars in training are part of the Australian Government's broader financial support for general practice training. These payments fall within the financial responsibilities of Medicare Australia, rather than GPET.

increase the number of GPs. Between 2004 and 2008 inclusive, the number of AGPT new intake training places funded by government was stable at 600 per year. The number rose to 675 new intake training places for the 2009 training year.<sup>10</sup> The total number of GP registrars enrolled in AGPT at that time was approximately 2500.

**19.** AGPT is budgeted to provide 700 new intake training places in the 2010 training year, 900 new intake training places in 2011, and 1200 in 2014.

**20.** Up until 2010, AGPT was the only training activity that GPET managed and all GPET activity, directly or indirectly, related to that program. In 2010, GPET's funding for AGPT accounted for some 84 per cent of the total training program funding, the remainder related to PGPPP.

**21.** Between 2005 and 2009 inclusive, some 2058 GP registrars successfully completed AGPT and the required professional college assessments and became eligible for vocational recognition as GPs.

#### Indigenous Health Training

**22.** Training in Indigenous health (Indigenous Health Training—IHT) is a component of AGPT. The two components of GPET's IHT for GP registrars are: IHT posts whereby GP registrars undertake general practice training at Aboriginal Medical Services; and GP registrars undertaking learning activities specific to Indigenous health as part of the colleges' Aboriginal health curricula for GP registrars. A major part of the learning activities is Indigenous cultural training, to provide GP registrars with an insight into Indigenous culture as well as factors (such as demographic, economic and lifestyle factors) that affect Indigenous health.

**23.** All GP registrars are required to undertake IHT learning activities as provided by their RTP; however it is not a requirement that all GP registrars complete an IHT post. In 2009, six per cent of GP registrars undertook training at an Aboriginal Medical Service, up from five per cent in 2008.

#### *Prevocational General Practice Placements Program*

**24.** PGPPP provides prevocational trainees (called junior doctors) with the opportunity to experience the general practice environment prior to

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<sup>10</sup> A training year broadly corresponds to a calendar year, commencing in January of one year and finishing in January of the next.

determining their area of specialty. The program offers these junior doctors voluntary, supervised and supported placements for a nominal 12 weeks in outer metropolitan, regional, rural and remote areas in accredited training environments.

25. Selections for PGPPP are made by the junior doctors' hospitals as junior doctors are in their employ. Completion of PGPPP, as a work experience program, depends on satisfactory completion of the placement.

26. From 1 January 2010, the management of PGPPP became the responsibility of GPET. GPET is budgeted to provide 380 PGPPP placements in 2010 and 910 placements in 2011.

### **How GPET's training programs relate to action on workforce shortage**

27. Although GPET, as a Commonwealth company, has independence from some detailed government planning, operational and review processes, the Australian Government determines some key parameters for GPET, namely the number of training places and amount of funding for training and education.

28. GPET's functions also make it one of many parties with an interest in health workforce issues. Health workforce shortage problems (particularly in rural and remote locations)<sup>11</sup> are matters of significance to the Australian Government, as evidenced in the Health and Ageing Portfolio Budget Statements and the Statement of Expectations issued by the Minister for Health and Ageing to GPET in 2009. Although some of GPET's specific processes in placing GP registrars in particular locations respond to these considerations, GPET has limited influence over general practice workforce matters.

### **Audit objective and scope**

29. The objective of the audit was to assess the administrative effectiveness of GPET's management of the general practice training programs, AGPT and PGPPP, the latter being a responsibility that GPET assumed in 2010.

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<sup>11</sup> Media coverage in 2009 and 2010 highlighted factors bearing on the availability of GPs, particularly shortages of GPs in rural and remote areas (as well as some metropolitan areas). Coverage highlighted calls for additional government-funded GP training positions, especially for rural GPs.



30. Particular emphasis was given to GPET's governance functions such as planning and performance reporting, and to its program delivery, with attention to whether the:

- planning and reporting regimes were integrated to allow GPET to monitor its progress appropriately, with alignment between the entity's overall purpose, its high-level strategies articulated at the enterprise level, and its performance information;
- delivery and review processes for AGPT and PGPPP allowed GPET to administer these programs appropriately; and
- key supporting processes (information management, communications and marketing and stakeholder engagement) suitably assisted program delivery and accountability.

31. The ANAO also examined how GPET contracted with, managed and supported regional training providers; and how well GPET managed the transition in assuming responsibility for PGPPP and the program's subsequent implementation in its very early phase.

## Overall conclusion

32. General Practice Education and Training Limited (GPET) is a relatively small public sector organisation in terms of expenditure and staffing, with expenditure of \$106.7 million and an average staffing level of 35 people in 2009–10. However, its responsibility for managing the delivery of general practice training and education across Australia is of growing significance. Linked to this, there are increasing expectations from government regarding GPET's contribution to addressing health workforce shortages when allocating training places for general practice registrars (GP registrars).

33. When GPET was established in 2001, its focus was to set up a regionalised vocational training regime. This was to involve contracting with regional training providers (RTPs) for the delivery of quality vocational education and training for GP registrars. This vocational training was directed to GP registrars seeking to specialise as GPs, recognised with fellowship of the relevant professional colleges. As GPs they would thus be able to consult with patients unsupervised and unrestricted and to provide a Medicare rebate for the cost of medical services delivered.

34. Since its establishment, GPET has successfully administered the vocational training program, Australian General Practice Training (AGPT),

and also successfully managed the transition and early implementation phases of the Prevocational General Practice Placements Program (PGPPP). Overall, GPET's delivery and review processes for both AGPT and PGPPP are sound. GPET has comprehensive administrative processes and controls underpinning AGPT delivery and review, with sound mechanisms relating to the: management and improvement of its funding agreements with the Department of Health and Ageing (DoHA) and contracts with RTPs; accreditation of training providers; allocation of training places and distribution of funding to training providers; recruitment of applicants; and selection of GP registrars.

35. As well as having sound delivery and review processes for AGPT and PGPPP, GPET pays appropriate attention to the key processes supporting its management of GP registrar training and education (namely information management, communications and marketing, and stakeholder engagement). This has been demonstrated by GPET acting in 2009 to address problems with its information management systems; using a range of communications and marketing mechanisms; and working effectively with a wide range of stakeholders. The results of successive GP registrar satisfaction surveys reflect well on GPET's attention to engaging with key stakeholders and the effectiveness of its management of general practice education and training.

36. Over time, and particularly since 2008 in the face of particular health workforce supply challenges, the government has increased its expectations of GPET. GPET's training and education activities are expected to take greater account of workforce shortages in its allocation of training places and to pay more attention to providing GP registrars with training in Indigenous health.

37. The changing expectations of GPET, including the need to balance its initial function to provide quality training with its increasing role in addressing health workforce shortage issues, had not been fully reflected in updated, clear and aligned statements of its objectives, strategies, priorities and performance information. GPET's work in 2010 to update the Constitution that had been in place since 2001, culminating in the company's sole Member, the Minister for Health and Ageing, approving GPET's Amended Constitution in

December 2010<sup>12</sup>, was an important step towards improving the basis for communication, governance and accountability to stakeholders.

38. With the Amended Constitution in place, there are opportunities for GPET to clarify its directions and the alignment of strategies across key corporate documents. The major benefits in having clarity of purpose and alignment of its priorities and performance expectations would include: a common language to inform external stakeholders of GPET's purpose and directions; and a shared understanding of the activities planned to deliver and report on its priorities.

39. GPET's main responsibilities lie in the management of general practice education and training; GPET has limited ability to influence overall trends in issues such as addressing workforce shortages or meeting the health needs of Indigenous Australians. However, it is important for GPET to be able to communicate its performance expectations in administering its programs and contracts with RTPs and to demonstrate clearly its particular contribution to meeting these changing expectations.

40. With these changing expectations in mind, GPET could improve its capacity to report its unique contribution to general practice education and training that helps communities facing workforce shortage. GPET could do this by improving and aligning its high-level planning and performance information and reporting processes, with better alignment between GPET's high-level statements of performance intent (especially GPET's Strategic Plan and the Health and Ageing Portfolio Budget Statements). GPET's appreciation of the state of workforce issues relevant to informing its own strategies on new and emerging workforce priorities would be improved by the company having access to additional workforce data from DoHA. DoHA has agreed with this view and advised that it has commenced processes to establish standardised reports that will be provided to GPET regularly, in line with its business needs.

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<sup>12</sup> Among other things, the Amended Constitution updated GPET's stated functions and objectives, with changes reflecting its altered functions since its establishment, including gaining responsibility for PGPPP in 2010.

## Key findings by chapter

### Planning and reporting (Chapter 2)

#### *Clarity of purpose and objectives*

41. Sound corporate governance for any organisation requires an appropriate planning and reporting regime. To enable an entity to monitor its progress, it is important that planning and reporting are integrated and there is alignment between the entity's overall purpose, its high-level strategies articulated at the enterprise level, and its performance information.

42. GPET's high-level guiding documents (for example the 2001 Constitution, Strategic Plan and the Health and Ageing Portfolio Budget Statements) communicated different points of emphasis for GPET's purpose and main objectives, with varying degrees of attention to education, provision of primary health care services, meeting community needs and meeting workforce shortages.

43. Until its amendment in late 2010, GPET's Constitution had not changed since GPET was first established in 2001. Aspects of GPET's Constitution, particularly in relation to the objects of the company, had become outdated, with expressions of GPET's role and coverage of operations not reflective of current approaches. For example, one of the company objects dealt with *establishing* the framework for vocational training, a matter overtaken by events with GPET now much more involved in *maintaining or expanding* the vocational training arrangements. The Constitution of 2001 also did not refer to the prevocational training responsibilities that GPET had assumed in 2010 via PGPPP. In mid-2010, GPET and DoHA commenced a review of GPET's Constitution to reflect better the current operating environment. The Amended Constitution, finalised in late 2010, deals with these matters.

#### *High-level strategies and performance information and reporting*

44. There is also scope for GPET to improve the consistency of how it expresses and aligns its key strategies. Analysis of GPET's high-level guiding documentation shows that if GPET were to set out more clearly and consistently its strategies and priorities, it would be better placed to determine what has to be achieved over time to realise its objectives.

45. Improved alignment across GPET's high-level guiding documents would also assist in obtaining a clear 'line of sight' between the strategies articulated at the enterprise level, key performance indicators, and targets so

that they are consistent with GPET's overall purpose. In particular, GPET's four Key Result Areas and associated performance indicators, as presented in its Strategic Plan 2010–13, do not correspond with GPET's three Major Activities and the associated performance indicators, as provided in the Health and Ageing Portfolio Budget Statements 2010–11.

46. A strategic matter for GPET, given its reliance on contracts with a relatively small number of providers delivering training services on its behalf, is how to provide assurance that it is obtaining value for money in procurement. While GPET is not required to comply with the Commonwealth Procurement Guidelines, it did use a competitive tender approach for the selection of RTPs for the 2007–09 triennium. In choosing to use direct source contracting rather than an open tender for RTPs for the 2010–12 triennium, GPET's approach to procurement and contracting with RTPs used legal advice and other processes to provide it with assurance that its intended RTP engagement processes could be 'supported as a responsible and prudent strategy'.<sup>13</sup> The longer term approach for GPET should take into consideration testing the market from time to time. GPET could use that process to provide assurance that it is obtaining value for money while also encouraging competition in the delivery of services.

## **Management of AGPT (Chapter 3)**

### *Management of delivery*

47. GPET's frameworks and procedures to manage AGPT program delivery include: the Funding Agreement with DoHA and the contracts with RTPs; the accreditation of training providers; the allocation of training places and the distribution of funding to training providers; and the recruitment and selection of suitable applicants for GP registrar positions.

### *Funding Agreements with DoHA and contracts with RTPs*

48. Although containing some of the features of an appropriate framework for AGPT delivery, such as specified service objectives and deliverables and funding levels, the Funding Agreement and contracts for 2007–09 did not contain adequate performance indicators or targets by which to assess the effective delivery of the program. This position improved with the

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<sup>13</sup> This expression was used in the legal advice to GPET, October 2008.

development of the Funding Agreement with DoHA and the RTP contracts for 2010–12. The new contracts with RTPs for 2010–12 provide the basis for more effective management of AGPT, as GPET is better placed to measure and assess the delivery of selected key aspects of AGPT by RTPs.

49. Aspects of GPET's operational decisions and subsequent performance measures rely on data being received from DoHA. For GPET, data from DoHA on GP servicing can highlight districts of workforce shortage, or the location of GP registrars who completed AGPT and are now practising GPs (that is, GP registrars 'retained' in the profession, particularly in rural and remote areas). Such information on districts of workforce shortage and rates of GP retention helps inform GPET of one of the factors that contributes to its decisions on the allocation of training places to RTPs and helps GPET consider its results, in terms of adding to the supply of practising GPs, particularly in areas of need.

50. GPET's capacity to manage AGPT would be improved by GPET and DoHA reaching an understanding on GPET having access to relevant workforce data that bears on GPET's capacity to perform and assess its functions, and helps it to consider and report on emerging workforce priorities.

51. Although DoHA is not obliged to provide GPET with this data under the terms of either Funding Agreement, DoHA appreciates that access to the data would provide GPET with a broader context in which to make decisions about GP education and training. During the latter part of the audit, DoHA advised that it had commenced processes to establish standardised reports that will be provided to GPET regularly, in line with its business needs.

#### *GPET's other procedures to manage AGPT delivery*

52. GPET has comprehensive processes underpinning program delivery, with sound mechanisms relating to the: accreditation of training providers; allocation of training places and distribution of funding to training providers; and recruitment and selection of GP registrars.

#### *Performance monitoring and reporting*

53. GPET's Board and DoHA receive activity reports on AGPT, including training in Indigenous health (Indigenous Health Training—IHT). GPET also examines RTP activity to monitor comparative and absolute performance of RTPs and AGPT over time.

54. Increasing the incidence of GP registrars undertaking IHT at an Aboriginal Medical Service (that is, an IHT post) is not a straightforward

objective to achieve. GPET has acted on several fronts since 2008 at the strategic and operational levels, consistent with government priorities and additional Council of Australian Governments funding, to boost the numbers of GP registrars taking IHT posts. Nonetheless, IHT continues to be an area requiring concerted attention.

55. Once the AGPT and GPET objectives are more clearly defined, GPET's capacity to monitor AGPT activity and assess performance would be enhanced by it:

- continuing to develop its performance indicators relating to the overall success of the program;
- determining the information required against these performance indicators; and
- formulating measurable targets for these performance indicators.

56. Like many public sector entities, GPET operates within constraints over which it has limited or little control—funding amounts, training place numbers, levels of GP retention and their location on qualification. However, GPET's management of AGPT would be enhanced by it seeking to provide greater explanation, and drawing conclusions as to the success or otherwise of the overall AGPT program against its strategic aims and targets.

## **Management of PGPPP (Chapter 4)**

57. In January 2010, GPET assumed responsibility for PGPPP. GPET managed the PGPPP preparation and handover well. For example, GPET entered into contracts appropriately with the colleges and DoHA to support its handover and the relevant operational processes. It also commissioned a study to identify and map the operations the colleges used and to appreciate the key management issues requiring consideration.

58. To manage the transition, GPET worked with the colleges to arrange and finalise the 2010 placements and undertook appropriate funding processes. Stakeholders who offered comment during the audit fieldwork were supportive of the work that GPET undertook in the preparation, handover and transition phases evident at that time.

59. The review of GPET's internal documentation and Board processes indicate that GPET also had an appropriate focus on future reform of the program and future challenges.

## **Supporting processes (Chapter 5)**

60. GPET pays appropriate attention to key processes supporting its management of GP registrar training and education activities (namely information management, communications and marketing and stakeholder engagement).

61. The way GPET conducts its information management activities continues to be important, particularly in its operations with RTPs. GPET sought to address significant problems in the functionality and reliability of key parts of its information management systems, deciding in the latter part of 2009 to replace two core IT systems and to redesign its approach to managing IT. GPET and RTPs also agreed in 2009 on a minimum data set to be provided to GPET on a routine basis. This tool is essential to GPET's ongoing monitoring of its general practice training programs and reporting to key stakeholders.

62. GPET sets out its approaches to communication in a structured way in its Marketing and Communication Strategy 2009–11. Consistent with its Marketing and Communications Strategy, GPET uses a range of activities and devices for communication and marketing. GPET evaluates its marketing and communication methods and acts on these evaluations.

63. Stakeholder engagement is particularly important for GPET to secure its broad goals of improving the overall system of medical education and training for junior doctors and GP registrars. GPET works effectively with a wide range of stakeholders. The nature, timing and scope of these interactions reflect the circumstances. GPET and RTPs have worked together to manage differences and maintain effective working relationships.

64. In considering the achievement of its goals, including work with stakeholders, GPET can take some reassurance from the results of its annual GP registrar satisfaction surveys. Successive survey results reflect well on GPET's attention to engaging with key stakeholders and indeed the effectiveness of its activities managing general practice education and training.

## **Summary of GPET response and Department of Health and Ageing comment**

65. GPET provided the following response to the audit report:

The Australian Government has made significant investments in general practice education and training over recent years, with entry places in the AGPT program rising from 600 in 2008 to 1200 in 2014. Placements in the



PGPPP have increased from 380 in 2010 to 975 in 2012. This growth in general practice training is an important component of the Government's health reform and workforce strategies. As noted by the ANAO, GPET has successfully established and administered the AGPT program and successfully managed the transition and early implementation of the PGPPP.

Throughout its short history GPET has applied the highest standards of corporate governance. GPET's strategic and business planning has successfully supported the establishment of a network of regional training providers, the implementation of a regionalised approach to general practice training, and the subsequent expansion of the AGPT program and the PGPPP. GPET's high level corporate guidance materials and plans have reflected the strategic priorities of the Company at each stage during the transition from the establishment and start-up phase of the training programs through the consolidation of the regional training provider network and on to the current growth phase.

The changes to the Company Constitution in 2010 have provided the basis for a clear alignment between the Company's objects, its strategic planning, and the key performance outcomes set out in the Health and Ageing Portfolio Budget Statements, in the current context of an unprecedented growth phase in general practice training.

**66.** GPET agreed with the two recommendations in this report. GPET's responses to each of the recommendations are shown in the body of the report following the relevant recommendation. GPET's full response to the audit is included at Appendix 1 of the report.

**67.** The ANAO provided DoHA with the opportunity to comment on the report, recognising DoHA's important role regarding policy matters for general practice training and its particular responsibilities regarding the Funding Agreement. The Secretary of DoHA commented that:

It is pleasing to note that overall, the outcome of the review is positive and the recommendations provide constructive suggestions which the Department and GPET are already working to address. I appreciate that the report acknowledges the Department's agreement to commence processes to establish standardised reports that will satisfy GPET's business requirements.

# Recommendations

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*The ANAO has made the following recommendations aimed at improving GPET's administration of the general practice vocational training program, Australian General Practice Training, and the Prevocational General Practice Placements Program. Report references and abbreviated entity responses are included below, with GPET's more detailed responses to each recommendation included in the body of the report.*

## **Recommendation No.1**

### **Para 2.47**

To improve GPET's ability to communicate consistently and clearly with external stakeholders, the ANAO recommends that GPET articulates its purpose, objectives, strategies and associated priorities and performance indicators consistently in its high-level corporate guidance material and plans, including through clearer linkages between GPET's Strategic Plans and the Health and Ageing Portfolio Budget Statements.

**GPET response:** *Agreed.*

## **Recommendation No. 2**

### **Para 3.29**

To improve GPET's management of general practice education and training, the ANAO recommends that GPET pursues with the Department of Health and Ageing arrangements for the Department to provide general practitioner workforce information that assists GPET to take into consideration and to report on new and emerging workforce priorities.

**GPET response:** *Agreed.*

## **Audit Findings**



# 1. Introduction

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*An overview of general practice education and the Commonwealth company providing such education, General Practice Education and Training Limited, is set out in this chapter. The chapter also outlines the audit objective, scope and methodology.*

## Background—general practice

**1.1** General practice is a core component of the Australian health system, with general practice being the first point of contact for the majority of people seeking health care. Data in 2005<sup>14</sup> showed that about 85 per cent of the population saw a general practitioner (GP<sup>15</sup>) at least once a year.

**1.2** General practice is defined as the provision of primary, continuing comprehensive whole-patient care to individuals, families and their communities. Primary health care involves services that: provide the first point of contact with the health system; have a particular focus on prevention of illness and/or early intervention; and are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.

**1.3** Although the majority of GPs provide services in a general practice through providing and supervising health care for patients presenting to the practice, some GPs are employed by hospitals, community health services or other organisations.

**1.4** Based on Medicare claims data, there were 25 726 vocationally recognised GPs and other medical practitioners billing Medicare in Australia

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<sup>14</sup> *Australia's Health 2008*, Australian Institute of Health and Welfare, 2008, p. 330.

<sup>15</sup> GPs are medical practitioners who, (for the purposes of Medicare arrangements for service and payment), are vocationally recognised under s.3F of the *Health Insurance Act 1973*, hold fellowship of the relevant professional college, or hold a recognised training placement.

'Medicare' is Australia's universal health insurance scheme, providing free or subsidised treatment by medical practitioners.

Medical practitioners who are not vocationally recognised GPs can also provide medical services. Classified for Medicare purposes as 'other medical practitioners', their services attract conditions under the Medicare arrangements.

in 2008–09. On a full-time workload equivalent basis<sup>16</sup>, there were 19 231 vocationally recognised GPs and other medical practitioners.

## General practice education

**1.5** The Australian Government has a key role in general practice education. As well as supporting the initial education of medical students via the tertiary education system, the Australian Government also supports specific postgraduate education and training programs and provides Medicare benefits in respect of medical services provided by GP trainees while they are undertaking recognised training.

**1.6** The Australian Government funds General Practice Education and Training Limited (GPET) to manage two specific, optional general practice training programs, namely the Prevocational General Practice Placements Program (PGPPP) and the vocational training program, Australian General Practice Training (AGPT). The system and the programs are introduced below.

## Specific education and training programs for general practitioners

**1.7** In order to become a qualified GP, able to consult with patients unsupervised and unrestricted, and provide a Medicare rebate to those patients for the cost of medical services delivered, a medical practitioner must hold fellowship of the relevant professional college—the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). In order for this to occur, the individual must complete an undergraduate or postgraduate medical degree, an internship, and pass assessments set by the relevant college.

**1.8** Many potential GPs working through this process choose to undertake the structured training funded by the Australian Government, involving either PGPPP or AGPT or both. AGPT is the most common method of training that GP trainees undertake to seek to become fellows of either, or both, professional college, with 73.3 per cent of those who took the RACGP fellowship examination in 2009 having done AGPT.

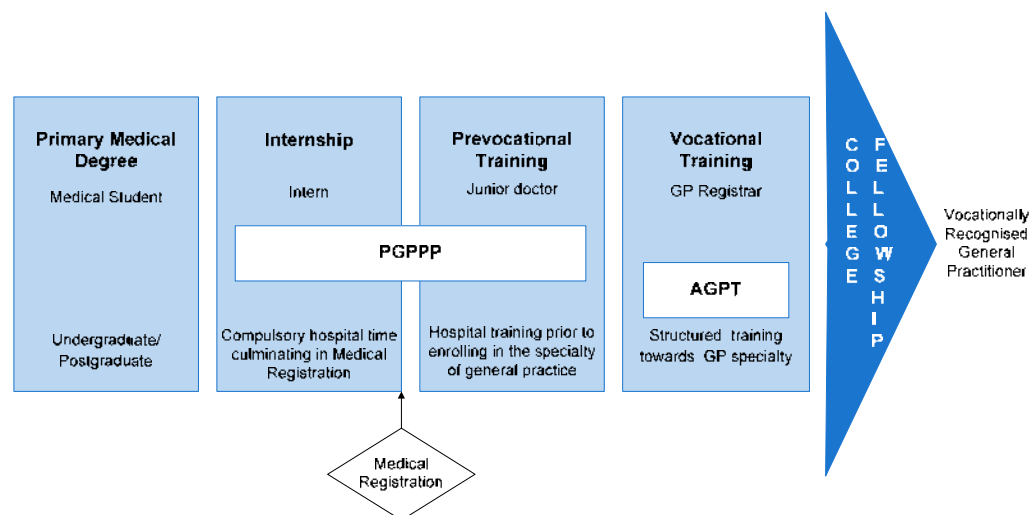
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<sup>16</sup> Full-time workload equivalent is a measure of medical practitioner supply based on claims processed by Medicare in a given period. It is calculated by dividing the practitioner's Medicare billing by the mean billing of full-time practitioners for that period. For example, a full-time workload equivalent value of 'two' indicates that the practitioner's total billing is twice that of the mean billing of a full-time practitioner.

**1.9** The broad stages of general practice education, including the stages to which PGPPP and AGPT relate, are depicted in Figure 1.1.

**Figure 1.1**

**The structured programs in the learning sequence of a GP**



Source: ANAO depiction of GPET information.

## GPET—the government context

**1.10** GPET is a portfolio agency within the Health and Ageing portfolio. GPET contributes to the Department of Health and Ageing's (DoHA's) Outcome 5—Primary Care: 'Access to comprehensive, community-based health care, including through first point of call services for prevention, diagnosis and treatment of ill-health, and for ongoing management of chronic disease'.

**1.11** Reflecting this position within the Health and Ageing portfolio, GPET's stated Outcome is: 'Improved access to primary care across Australia, including through general practitioner vocational education and training for medical graduates'.<sup>17</sup>

**1.12** GPET has a formal relationship with DoHA, resulting from the contractual arrangements associated with the formal Funding Agreements

<sup>17</sup> Portfolio Budget Statements 2010–11, Budget Related Paper No.1.11 Health and Ageing Portfolio, p. 651.

between the Australian Government (represented by DoHA) and GPET. DoHA also has policy advisory responsibilities to the Minister for Health and Ageing.

**1.13** Although GPET is independent from DoHA in relation to strategic and operational matters, the Australian Government determines some key parameters for GPET, namely the number of training places and amount of funding for training and education, as outlined below.

### **Government measures concerning the number of places and program funding**

**1.14** The series of government measures since 2001 relating to AGPT and PGPPP is outlined in detail in Appendix 2.

**1.15** DoHA has a role in providing advice to government on GP training issues, including the number of training places and funding amounts. DoHA has informed the ANAO that in deciding on the optimal number of general practice training places, government has regard to factors such as:

- the sectors of the medical workforce experiencing shortage (particularly shortages of GPs);
- the geographical areas of the general practice workforce shortage (particularly rural and outer metropolitan areas);
- the number of applicants for AGPT compared to the government's quota of available places for AGPT;
- GPET advice to the Minister, and analyses by the Australian Medical Association and the Australian Medical Workforce Advisory Committee of the numbers of general practice training places needed, given GP workforce needs and AGPT training capacity; and
- the numbers of medical school graduates projected to emerge, and the numbers of registrars choosing general practice as their preferred specialisation.

**1.16** In relation to funding decisions, DoHA has advised that government decisions on funding for general practice training are informed by advice from DoHA regarding:

- for AGPT, the average cost per training placement, which includes components such as the management of placements, payment of educational costs including engaging medical educators, teaching



allowances and supervision costs, relocation and travel costs for registrars, and practice reimbursements;

- for AGPT, flow-on costs to take account of registrars' billing on the Medicare Benefits Schedule (including the costs associated with referrals for pathology, diagnostic imaging and other specialist services), prescribing under the Pharmaceutical Benefits Scheme, and incentive payments under the Practice Incentives Program and the General Practice Rural Incentives Program; and
- for PGPPP, the cost of placing a junior doctor in a 12-week training placement, administrative fees to the training providers for management and coordination of placements, a component to GPET for the administration of the program, and on-costs for billing on the Medicare Benefits Schedule (including costs associated with referrals for pathology, diagnostic imaging and other specialist services), and prescribing under the Pharmaceutical Benefits Scheme.

## GPET—the organisational arrangements

### Establishment

**1.17** GPET was founded in 2001, following a 1997 ministerial review of the then existing general practice education and training arrangements. Under the model at the time, RACGP was funded by government and was solely responsible for the provision of GP training. By the mid-1990s, training was delivered through 21 regions that were attached to RACGP's six state-based offices.

**1.18** The report of the ministerial review, *General Practice Education: the way forward*<sup>18</sup>, recommended national structures and local processes to: promote better coordination of education and training; develop local collaborative arrangements for delivery; and foster community-based education, including developing teaching practices that encourage best practice and reward teaching in the community.

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<sup>18</sup> *General Practice Education: the way forward*, Final Report of the Ministerial Review of General Practice Training, March 1998.

**1.19** In response, in June 2000 the Government announced significant changes to the structure and delivery of general practice vocational training. GPET was established as a government company to implement the regionalised and contestable general practice vocational training program—to be known as Australian General Practice Training. Training under the regionalised training program commenced in 2002.<sup>19</sup>

**1.20** As set out in detail in Appendix 2, in 2006 the Council of Australian Governments increased the number of medical school places to address medical workforce shortages, which resulted in increased numbers of graduates from Australian medical schools, and, in turn, in record numbers of applications in 2008 for AGPT for the 2009 training year. Since 2008, the Australian Government has increased the number of AGPT intake training places it funds on a number of occasions, most recently in March 2010.

## **Legislative framework**

**1.21** GPET is a wholly owned Commonwealth company, limited by guarantee<sup>20</sup>, under the *Commonwealth Authorities and Companies Act 1997* (CAC Act), as defined in section 34(1) of that Act.

**1.22** GPET's scope and operations are framed by the Company's Constitution, the *Corporations Act 2001* (Corporations Act) and the CAC Act. GPET's Constitution of 2001, (executed in March 2001 when GPET was originally established) specified the company 'objects' (that is, objectives or purposes) regarding the implementation of regionalised and contestable general practice vocational training.<sup>21</sup> GPET's 2001 Constitution was amended

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<sup>19</sup> As well as setting up GPET and a system of regionalised general practice training, the Government at the same time also: increased the quota of available first-year training places from 400 to 450, effective 2001; introduced a dedicated Rural Pathway, for registrars undertaking training in moderate to very remote locations and a General Pathway for mainly urban locations; and provided financial incentives for rural pathway GP registrars undertaking the program.

<sup>20</sup> A company limited by guarantee is a company whose members have limited liability.

<sup>21</sup> The first object listed in GPET's Constitution of 2001 was to 'ensure high quality general practice education and vocational training across Australia that is responsive to the existing and changing needs of the community and individual sections of the community'. Chapter 2 sets out the objects in GPET's 2001 Constitution and in its Amended Constitution.

on 21 December 2010 in order to reflect better GPET's current operating environment.<sup>22</sup> GPET does not have specific enabling legislation.

## **GPET Board, management and resources**

**1.23** The sole member of GPET is the Commonwealth, represented by the Minister for Health and Ageing. GPET is governed by a board of directors. The GPET Board is directly accountable to the member (the Minister for Health and Ageing) for its performance in meeting the objectives of the company and, in that context, addressing government priorities.<sup>23</sup> Consistent with the duties of directors under the Corporations Act, the Board is independent in its capacity to determine GPET's strategies and work program to achieve these outcomes.

**1.24** The 2001 Constitution provided that the member may appoint up to 12 directors to the Board; a chair and 11 other directors. In 2009–10, GPET had a Board membership of 12. The 2001 Constitution also specified that the majority of Board directors must have been GPs or GPs in training, and that the Board may also contain persons nominated by the medical profession. The Amended Constitution retains these provisions.

**1.25** GPET's expenses in 2009–10 totalled \$106.7 million, with an average staffing level of 35 people. GPET's revenue in the same period totalled \$124.8 million, the majority of which was revenue from government (\$118.6 million).<sup>24</sup> In 2010–11, GPET's revenue from government is expected to increase to \$150.4 million and average staffing is expected to increase to 38 people.

**1.26** GPET's organisational structure is depicted in Appendix 3.

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<sup>22</sup> The revised constitution, known in this report as the 'Amended Constitution', modified the company objects dealing with general practice education and training, but retained most of GPET's other procedural requirements. The Amended Constitution modified processes in some areas, for example introducing a provision dealing with conflicts of interest. See Chapter 2.

GPET's direction under its original constitution, known in this report as the '2001 Constitution' was a focus of the audit, as the 2001 Constitution was current during audit fieldwork. Where appropriate, the ANAO has updated the report to reflect the Amended Constitution.

<sup>23</sup> The Minister's Statement of Expectations outlines government priority areas for general practice training. GPET responds to this with a Statement of Intent detailing how it will fulfil the Minister's expectations. This mechanism is outlined in more detail in Chapter 2.

<sup>24</sup> GPET's revenue comprises mainly revenue from government, interest earnings and other income. GPET does not receive fees.

## Scheme design for general practice education

**1.27** The Australian Government places a quota on the number of new training places it funds through GPET each year. In broad terms, GPET's role is essentially one of managing and supporting outsourced training delivery within a global budget for places and funding specified by government, to meet training quality standards specified by the relevant separate authorities.<sup>25</sup>

### Training places and funding

**1.28** As previously indicated, the Australian Government determines the number of new training places it funds through GPET each year. GPET receives funding from the Australian Government, represented by DoHA, under three-year Funding Agreements that are based on the number of training places being funded.

**1.29** GPET's role is to allocate the funded training places and associated funding to the organisations that deliver the education and training courses across Australia, and to contract-manage those training providers. The system of regional delivery, and GPET's role in this, are discussed below.

### Regional delivery

**1.30** GPET contracts with training providers across Australia to deliver its general practice training and education programs. A training year is broadly aligned with a calendar year.

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<sup>25</sup> The training of GPs broadly follows an apprenticeship model, with trainees undertaking structured education as well as supervised practical (clinical) training over the course of their learning time. Therefore GPET's responsibilities cover both 'education' and 'training'.

The limits of GPET's responsibilities are in managing general practice training and education; it is not responsible for the registration of doctors. This is a function of the medical boards in each state and territory. Nor is GPET responsible for the assessment of international medical graduates who may wish to practise in Australia; this is a function of the Australian Medical Council.

Training quality standards for AGPT are set by the professional colleges. Training standards in respect of PGPPP are set by the Post Graduate Medical Education Councils in each state and territory in respect of interns and by the professional colleges in respect of junior doctors who have completed their intern year.

**1.31** Regional training providers (RTPs) are not-for-profit organisations that deliver education and training within a specific location.<sup>26</sup> RTPs deliver general practice training in local practices using networks of GPs who are able to provide experience and support to the trainees (the GP registrars who are undertaking AGPT and the junior doctors undertaking PGPPP).<sup>27</sup>

**1.32** At the time of audit fieldwork in early 2010, there were 17 RTPs delivering AGPT. PGPPP was delivered by these RTPs, plus a few additional providers such as universities and divisions of general practice.<sup>28</sup>

**1.33** GPET distributes to individual RTPs or other training providers the training places provided annually by government. Once GPET allocates places to RTPs or other training providers, these bodies determine the placement of the junior doctors in PGPPP and the GP registrars in AGPT in particular locations within their regions in collaboration with relevant hospitals and general practices.

**1.34** Trainees do not pay fees for their education and training; education and training costs are met from government funding. Based on the 2009 figures for GPET, in broad terms, the education and training cost per GP registrar is \$45 000 per year.

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<sup>26</sup> Typically, an RTP is a consortium of partners, involving universities, the relevant professional colleges, divisions of general practice, bodies representing GP registrars and GP supervisors and others reflecting particular areas of focus. Divisions of general practice are voluntary associations of GPs that support GPs professionally and also undertake local primary care initiatives. An example of a partner linked to a particular focus area is the Aboriginal Medical Services Alliance NT which is represented in the Northern Territory's RTP, Northern Territory General Practice Education.

The precise structure of RTPs differs from RTP to RTP, but in broad terms it involves a Board and dedicated RTP staff in one or more offices. Staff include a Chief Executive Officer, trainers, medical educators, specialist consultants, GP registrar liaison officers, and support staff dealing with functions such as marketing and finance. The RTPs often have areas of special educational interest and expertise reflecting their regional focus. Examples are training in Indigenous health, tropical medicine and expedition medicine (embracing training in wilderness and polar locations).

<sup>27</sup> A GP registrar is a doctor who is undertaking vocational training in the speciality of general practice. A junior doctor is one who is undertaking prevocational training (PGPPP).

<sup>28</sup> As noted previously, divisions of general practice are regionally based voluntary associations of GPs that seek to provide professional support for GPs and to coordinate and improve local primary care services, including by running some programs.

## The programs

### Australian General Practice Training

**1.35** AGPT is a three to four-year full-time vocational education and training program for medical graduates wanting to pursue a career in general practice, that is, those wanting to choose general practice as their medical specialisation. Training is conducted within accredited medical practices and hospitals and is supervised and assessed by experienced medical educators, as illustrated in Figure 1.2.

**Figure 1.2**

**Trainee conducting a clinical examination under supervision**



Source: Photo courtesy of GPET.

**1.36** Training quality standards for AGPT are set by the professional colleges. GPET uses the accreditation of RTPs and their networks of training practices against college standards to assure itself that the education and training provided by RTPs is in accordance with required college standards.

**1.37** AGPT is competitive; not all applicants to the program are successful. GPET undertakes a selection process to determine that the successful GP registrars are suitably qualified. Although the vast majority of the AGPT potential intake is filled each year, in some years not all funded places are filled.

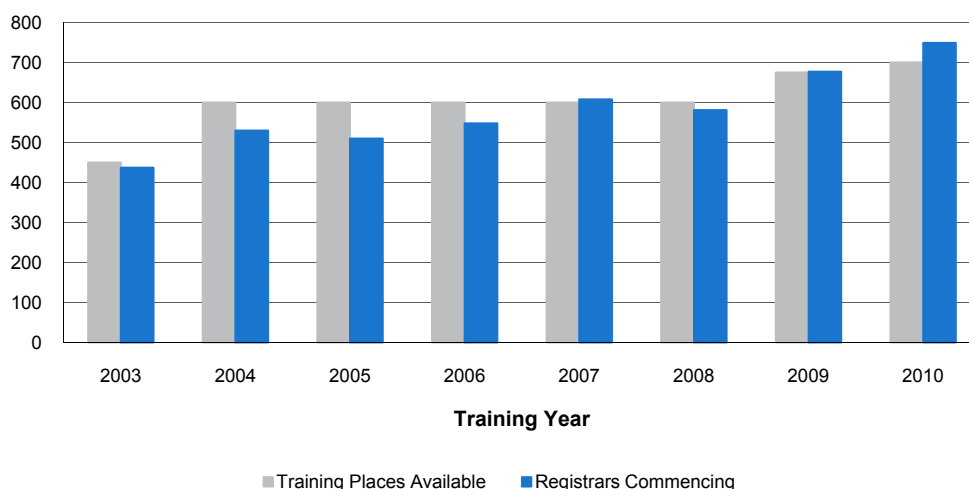
**1.38** AGPT is successfully completed when the GP registrar meets the requirements for fellowship, set by the professional colleges. The colleges may award fellowship following the successful completion of their assessment processes.

**1.39** Between 2004 and 2008 inclusive, the number of AGPT new intake training places funded by government was stable at 600 per year. The number rose to 675 new intake training places for the 2009 training year. The total number of GP registrars enrolled in AGPT at that time was approximately 2500.

**1.40** Figure 1.3 depicts the trend of training places available and filled in 2003 to 2010, inclusive.

**Figure 1.3**

### Registrars commencing AGPT training compared to available places



Source: ANAO analysis of GPET information.

**1.41** AGPT is budgeted to provide 700 new intake training places in 2010 and 900 new intake training places in 2011.

**1.42** AGPT serves a two-fold purpose: as well as training GP registrars it also helps to address workforce shortages through the placement of AGPT

trainees (GP registrars). This is because AGPT trainees, as medical practitioners holding a recognised training placement, can provide medical services and can access the GP items in the Medicare Benefits Schedule.<sup>29</sup> As well as helping to augment the provision of general practice medical services overall, AGPT can also assist with the provision of general practice services in locations of medical need, because AGPT placements occur in outer metropolitan, rural and remote areas, areas that are often areas of medical workforce need.

### *Indigenous health training*

**1.43** Training in Indigenous health—known as Indigenous Health Training (IHT)—is an important component of GPET’s vocational GP training, especially in the context of the government’s policy priority to close the life expectancy gap between Indigenous and non-Indigenous Australians.

**1.44** IHT is designed to provide training for GP registrars in Aboriginal and Torres Strait Islander health matters, access to medical services for Aboriginal and Torres Strait Islander people via the GP registrar, and ultimately to provide GPs, and especially rural GPs, with appropriate clinical and cultural skills in order to provide better quality care and access to services for Aboriginal and Torres Strait Islander people.

**1.45** GPET’s IHT for GP registrars has two components. One is IHT posts whereby GP registrars undertake general practice training placements (posts) at Aboriginal Medical Services. The other involves GP registrars undertaking learning activities specific to Indigenous health, as part of the colleges’ Aboriginal health curricula for GP registrars. A major part of such learning activities is Indigenous cultural training, to provide GP registrars with an insight into Indigenous culture as well as exposure to factors such as demographic, economic and lifestyle issues that affect Indigenous health.

**1.46** All GP registrars are required to undertake IHT learning activities as provided by their RTP; however it is not a requirement that all GP registrars complete an IHT post. In 2009, six per cent of GP registrars undertook training

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<sup>29</sup> This means that, even though they are not yet vocationally recognised GPs, AGPT trainees can provide a Medicare rebate to their patients under the *Health Insurance Act 1973* for the period of their approved training placements.

Medicare is Australia’s universal health insurance scheme, providing free or subsidised treatment by medical practitioners.



at an Aboriginal Medical Service, up from five per cent in 2008. The numbers of full-time equivalent weeks training undertaken by GP registrars in Aboriginal Medical Services in the same periods were 3119 and 2761, respectively. In the 2010 training year, GPET was budgeted to deliver 3099 full-time equivalent weeks of training in IHT posts, rising to 3832 in the 2011 training year.

## **Prevocational General Practice Placement Program**

**1.47** PGPPP was launched by the Australian Government in 2003, with funding to RACGP and ACRRM to run the program.

**1.48** PGPPP provides junior doctors with the opportunity to experience the general practice environment prior to determining their area of specialty. The program offers prevocational trainees voluntary, supervised and supported placements for a nominal 12 weeks in outer metropolitan, regional, rural and remote areas in accredited training environments. PGPPP trainees undertake 'work experience' in a general practice situation.

**1.49** Junior doctors are employed by the hospitals and their participation in PGPPP depends on their release from other formal, in-hospital intern training (such as training in accident and emergency, obstetrics and gynaecology or surgery). Selections for PGPPP are made by the relevant hospitals, as junior doctors are in their employ.

**1.50** The relevant regulatory authorities setting the training standards in respect of PGPPP are the Post Graduate Medical Councils in each state and territory.

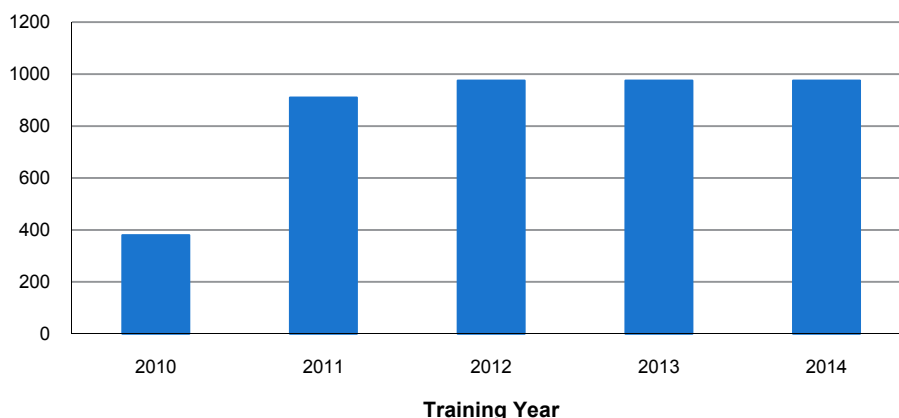
**1.51** Completion of PGPPP, as a work experience type of program for the junior doctor, depends on satisfactory completion of the placement, with performance feedback collected from the trainee and the general practice supervisor and provided to the hospital.

**1.52** GPET took over the management of PGPPP from RACGP and ACRRM in 2010.

**1.53** GPET was budgeted to provide 380 PGPPP placements in 2010 and 910 placements in 2011, with the intent of increasing general practice training rotations for junior doctors in primary care settings in order to increase the capacity of the hospital system to train the rising number of medical graduates entering the system. Figure 1.4 shows the increase in training placements to be offered in PGPPP in the training years 2010 to 2014 inclusive.

**Figure 1.4**

**Number of PGPPP training placements available**



Source: ANAO analysis of Health and Ageing Portfolio Budget Statements 2010–2011.

## **GPET's operating context—trends, stakeholders and the wider context**

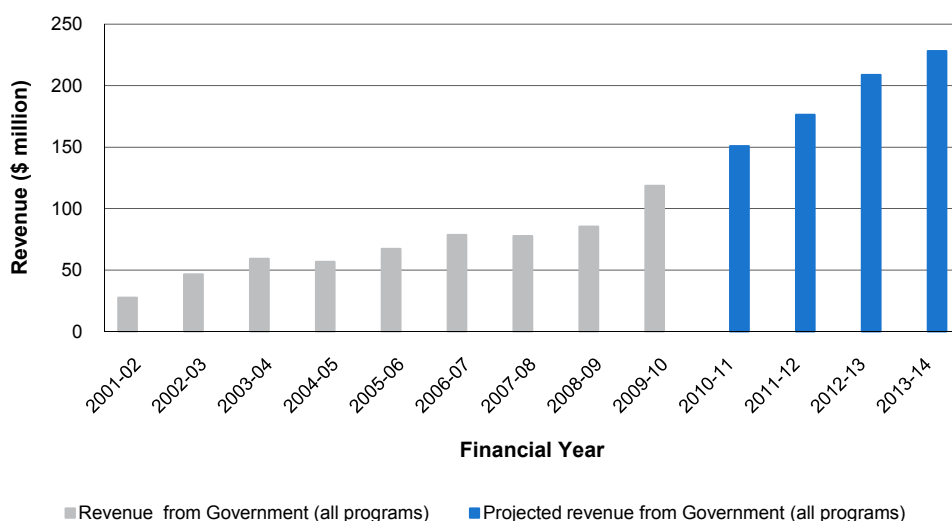
**1.54** GPET performs significant public functions in the health context. Assessment of GPET's management of these functions requires recognition of the dynamic and sensitive operating context and the larger context in which GPET's programs operate and which GPET's programs affect.

**1.55** GPET's operating context has changed considerably since its establishment in 2001. GPET's activities have changed from those associated with establishing a new training framework and infrastructure in a sensitive professional and political environment, to those associated with running an established (and more recently growing) general practice training program.

**1.56** GPET has secured increased revenue from government, especially since 2008–09, reflecting the increased number of training places being funded by government, as highlighted earlier. This trend is shown in Figure 1.5, illustrating the increasing significance of GPET's activities.<sup>30</sup>

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<sup>30</sup> GPET spends a modest proportion of its revenue on administration, as distinct from training program costs. Under GPET's 2010–12 Funding Agreement with DoHA, expenditure on administration is limited to five per cent of total GPET funding. Under the 2007–09 Funding Agreement, administrative expenditure was a fixed amount that, over time, averaged 4.7 per cent of total funding.

**Figure 1.5****Revenue and projected revenue from government to GPET**

Source: ANAO analysis of GPET Annual Reports and Health and Ageing Portfolio Budget Statements 2010–11.

**Stakeholders**

**1.57** GPET operates in a complex environment with a large number of parties bearing on its activities. For example, GPET works with stakeholders having public, professional, commercial and community interests. Stakeholders include government; the medical profession and academics; training providers; trainees and their representatives; and the community.

**General practice—the wider context*****Availability of GPs***

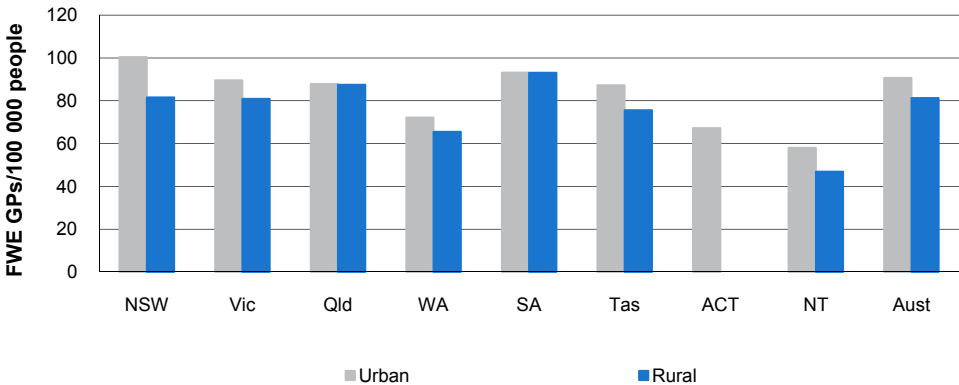
**1.58** General practice services in Australia are affected by a variety of factors, including those affecting demand and supply, such as an ageing population, the increasing burden of chronic disease such as diabetes and obesity, and workforce shortage problems, particularly in rural and remote locations.<sup>31</sup>

<sup>31</sup> Media coverage in 2009 and 2010 highlighted factors bearing on the availability of GPs, particularly shortages of GPs in rural and remote areas (as well as some metropolitan areas). The media highlighted calls for additional government-funded GP training positions, especially for rural GPs.

**1.59** Figure 1.6 illustrates the availability of vocationally recognised GPs and other medical practitioners across Australia, based on Medicare claims data. The diagram shows that there were more vocationally recognised GPs and other medical practitioners available in urban areas than in rural areas in almost all states and territories. The figure also shows the wide variation in the availability of vocationally recognised GPs and other medical practitioners across states and territories.

**Figure 1.6**

**Availability of GPs (full-time workload equivalent) 2008–09**



Source: Productivity Commission, *Report on Government Services 2010*, Table 11A.12.

**General practice and the wider health system**

**1.60** Different levels of government are involved in general practice. For example, the Australian Government provides the majority of general practice income through Medicare fee for service and other payments. State and territory bodies register and license GPs in their jurisdiction, based on the policies set by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency. Governments at both the Australian Government level and in the states and territories also provide support for general practice services via particular initiatives (such as the Practice Incentives Program<sup>32</sup>) and incentives and support for GPs to work in rural and

<sup>32</sup> The ANAO conducted an audit of the Practice Incentives Program, which provides incentives that encourage general practices to improve the quality of care provided to patients. This was reported in Audit Report No.5 2010–11 *Practice Incentives Program*, Canberra, 2010.

remote areas, such as financial incentives, and other services such as housing and relocation support.

**1.61** General practice is only a part of the much broader and complex health system. As an example of the interrelationships across the health system, the degree to which people can gain prompt and convenient access to general practice services can affect the utilisation of other, more costly health services. Difficulties in gaining access to GP services may lead people to seek services at hospital emergency departments, although their medical conditions might be better managed in the primary and community health sector.

## Previous audit coverage and reviews

**1.62** The ANAO conducts annual audits of GPET's financial statements but has not previously undertaken a performance audit of the entity. The ANAO has undertaken performance audits relevant to GPET's general context<sup>33</sup>, however none have direct relevance to GPET's training operations and processes.

**1.63** GPET has been subject to several major external and internal reviews since its establishment. Major reviews of GPET commissioned by DoHA include the review by the consultants ACIL Tasman in 2004 to evaluate the regionalisation of general practice vocational training and the review by the consulting firm, Deloitte, in 2007, which examined GPET's business processes. These reviews provided assurance about the appropriateness of GPET's processes and identified some areas for improvement. GPET has acted on these reviews.

## Audit objective and scope

### Objective

**1.64** The objective of the audit was to assess the administrative effectiveness of GPET's management of the general practice training programs, AGPT and PGPPP, the latter being a responsibility that GPET assumed in 2010.

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<sup>33</sup> The reports are: Report No.5 2010–2011 *Practice Incentives Program*, Canberra, 2010; Report No.26 2008–09 *Rural and Remote Health Workforce Capacity—the contributions made by the programs administered by the Department of Health and Ageing*, Canberra, 2009; Report No.25 2007–08 *Administering Round the Clock Medicare Grants*, Canberra, 2008; and Report No.41 2005–06 *Administration of Primary Care Funding Agreements*, Canberra, 2006.

## Scope

**1.65** Particular emphasis was given to GPET's governance functions such as planning and performance reporting, and to its program delivery, with attention to whether the:

- planning and reporting regimes were integrated to allow GPET to monitor its progress appropriately, with alignment between the entity's overall purpose, its high-level strategies articulated at the enterprise level, and its performance information;
- delivery and review processes for AGPT and PGPPP allowed GPET to administer these programs appropriately; and
- key supporting processes (information management, communications and marketing and stakeholder engagement) suitably assisted program delivery and accountability.

**1.66** Given the very short period for which GPET was responsible for PGPPP, the audit examined how well GPET managed the transition process and the program's implementation at its very early phase.

**1.67** The ANAO did not examine the RTPs themselves, but examined how GPET contracts with, manages and supports RTPs.

**1.68** While seeking to appreciate DoHA's roles in contributing to the government framework in which GPET operates, the audit did not examine DoHA's administration of primary care education and training, particularly GP training.

## Methodology

**1.69** In order to form an opinion against the audit objective, the ANAO:

- examined policy documents, guidelines, procedures, operational documents and reports;
- reviewed files, reports and publications (including data reports);
- interviewed relevant GPET staff; and
- consulted with a range of stakeholders including representatives from DoHA, RACGP, ACRRM, Aboriginal Community Controlled Health Organisations; staff in a selection of RTPs, including CEOs, program managers and medical educators; and two GP registrar representatives.

**1.70** The audit focused on documents and procedures from 2009, as the last complete training year at the time of evidence collection and analysis, noting changes in 2010, where relevant. A significant change in December 2010 was GPET's Amended Constitution, replacing the one that had applied from 2001, when GPET was established. The audit examined GPET's 2001 Constitution but reflects developments, where appropriate, including drawing on GPET's advice regarding steps being undertaken to implement and apply the Amended Constitution.

**1.71** The audit was conducted in accordance with ANAO Auditing Standards at a cost of \$591 000.

## **Acknowledgements**

**1.72** The ANAO thanks GPET staff for their assistance during the audit. The ANAO also expresses appreciation to the general practice training stakeholders, and especially the RTPs, consulted during the audit.

## **Structure of the report**

**1.73** The report has the following structure:

- Chapter 1 – Introduction;
- Chapter 2 – GPET's Planning and Reporting;
- Chapter 3 – GPET's Management of AGPT;
- Chapter 4 – GPET's Management of PGPPP; and
- Chapter 5 – GPET's Supporting Processes.

## 2. GPET's Planning and Reporting

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*GPET's planning and reporting framework, including the alignment of its strategic directions and performance information, is examined in this chapter.*

### Introduction

**2.1** Governance is the combination of responsibilities, practices, policies and procedures exercised by an entity's leadership group (for example, the board of directors) to provide strategic direction, and to ensure that objectives are achieved, risks are managed and resources used responsibly.<sup>34</sup> In the corporate or business context, reflecting the content of the Australian Standard, *Good Governance Principles*, corporate governance is concerned with improving the performance of companies for the benefit of shareholders, stakeholders and economic growth.<sup>35</sup>

**2.2** A key element of sound corporate governance for any organisation is to establish an appropriate planning and reporting regime. To enable an entity to monitor its progress, it is important that planning and reporting are integrated and there is alignment between the entity's overall purpose, its high-level strategies articulated at the enterprise level, and its performance information.

**2.3** To understand and assess the strength of GPET's planning and reporting regime, the ANAO:

- examined GPET's legislative arrangements and formal operating environment and related recent developments;
- considered whether GPET's articulation of its purpose and objectives was consistent, up-to-date, and reflected external requirements and influences;
- assessed whether GPET's high-level strategies identified clearly and consistently GPET's directions and priority areas;

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<sup>34</sup> Australian National Audit Office and the Department of the Prime Minister and Cabinet, *Implementation of Programme and Policy Initiatives*, Better Practice Guide, ANAO, Canberra, 2006, p. 13.

<sup>35</sup> Investment and Financial Services Association Guidance Note No.2.00, as cited in Australian Standard AS 8000–2003 *Good Governance Principles*.



- examined GPET's performance information and reporting for the 2008-09 and 2009-10 reporting periods; and
- as an inherent part of GPET deciding on its most important priorities, reviewed GPET's approach to managing risk.

## Legislative arrangements

**2.4** As noted in Chapter 1, GPET is a wholly owned Commonwealth company, limited by guarantee, under the CAC Act.<sup>36</sup> GPET's scope and operations are also framed by the Corporations Act and its Company Constitution. GPET does not have its own enabling legislation.

**2.5** The sole member of GPET is the Commonwealth, represented by the Minister for Health and Ageing. GPET is governed by a board of directors, responsible for setting the strategic direction of the company. It has a Chief Executive Officer responsible for overseeing the operations of the company.

## Legislation and Constitution

**2.6** The Corporations Act sets out formally GPET's governance and operational requirements, for example provisions relating to its establishment and internal management, the conduct of directors and employees, the conduct of meetings, required financial reports, audit processes and directors' reports and presentation of information to the company's sole member.

**2.7** A notable requirement under the Corporations Act is for directors to act with care and diligence, in good faith, in the best interests of the corporation. Consistent with the duties of directors under the Corporations Act, the GPET Board is independent in its capacity to determine GPET's strategies and work program to execute these strategies.

**2.8** The CAC Act cross-references and supplements the operational requirements under the Corporations Act, requiring additional activity by directors in relation to key government processes such as the provision of

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<sup>36</sup> GPET's status as a Commonwealth company was confirmed by the then Government in 2006, following an assessment that government required of all portfolio bodies at the time. As required, GPET was assessed against the governance principles and templates recommended by the 2003 *Review of the Corporate Governance of Statutory Authorities and Office Holders* (known as the Uhrig Review). Following the assessment, the government decided in 2006 that GPET should continue to operate as a Commonwealth company subject to the CAC Act.

information on operations to the responsible Minister and Minister for Finance, maintenance of an audit committee and annual reporting in Parliament.

**2.9** The legal and regulatory frameworks for GPET, as a Commonwealth company, provide it with independence from some detailed government planning, operational and review processes applicable to CAC Act authorities.

**2.10** Examples of differences in requirements for GPET as a Commonwealth company, compared to a CAC Act authority are that GPET is:

- not required to publish a corporate plan;
- not required to comply with the Commonwealth Procurement Guidelines; and
- not required to report on its outcomes and programs, in a form consistent with its Portfolio Budget Statements, in a Report of Operations.<sup>37</sup>

**2.11** Although not formally required to do these activities, GPET adheres to many of these practices, to demonstrate that it is accountable for its conduct and performance as a recipient of Commonwealth funds.

## **The relationship between GPET, the Minister and the Department of Health and Ageing**

**2.12** The GPET Board is directly accountable to the Minister for Health and Ageing for its performance in meeting the objects of the company outlined in the Company Constitution and in this context, government expectations and priorities. However, consistent with the Corporations Act, the Board is independent in its capacity to determine GPET's strategies and work program.

**2.13** GPET has a formal relationship with DoHA, resulting from the contractual arrangements associated with the formal Funding Agreement between GPET and the Commonwealth. DoHA also has policy advising responsibilities to the Minister for Health and Ageing and GPET cooperates with DoHA in meeting those responsibilities by providing relevant

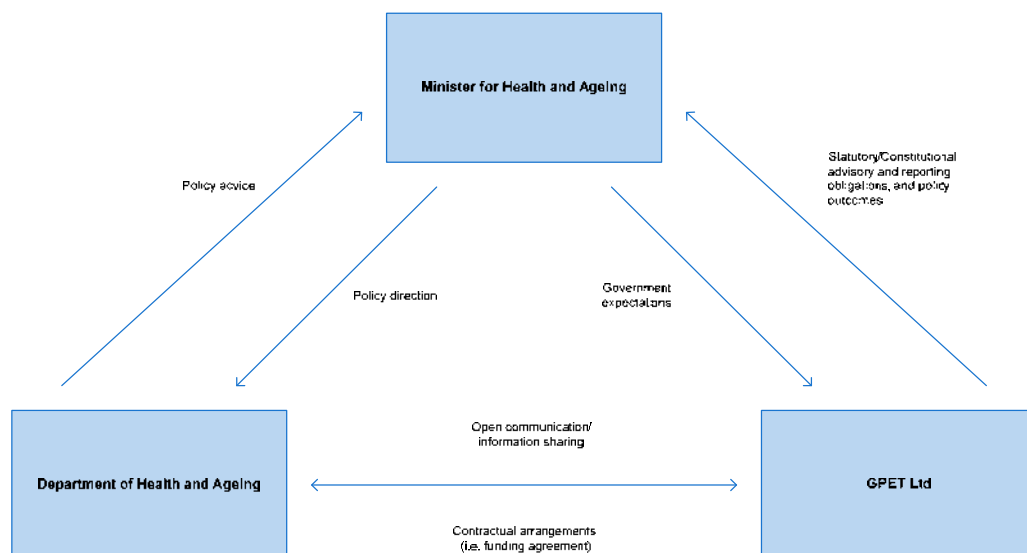
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<sup>37</sup> Agencies that are part of the General Government Sector, including GPET, are required to follow Department of Finance and Deregulation guidance for the preparation of Portfolio Budget Statements—particularly when determining whether new programs, or changes to existing programs, are necessary. However, as a wholly owned Commonwealth company, GPET is not required to present information in its Annual Reports that is consistent with its Portfolio Budget Statements.

information. The elements of the relationship between GPET, the Minister and DoHA are depicted in Figure 2.1.

**Figure 2.1**

### The relationship between GPET, the Minister and the Department



Source: ANAO adaptation of DoHA information.

## Articulation of its purpose and objectives

**2.14** The articulation of the purpose of an organisation should draw on an understanding of external requirements and influences. In the case of GPET this includes:

- its Constitution;
- the Minister's Statement of Expectations and GPET's Statement of Intent;
- GPET's Strategic Plan; and
- GPET's Portfolio Budget Statements.

## GPET's 2001 Constitution

**2.15** GPET's 2001 Constitution (executed in March 2001 when GPET was originally established), specified the company objects and formalities<sup>38</sup> connected with its operations.

**2.16** The Australian Government established GPET to develop, oversee and fund regionally based vocational education and training in general practice for medical graduates.

GPET's 2001 Constitution listed the following objects:

- ensure high-quality general practice education and vocational training across Australia that is responsive to the existing and changing needs of the community and individual sections of the community;
- promote Australia as a world leader in establishing innovative and effective mechanisms for general practice education vocational training;
- work closely with the medical profession to ensure that all general practice education and vocational training continues to meet the standards which are set by the profession's relevant colleges;
- establish a national framework for regionalisation and contestability of vocational training for general practitioners, including the funding and allocation of places, and monitor progress with implementation;
- ensure value for money in the provision of vocational training;
- ensure that vocational training is well structured and produces doctors that are capable of meeting community needs, in particular those of rural and remote Australia;
- promote vertical and horizontal integration of education and training at a regional level;
- establish a national framework for the evaluation of general practice education and training outcomes; and
- provide advice to the Minister for Health and Aged Care regarding undergraduate and postgraduate training issues.

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<sup>38</sup> The formal operational matters specified in GPET's 2001 Constitution included: the establishment and operation of a Trust Fund to hold funds from the Commonwealth; Board membership; meeting arrangements; Board members' roles and management; and auditing, accounting and reporting obligations. GPET's Amended Constitution, among other things, removes references to the Trust Fund (which is no longer used), modifies required processes in some areas but retains most of the procedural requirements of the 2001 Constitution. Some additional information on the Amended Constitution is presented at para 2.86.

**2.17** The first of the above points suggests a clear purpose or objective for GPET, and the later points outline ways GPET is to go about achieving it.

## **Statement of Expectations and Statement of Intent**

**2.18** The then Government's acceptance of the recommendation of the 2003 *Review of the Corporate Governance of Statutory Authorities and Office Holders* (known as the Uhrig Review) led to the formulation of a policy detailing the governance arrangements for Australian Government bodies. Under these governance arrangements, Ministers are required to outline their expectations of each CAC body in a public Statement of Expectations (SoE). Each entity must then respond with a Statement of Intent (SoI), which details how it will fulfil the Minister's expectations.

**2.19** The Minister's SoE to GPET provides advice on government priority areas for general practice training. The most recent SoE, issued in August 2009, sets out the Australian Government's main strategic priority areas for GPET as:

- Indigenous health training (IHT);
- innovation in general practice education and training;
- increasing the attractiveness of general practice as a career; and
- streamlined accreditation arrangements.

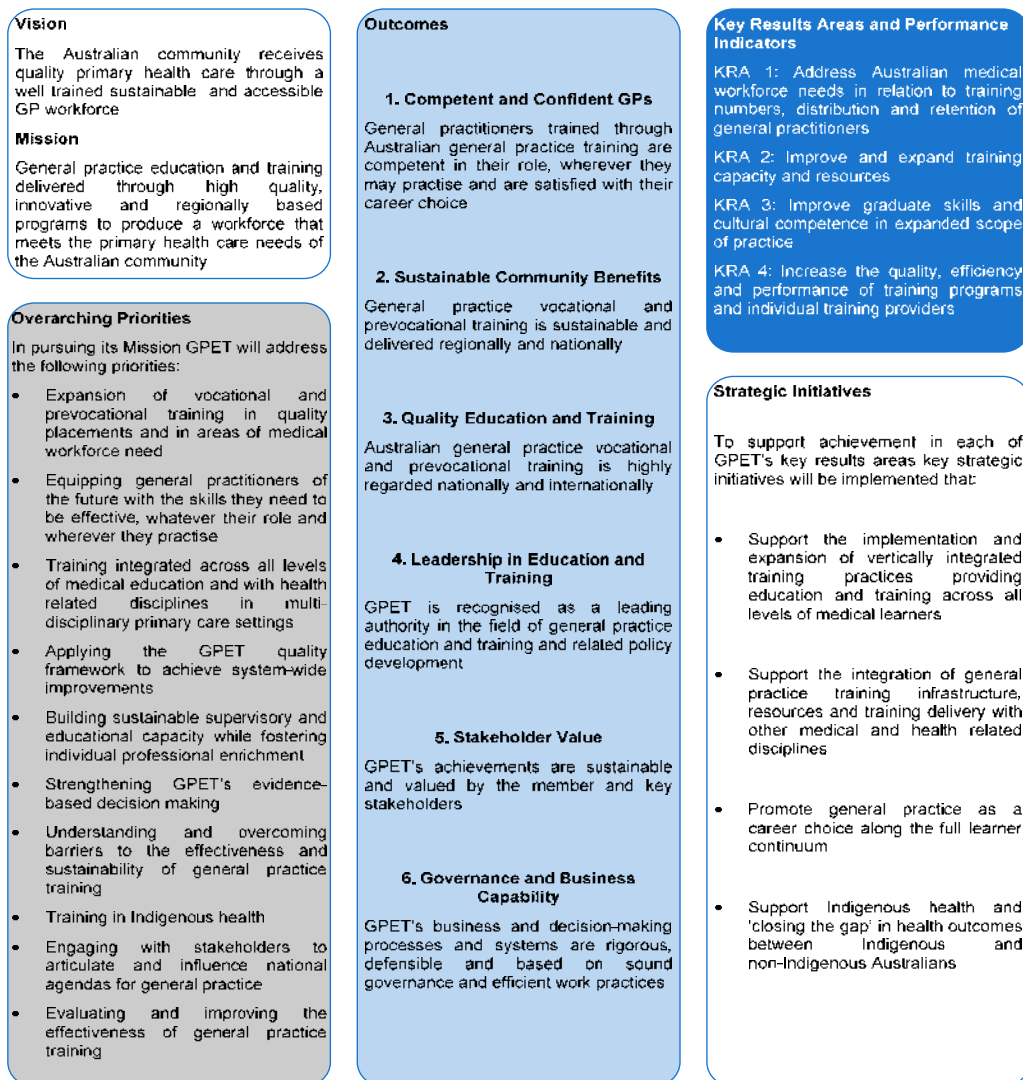
**2.20** GPET responded to the Minister in October 2009 in its SoI outlining how it would act on the Government's priorities.

## **GPET's Strategic Plan 2010–13**

**2.21** GPET's multi-year, strategic plans are succinct documents that outline in one page GPET's perspectives on its goals and strategic directions, business context, operating priorities and intended strategic results. GPET's current strategic plan (Strategic Plan 2010–13) is reproduced in Figure 2.2.

**Figure 2.2**

## GPET Strategic Plan 2010–2013



Source: ANAO depiction of GPET document.

## GPET's Portfolio Budget Statement 2010–11

**2.22** GPET's Portfolio Budget Statements (PBS) for 2010–11 in the Health and Ageing Portfolio Budget Statements 2010–11, outline GPET's objectives and purpose as: overseeing and funding high-quality education and training for medical graduates seeking to become GPs; managing AGPT; and managing PGPPP.

**2.23** The PBS for 2010–11 gives prominence to improving quality and access to primary care, stating that GPET is to focus on improving access to primary care by ensuring that the distribution of education and training supports communities experiencing workforce shortages, thereby seeking to ensure that training and education is responsive to the needs of the community.

## Clarity of purpose and objectives

**2.24** Clarity of purpose and objectives provides a sound basis for articulating and communicating entity plans and deciding on priorities. It also provides the basis for establishing performance indicators and related targets for monitoring progress.

**2.25** The ANAO examined the description of GPET's purpose and objectives included in its high-level guiding documents—GPET's 2001 Constitution, Strategic Plan 2010–13, and GPET's PBS for 2010–11.<sup>39</sup> The results of this analysis are depicted in Table 2.1.

**Table 2.1**

### Comparison of GPET's stated purpose and objectives

| GPET purpose or objective                         | GPET's 2001 Constitution | Strategic Plan 2010–13 | PBS 2010–11 |
|---|--------------------------|------------------------|-------------|
| Provide quality education and vocational training | ✓                        | ✓                      | ✓           |
| Meet workforce needs                              | ×                        | ✓                      | ×           |
| Meet community health care needs                  | ✓                        | ✓                      | ×           |
| Meet workforce shortage                           | ×                        | ×                      | ✓           |
| Provide prevocational training                    | ×                        | ✓                      | ✓           |

✓: purpose or objective included;      ×: not included

Source: ANAO analysis of GPET documents.

**2.26** As illustrated in Table 2.1, GPET's high-level guiding documents communicate different points of emphasis for GPET's purpose and main objectives, with varying degrees of attention to education, meeting community and workforce needs and meeting workforce shortages.

<sup>39</sup> Table 2.1 does not refer to the Minister's Statement of Expectations or GPET's Statement of Intent. The SoE focuses on the Minister's strategic and operational priorities for GPET in the long and short term—it was not designed to be a statement of GPET's overall purpose.

**2.27** Although GPET's activities were broadly consistent with the objects of its 2001 Constitution, GPET's 2001 Constitution had remained the same as when GPET was established in 2001 and the stated objects of the company had become outdated, with expressions of GPET's role and coverage of operations not reflective of current approaches. For instance, one of the company objects dealt with *establishing* the framework for vocational training. The Constitution of 2001 also did not refer to the prevocational training responsibilities that GPET assumed in 2010, PGPPP.

**2.28** An ongoing objective for GPET is to meet community health care needs. However, there was no definition in the 2001 Constitution of 'community needs'—a key term in GPET's objects. For example, 'community needs' in the context of GP training could be taken to mean the needs of the community in relation to health, including special health needs (such as those faced by Indigenous people and the aged); as well as the special needs of particular communities relevant to their location (such as those in remote locations).

**2.29** A central rationale for ensuring the clarity of purpose and objectives is to assist an entity to articulate and communicate its vision and objectives, and to monitor whether planned actions to achieve them are working. The major benefits for GPET in ensuring consistency and alignment of its purpose and objectives would include: a common language to articulate and communicate GPET's direction to external stakeholders; a shared understanding of the activities planned to deliver the objectives; and a dialogue within GPET about its objectives and stakeholder expectations.

**2.30** During 2010, GPET and DoHA undertook a review of GPET's 2001 Constitution in order to reflect better GPET's current operating environment, including considering changes dealing with the objects of the company. The amended GPET Constitution was approved by the company Member (the Minister for Health and Ageing) on 21 December 2010 and lodged with the Australian Securities and Investments Commission on 4 January 2011. The Amended Constitution deals with some of the issues highlighted above, most significantly, updating statements of GPET's role and coverage of operations.

## High-level strategies

**2.31** Strategic management is the systematic process of analysis by which an entity aligns itself to its purpose and makes decisions about the most appropriate options, or strategies, for achieving its objectives. If entity



strategies are not properly focused, the organisational directions and priorities may have a poor relationship to factors that are important to achieving desired objectives, and to matters that are critical to responsibility and accountability.

**2.32** The specific purpose of determining high-level strategies is to focus entity attention on its priorities in order to make sure that the defined objectives are achieved within pre-determined timeframes. As such, strategies assist an entity to decide which activities need to be undertaken first and how to prioritise the use of resources.

### **GPET's strategic direction and priorities: 2009 and 2010**

**2.33** The ANAO examined the stated strategic directions and priorities for GPET for 2009 and 2010, comparing particular strategic priority, policy and key result areas for these two periods, as identified in GPET's high-level guidance documents.

**2.34** The high-level documents reviewed were:

- GPET 2001 Constitution, executed 2001;
- GPET Corporate Governance Framework, last revised 2008;
- Strategic Plans 2008–10 and 2010–13;
- Business Plans 2009–10 and 2010–11;
- Statement of Expectations issued by the Minister for Health and Ageing August 2009;
- Statement of Intent, issued September 2009; and
- Portfolio Budget Statements 2009–2010 and 2010–11.

**2.35** Although GPET's strategic directions and priorities could be expected to change over time, GPET's planning, reporting and communication should allow stakeholders to track different points of emphasis. Such transparency requires the use of clear and consistent terms.

**2.36** In comparing GPET's stated strategies and priorities, very few of the key terms used in the high-level guiding documents are explained. As a result, the meanings of the terms can only be surmised, based on the context in which the terms are used. For example, although the meaning of terms such as 'high quality of GP training', 'innovation', 'Indigenous Health Training' and 'PGPPP' might be able to be deduced by the general reader with some degree of confidence, the meaning of terms such as 'training addressing community needs', 'addressing workforce needs' and 'addressing workforce shortage' and

the relationship between these terms are less clear. GPET has advised the ANAO that it is guided by the analysis of the Australian Medical Workforce Advisory Committee when considering the latter terms but their meanings often differ, depending on their particular context.<sup>40</sup>

**2.37** Underpinning its analysis, depicted in Figure 2.3, the ANAO used the following explanations of the terms and the relationships between them:

- training addressing community need—training of GPs that addresses the health needs of the community. These health needs would reflect the health status of the community, including taking account of, for example, demographics such as the representation of the aged and Indigenous people;
- training addressing workforce need—training addressing the needs of GPs (that is, meeting the needs of trainees undertaking PGPPP and AGPT and the current and future needs of GPs, when qualified). Matters connected with this training might relate to issues of:
  - trainee numbers;
  - skills (for example, medical training and issues in personal and professional maintenance and sustainability); and
  - support (for example, other medical workforce participants such as other complementary professionals including practice nurses to assist GPs; non-monetary rewards and recognition, and monetary support).
- workforce shortage—the gap between the workforce needed to deal with community health needs (workforce demand) and workforce supply (provided via the health workforce including GP registrars and GPs).<sup>41</sup>

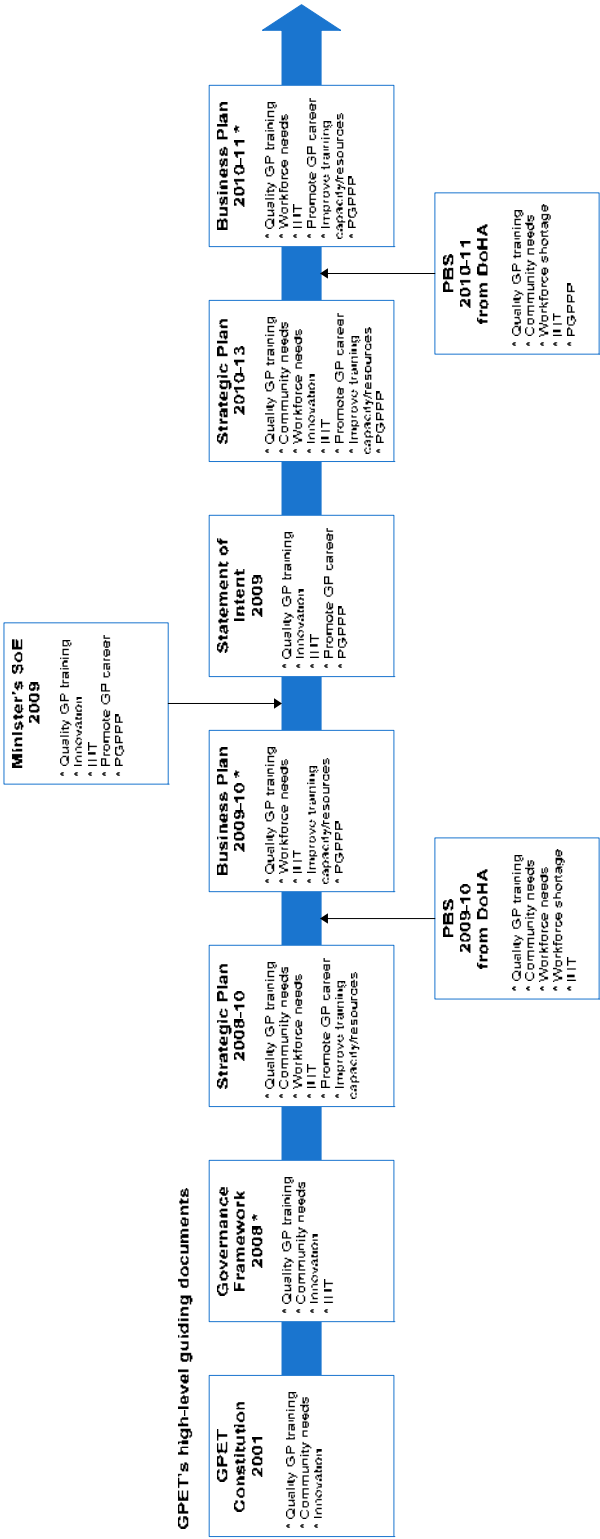
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<sup>40</sup> The Australian Medical Workforce Advisory Committee, (which, as noted in Chapter 3, provides core material for GPET's analysis of training places) does not use the term 'workforce shortage' or 'workforce need', using instead the terminology 'workforce requirements', 'workforce supply' and 'workforce balance'. See *The General Practice Workforce in Australia – Supply and Requirements to 2013*, AMWAC Report 2005.

<sup>41</sup> DoHA defines a 'district of workforce shortage' as 'a geographical area in which the population's need for healthcare has not been met'. DoHA deems such needs not to be met if a district has less access to medical services than the national average. Accordingly, DoHA deems an area to be a 'district of workforce shortage' if it falls below the national average for the provision of medical services of the relevant type.

Figure 2.3

Strategies and priorities<sup>42</sup> for GPET in high-level guiding documents: 2009 and 2010



Note: \* denotes a document not released publicly.

Source: ANAO analysis of GPET documents.

<sup>42</sup> The ANAO's listing of priority topic areas in Figure 2.3, while comprehensive, is not exhaustive.

**2.38** As illustrated in Figure 2.3, the strategies are listed in different ways and are not represented consistently across GPET's overarching governance documents. The only GPET strategy represented in all the documents presented in the analysis was the provision of high-quality GP training.

**2.39** In comparing GPET's strategic direction and priorities in 2009 and 2010, an important consideration is the influence of the SoE issued by the Minister for Health and Ageing in August 2009.

**2.40** Because the Minister's SoE provides advice on government priority areas for GP training and the Minister is the sole member of the company, it is important that GPET has appropriate processes to achieve the Minister's priorities. More specifically, it is important that the priorities as set out in the SoE are adequately reflected by the Strategic Plan 2010–2013 to ensure GPET is effectively working towards the government's key priority areas.

**2.41** Figure 2.3 illustrates that GPET's recently updated documents, for example its Strategic Plan 2010–13, encompass more explicitly and more prominently the Minister's priority areas, such as innovation. This is a positive sign that GPET is obtaining a greater measure of consistency in specifying its important strategic areas across its high-level guiding documents.<sup>43</sup>

**2.42** There remains scope, however, for GPET to improve the clarity of expression and the alignment of important strategies. GPET has a range of strategic directions and priorities that are articulated in both external and internal publications. Analysis of GPET's guiding documentation highlights that if GPET were to set out more explicitly and more consistently its strategies and priorities, it would be better placed to articulate clearly, consistently and publicly a shared understanding of what is supposed to be achieved over time in order for GPET to demonstrate that it is on track to realise its objectives (for example, dealing with issues of health workforce shortage).

**2.43** Improving the alignment between stated strategies and priority areas would also assist in obtaining a clear 'line of sight' between the strategies articulated at the enterprise level, key performance indicators, and targets, so

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<sup>43</sup> In the context of giving clearer priority to the Minister's highest SoE priority areas, the ANAO notes that GPET's Strategic Plan 2010–13 and Business Plan 2010–11 list Indigenous Health Training as a higher priority than previously.

that they are consistent with the overall purpose of the entity. The following section deals with GPET's Key Result Areas and performance indicators.

## Alignment of GPET's Key Result Areas and associated performance indicators for 2010–13

**2.44** Agencies that are part of the General Government Sector, including GPET, are required to follow Department of Finance and Deregulation guidance for the preparation of Portfolio Budget Statements—particularly when determining whether new programs, or changes to existing programs, are necessary.<sup>44</sup>

**2.45** The ANAO examined the performance indicators provided in GPET's Strategic Plan 2010–13 and the performance indicators set out in GPET's PBS 2010–11. The results of this analysis are summarised in Table 2.2.

**Table 2.2**

### Comparison of GPET's performance indicators

| GPET's four key result areas and performance indicators as provided in its Strategic Plan 2010–13              | GPET's three major activities and key performance indicators as provided in its PBS for 2010–11 |
|--|---|
| Address Australian medical workforce needs in relation to training, numbers, distribution and retention of GPs | The uptake of available entry training places for vocational training                           |
| Improve and expand training capacity and resources   | Uptake of training time in IHT posts  |
| Improve graduate skills and cultural competence in expanded scope of practice                                  | Uptake of minimum available entry places for prevocational training                             |
| Increase the quality, efficiency and performance of training programs and individual training providers        |   |

Source: ANAO analysis of GPET documents.

**2.46** As illustrated in Table 2.2, GPET's four Key Result Areas and associated performance indicators, as presented in its Strategic Plan 2010–13, do not correspond with GPET's three Major Activities and associated key performance indicators, provided in its PBS 2010–11. This lack of alignment between strategic, public documents affects the way performance expectations are expressed and, potentially, how future performance will be reported. It also bears on the extent to which GPET can clearly communicate to its stakeholders.

<sup>44</sup> However, as noted earlier, as a wholly owned Commonwealth company, GPET is not required to present information in its Annual Reports that is consistent with its PBS.

## Recommendation No.1

**2.47** To improve GPET's ability to communicate consistently and clearly with external stakeholders, the ANAO recommends that GPET articulates its purpose, objectives, strategies and associated priorities and performance indicators consistently in its high-level corporate guidance material and plans, including through clearer linkages between GPET's Strategic Plans and the Health and Ageing Portfolio Budget Statements.

### GPET response

**2.48** Agreed. A review of GPET's Company Constitution was undertaken during 2010 and a revised and updated Constitution was approved by the Member on 21 December 2010 and lodged with the Australian Securities and Investments Commission on 4 January 2011. The Objects in the new Constitution reflect GPET's current and anticipated future roles and provide for the annual Directors' report of the Company to include a report in relation to the Company's performance against the relevant key performance indicators set out in the Health and Ageing Portfolio Budget Statements. GPET has also commenced a review of its Corporate Governance Framework in the light of changes to its Constitution and to ensure the Framework reflects current best practice. GPET's annual strategic review in March 2011 will review the strategic plan in the light of changes to the Company's business environment and the Constitution.

## Performance information and reporting

**2.49** Performance information is quantitative or qualitative evidence about performance that is collected and used systematically to assist management decision-making and reporting on an entity's achievements.

**2.50** Reflecting the Australian Standard AS 8000–2300 *Good Governance Principles*, good governance requires regular monitoring and evaluation of performance and the reporting of results to meet the disclosure and transparency obligations of government entities and to support continuous improvement.

**2.51** The ANAO assessed how GPET planned, assessed and reported its performance for the period 2008–10. The ANAO examined GPET's key performance indicators (KPIs) as stated in its Strategic Plan 2008-10; and actual performance as reported in the corresponding Annual Report (GPET Annual Report to 30 June 2009). With the release of the GPET Annual Report to

30 June 2010 in the latter part of 2010, the ANAO was also able to review this performance reporting document.

## GPET's key performance indicators: 2008–10 and 2010–13

**2.52** GPET's Strategic Plan 2008–10 focused on GPET's delivery of AGPT. The plan contains four strategic aims. GPET formulated and used KPIs to assess its progress in meeting these strategic aims. These aims and KPIs are summarised in Table 2.3.

**Table 2.3**

### GPET's strategic aims and key performance indicators: 2008–10

| Strategic aims for 2008–10  | Key performance indicators in GPET Business Plan 2009–10  |
|---|---|
| 1. Address Australian medical workforce needs in relation to training, numbers, distribution and retention of GPs | 1.1 Australian medical graduates applying for AGPT  |
|   | 1.2 Registrars training in specific RRMA or ASGC-RA categories of locations (that is, categories of locations reflecting remoteness and population density)   |
|   | 1.3 AGPT graduates retained in general practice   |
|   | 1.4 AGPT graduates retained in their RTP or similar region  |
| 2. Increase training capacity   | 2.1 Ratio of new to lapsing training practices  |
|   | 2.2 Registrars involved in training or teaching within AGPT   |
| 3. Improve graduate skills in expanded scope of practice  | 3.1 Registrars undertaking procedural and/or special skills training  |
|   | 3.2 Registrars undertaking Indigenous health training in an Aboriginal Medical Service  |
| 4. Increase the efficiency and performance of AGPT and individual regional training providers                     | 4.1 Increase in AGPT and individual RTP performance against benchmarks established for: <ul style="list-style-type: none"> <li>• intake quotas;</li> <li>• cost-efficiency;</li> <li>• examination pass rates;</li> <li>• registrar satisfaction;</li> <li>• registrar completion rates; and</li> <li>• registrar retention.</li> </ul> |

Note: 'RRMA' is Rural Remote Metropolitan Areas. 'ASGC-RA' is Australian Standard Geographical Classification – Remoteness Areas.<sup>45</sup>

Source: GPET.

<sup>45</sup> ASGC-RA was developed by the Australian Bureau of Statistics as a statistical geography structure allowing quantitative comparisons between 'city' and 'country' Australia. As part of the 2009–10 Budget, the Government determined that from 1 July 2010, in managing AGPT, GPET should change from using the required RRMA classification to that of ASGC-RA, resulting in some changes to locations covered by the general and rural pathways, but aligning rural classifications with a range of other rural workforce and incentive programs operated by DoHA.

**2.53** GPET's Strategic Plan for 2010–13 labels the strategic aims from its previous strategic plan as 'key result areas' without significant change, except for some additional emphasis on the quality of skills and training, integrated training and cultural competence. The plan recognises GPET's additional responsibility for PGPPP from 1 January 2010, which is reflected in the new and amended KPIs outlined in GPET's Business Plan 2010–11.

### **Use of targets and benchmarks**

**2.54** GPET's KPIs are aligned with its strategic aims for the periods 2008–10 and 2010–13 and GPET has set targets during its business planning processes for 2009–10 and 2010–11, as data permits, for some of these KPIs, for internal performance assessment processes.

**2.55** GPET advised that to set some targets it needs benchmark data that it currently cannot obtain. An example of such data is that on GP retention rates. This matter is considered in Chapter 3.

**2.56** Setting benchmarks and targets allows GPET to express quantifiable performance levels or changes of level to be attained at a future date. Currently, GPET uses internal benchmarks and targets to provide the basis for performance assessment.

**2.57** If such targets and performance results were made public, they could also facilitate accountability, for example by allowing Parliament to assess whether GPET was delivering what it set out to achieve.

### **Performance reporting: GPET's 2009 Annual Report**

**2.58** As indicated previously, GPET's Business Plan 2009–2010 prescribes a set of KPIs. The ANAO's analysis of GPET's reported performance at 30 June 2009 against these indicators is summarised in Table 2.4.<sup>46</sup>

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<sup>46</sup> The Corporations Act and the CAC Act specify requirements of GPET regarding the content and handling of GPET's financial and directors' reports each year. The content and handling of GPET's Annual Report 2009 complied with legislative requirements.



**Table 2.4****GPET's reporting against key performance indicators: 2009**

| Key performance indicators  | Results reported in GPET's 2009 Annual Report  |
|---|--|
| 1.1 Australian medical graduates applying for AGPT  | Increasing trend in absolute numbers of applicants but no reference to the proportion of AMGs applying—either in relation to graduates or total applications.  |
| 1.2 Registrars training in specific RRMA or ASGC-RA categories of locations (that is, categories of locations reflecting remoteness and population density)   | Increasing trend with reference to absolute numbers of training activity   |
| 1.3 AGPT graduates retained in general practice   | One-off statistics showing AGPT graduates still actively claiming Medicare and their location of activity (particularly highlighting rural and remote locations) as at 2008  |
| 1.4 AGPT graduates retained in their RTP or similar region  | One-off statistic showing AGPT graduates still remaining in the region in which they trained, and actively claiming Medicare as at 2008  |
| 2.1 Ratio of new to lapsing training practices  | Increasing trend in absolute numbers of training practices   |
| 2.2 Registrars involved in training or teaching within AGPT   | Increasing trend in absolute numbers of supervisors  |
| 3.1 Registrars undertaking procedural and/or special skills training  | Fluctuating trend, but overall increase in absolute numbers of registrars undertaking procedural and/or special skills training—however, proportionally there has been a decrease in such training   |
| 3.2 Registrars undertaking Indigenous health training in an Aboriginal Medical Service  | Increasing trend in absolute numbers of registrars undertaking training in an Aboriginal Medical Service, however the proportion of registrars doing this is steady  |
| 4.1 Increase in AGPT and individual RTP performance against benchmarks established for: <ul style="list-style-type: none"> <li>• intake quotas;</li> <li>• cost-efficiency;</li> <li>• examination pass rates;</li> <li>• registrar satisfaction;</li> <li>• registrar completion rates;</li> <li>• registrar retention.</li> </ul> | Analytical tools to assess RTP management under development. Performance information provided for: cost-efficiency (in broad terms an increase in cost per FTE training week shows a declining cost efficiency); exams (variable pass rates); registrar satisfaction (high but variable) |

Source: ANAO analysis of GPET data.

**2.59** In reporting its performance in its Annual Report to 30 June 2009, GPET aligns its activity in the period to the four strategic aims in its Strategic Plan 2008–2010. This is a useful way to illustrate the higher level purposes of GPET's activity, and the indicators are useful dimensions of performance.

**2.60** The reported results highlight a positive picture of GPET's performance (for example, in the numbers of applicants, GP registrar satisfaction survey results and the presence of GP registrars in rural and remote areas) and in terms of trends over time.

**2.61** While recognising this positive picture, the scope to assess GPET's publicly reported performance is limited because GPET does not include targets or benchmarks for its activities in the annual report. GPET's ability to publicly report its performance could be enhanced by GPET making clear its performance targets. Where data permits, the inclusion of public performance targets along with the data on activity would allow the reader to appreciate results against expectations.

**2.62** For example, as well as knowing that 83 per cent of GP registrars who responded to GPET's registrar satisfaction survey in 2008 considered that they were satisfied or very satisfied with the training received (the comparable result being 94 per cent in 2007 and 94 per cent in 2006), it would be helpful to know the performance target and therefore a standard by which to judge GPET's performance.<sup>47</sup>

**2.63** As highlighted in Table 2.4, GPET's 2009 Annual Report often reported absolute numbers to outline its performance against its KPIs. This approach is valid when considering the absolute increases in 'services' or 'activities' provided by GPET (such as training opportunities for Australian medical graduates, the provision of medical services to people in particular regions—such as rural and remote regions—or the numbers of registrars undertaking an IHT post in their training). However, there is merit in GPET reporting its *relative* performance in respect of these indicators, that is, demonstrating how successful GPET has been in meeting its aims relative to the general trend in training and location of GP registrars. GPET did this to some extent in reporting its performance in the 2010 Annual Report, examined below.

## **Performance reporting: GPET's 2010 Annual Report**

**2.64** GPET's Annual Report to 30 June 2010 reported against its Strategic Plan for 2010–13 and the KPIs in the 2010–11 Business Plan, rather than against the 2008–10 Strategic Plan and associated KPIs so that it could reflect the additional responsibilities gained in 2010 (namely PGPPP). The ANAO's analysis of GPET's reporting performance at 30 June 2010 against these KPIs is summarised in Table 2.5.

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<sup>47</sup> The GP registrar satisfaction survey results are examined in Chapter 5, as part of assessing GPET's engagement with stakeholders.

Table 2.5

**GPET's reporting against key performance indicators: 2010**

| Key performance indicators  | Results reported in GPET's 2010 Annual Report   |
|---|---|
| 1.1 Australian medical graduates applying for AGPT  | Increasing trend in absolute numbers of applicants. 28% of Australian medical graduates applied for AGPT—1% below target  |
| 1.2 Placements filled in PGPPP  | Refers to transfer of responsibilities in January 2010. No reference to placements filled   |
| 1.3 Registrars and PGPPP doctors training in specific RRMA or ASGC-RA categories of locations (that is categories of locations reflecting remoteness and population density)  | Reports in terms of training activity in 2009, not registrar numbers. States that activity in areas other than RA1 was greater than 50%   |
| 1.4 PGPPP doctors entering general practice training  | No reference to PGPPP doctors entering general practice training  |
| 1.5 AGPT graduates retained in general practice   | No reference to retention of AGPT graduates in general practice   |
| 1.6 AGPT graduates retained in their RTP or similar region  | No reference to retention of AGPT graduates in their regions  |
| 2.1 Ratio of new to lapsing training practices  | Increasing trend in absolute numbers of training practices, but ratio of registrars to practices has remained the same  |
| 2.2 Registrars involved in training or teaching within AGPT or PGPPP  | Increasing trend in absolute numbers of supervisors   |
| 2.3 Practices delivering vertically integrated training and education   | Reported the establishment of a new Training Capacity and Resources Group in GPET in June 2010, to oversee vertical educational integration. No reference to practices delivering vertically integrated training and education                            |
| 2.4 Integrated training practice accreditation model  | No reference to model   |
| 3.1 Registrars undertaking procedural and/or special skills training  | Decreasing trend in absolute numbers of registrars undertaking procedural and/or special skills training. Also reported a fall in the proportion of registrars undertaking such training  |
| 3.2 Registrars undertaking Indigenous health training in an Aboriginal Medical Service  | Increasing trend in absolute numbers of registrars undertaking training in an Aboriginal Medical Service. No reference to the proportion of registrars doing this   |
| 3.3 Cultural awareness training   | Reported investment in professional development of cultural educators and mentors and 2 workshops in 2009–10 for registrars and one for educators   |
| 4.1 Increase in PGPPP and AGPT and individual RTP performance against benchmarks established for: <ul style="list-style-type: none"> <li>• intake quotas and placements;</li> <li>• cost-efficiency;</li> <li>• quality;</li> <li>• satisfaction;</li> <li>• completion rates;</li> <li>• retention.</li> </ul> | Analytical tools to assess RTP management further developed and refined. Performance information provided for: cost-efficiency (an increase in cost per FTE training week shows a decline in cost efficiency); registrar satisfaction (high but variable) |

Source: ANAO analysis of GPET data.

**2.65** In its 2010 Annual Report, GPET appropriately aligned its activity in the period to the four strategic aims in its Strategic Plan—the more recent Strategic Plan 2010–13.

**2.66** GPET's performance reporting in its 2010 Annual Report improves<sup>48</sup> on the approach used in 2009 in some areas. Improvements include the report specifying some targets and referring not only to absolute numbers, but also to performance against the relevant grouping or concept. Examples include performance results such as the *proportion* of the Australian medical graduate cohort applying for AGPT, not just the number of Australian medical graduates applying for AGPT, and the *proportion* of all GP registrars undertaking procedural and or special skills training, not just the number of GP registrars undertaking such skills training.

**2.67** GPET continues to report absolute numbers in assessing its performance with regard to registrar involvement in IHT, specifically KPI 3.2 'Registrars undertaking Indigenous health training in an Aboriginal Medical Service'—that is, an IHT post. GPET uses this KPI to report performance against GPET's KRA 3 'Improve graduate skills and cultural competence in expanded scope of practice'.

**2.68** GPET's KPI 3.2 counts the number of GP registrars undertaking an IHT post rather than the amount of training effort. Measuring both the number of people and the amount of training effort can be useful (GPET's PBS 2010–11 counts training effort rather than the number of people), but both indicators presuppose an agreed and appropriate definition of an IHT post in the context of GP registrar training. During 2010 GPET was working with stakeholders to determine an agreed, appropriate definition of IHT and what constitutes an IHT post and to make progress towards a common college curriculum for IHT. IHT is examined in Chapter 3.

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<sup>48</sup> GPET could enhance the transparent disclosure of its performance in future reports by: providing the reader with explanations or context for the performance outcomes such as the decreasing trend in absolute numbers of registrars undertaking procedural or special skills training; explaining why some KPIs are not reported in the 2010 report and why some of the KPIs used in the 2010 report differ from those used in the previous Annual Report, making it more difficult for readers to appreciate performance trends over time; and revising (mostly to only a minor degree) data reported in the earlier Annual Report, but without any disclosure note or reason. GPET advised the ANAO that data revisions in the 2010 Report stemmed from the correction of historical data errors and estimation errors arising from timing differences due to the need to publish the Annual Report before the training year is completed (and actuals are known).

## Risk management

**2.69** Managing risk involves systematically identifying, analysing and mitigating risks which could prevent an entity from achieving its business objectives. Risk management includes putting control activities in place throughout the organisation by developing risk management and fraud plans. The ANAO assessed whether GPET had a structured and systematic approach to risk management.

**2.70** The ANAO's analysis is outlined in Table 2.6.

**Table 2.6**

### GPET's Risk Management Plan for 2009–10

| Required elements                         | Incorporated | ANAO comment   |
|---|--------------|--|
| <b>Risk identification and assessment</b> | ✓            | Internal and external risks to the achievement of the GPET's goals were identified and assessed. |
| <b>Risk treatment</b>                     | ✓            | Control activities were implemented to minimise the identified risks.                            |
| <b>Risk monitoring</b>                    | ✓            | Ongoing assurance activities were scheduled for management review.                               |

Source: ANAO analysis of GPET's risk management documentation.

**2.71** GPET's Risk Management Plan 2009–10 is a comprehensive document giving consideration to relevant major categories of risk to GPET's operations and identifying the person responsible for managing each risk.

**2.72** At the operational level, GPET documents a well-constructed risk management approach for each of its centrally managed programs in its annual program budget templates, such as Program Budget Templates on Regional Training Providers, Review and Accreditation and AGPT Selection. Performance of these programs, including with regard to risks, is reported to the Board in GPET's Quarterly Program Performance Reports.

**2.73** Risk management is especially important for a small, dynamic organisation such as GPET that relies on contractual relations with RTPs to deliver services on its behalf, across Australia. Against this background, the ANAO assessed GPET's approach to managing its funding, procurement, and contracting risks associated with its:

- funding agreements with DoHA; and
- contracts with Regional Training Providers.

## Funding Agreements with DoHA

2.74 GPET's Funding Agreements with DoHA for 2007–09 and 2010–12 provided a sound basis for managing funding risks. The agreements were clear and comprehensive in setting out:

- the purpose of the funding;
- the expectations of the parties; and
- the roles and responsibilities of the parties.

2.75 The documents referred to key deliverables, reporting arrangements, financial arrangements, and management items such as conflict of interest requirements. The DoHA GPET Funding Agreement is examined in greater detail in Chapter 3.

## Policies on procurement and contracting with Regional Training Providers

2.76 GPET contracts with RTPs across Australia to deliver its general practice training and education programs to GP registrars and junior doctors. In early 2010, there were 17 RTPs delivering GPET training at specific geographical locations.

2.77 As a wholly owned Commonwealth company, GPET is not required to comply with the Commonwealth Procurement Guidelines (CPGs).<sup>49</sup> However, GPET's procurement policy states that GPET should have regard to the CPGs as best practice.

2.78 To secure value for money, the CPGs focus on competitive procurement processes. This intent was also enunciated in GPET's 2001 Constitution. The company objects in the 2001 Constitution at s 3.1 required, among other things, that GPET ensured value for money in the provision of vocational training and established a national framework for the regionalisation and contestability of vocational training for GPs.

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<sup>49</sup> GPET is not bound directly by the *Commonwealth Procurement Guidelines 2005*. CAC bodies are only bound by the CPGs if a specific direction has been given by the Minister for Finance under section 47A of the *Commonwealth Authorities and Companies Act 1997*. A direction can only be given to those entities appearing in the Schedule to the *Commonwealth Authorities and Companies Regulations 1997*. GPET is not listed in the Schedule.

**2.79** In addition, Clause 3(a) of Schedule 2 of GPET's 2001 Constitution<sup>50</sup> required GPET, in contracting providers, to first conduct a competitive tender process adhering to the principles in the CPGs and to select providers on the basis of those offering the best value for money.

**2.80** In accordance with this requirement, GPET's initial RTP contracts and the 2007-09 contracts were the result of a competitive tender process. However, GPET did not use an open tender round for the 2010–12 triennium and, instead, GPET built on the existing contractual relationships without a tender process. GPET obtained legal advice in 2008 which indicated that its preferred approach for the 2010–12 triennium, to contract directly with existing RTPs without a tender process, could be supported as a responsible and prudent strategy.

**2.81** Despite the provisions of Clause 3(a), direct contracting was considered by GPET's legal advisers to be allowable because the requirement to test the market had already been satisfied by the previous two tender processes; and the current CPGs (clause 8.65d) allow direct sourcing when there are no other providers. The argument used by GPET was that not only did training providers have unique technical qualifications but there had been no new, potential training providers evident in the previous tender round—there was usually a single provider in each region.

**2.82** Consequently, GPET's approach for the 2010–12 triennium was to offer contracts with the RTPs in place at the end of 2009 and to contract with them, if appropriate, after completing review and accreditation processes designed to ensure that the providers were delivering the appropriate standards and quality of training and education services.

**2.83** GPET undertook processes to assure itself that its approach to engaging RTPs could be supported as a 'responsible and prudent strategy'<sup>51</sup> and GPET also has other supporting processes regarding the engagement of RTPs (that is,

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<sup>50</sup> The Amended Constitution removes references to the Trust Regulations previously set out in Schedule 2 of the 2001 Constitution and to the CPGs. Relevant to purchasing, the Amended Constitution contains a revised object of GPET 3.1(d) to: 'administer and deliver a program of education and training in general practice, including through engagement of providers, to ensure the programs represent best practice and value for money, and comply with acceptable standards of ethics and probity in the procurement of services, and include processes to review and deal with complaints.' See the full listing of objects later in this chapter.

<sup>51</sup> Expression used in legal advice to GPET October 2008.

review and accreditation). This approach was supported by DoHA in late 2008 when GPET raised with it the matter of processes to engage RTPs for the next triennium.

**2.84** While noting GPET's approach to procurement for the 2010–12 triennium and recognising the particular features of RTPs and the training supply model as highlighted in Chapter 1, the longer-term approach for GPET should take into consideration testing the market from time to time. GPET could use that process to provide assurance that it is obtaining value for money while also encouraging competition in the delivery of services.<sup>52</sup>

**2.85** Apart from its RTP engagement arrangements, GPET applies other processes designed to demonstrate that it is achieving value for money in its management of RTPs. GPET's contractual and reporting arrangements with RTPs are examined in Chapter 3.

## Recent developments – revised constitution

**2.86** GPET's Constitution was revised following a 2010 review of the 2001 Constitution, designed to have the Constitution better reflect GPET's current operating environment. The Amended Constitution was approved by the company's sole Member (the Minister for Health and Ageing) on 21 December 2010 and was lodged with the Australian Securities and Investments Commission in January 2011.

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<sup>52</sup> The ANAO considered issues in direct source procurement in 2010. See Report No.11 2010–11 *Direct Source Procurement*, Canberra, 2010.



**2.87** The Amended Constitution introduces a number of changes for GPET, including modifying its objects, as set out below.

The objects of the Company are to:

- a) ensure high-quality general practice education and training across Australia that is responsive to the existing and changing needs of the community and individual sections of the community;
- b) work closely with the medical profession to ensure that all GP education and training continues to meet the standards which are set by the profession's relevant colleges, and where relevant, the requirements of accreditation bodies;
- c) manage a national framework for regionalisation and contestability of GP education and training, including the funding and allocation of places and supervising the performance of providers of education and training in general practice;
- d) administer and deliver a program of education and training in general practice, including through engagement of providers, to ensure the programs represent best practice and value for money, and comply with acceptable standards of ethics and probity in the procurement of services, and include processes to review and deal with complaints;
- e) ensure that education and training in general practice is well structured and produces doctors that are capable of meeting community needs, in particular those of rural and remote Australia;
- f) promote vertical and horizontal integration of education and training at a regional level;
- g) adopt a culture of continuous improvement in the delivery of education and training in general practice;
- h) provide advice to the Minister for Health and Ageing regarding education and training in general practice; and
- i) receive and administer funding provided by the Commonwealth for the purposes of ensuring high quality education and training in general practice across Australia or for any purpose for which funding is provided by the Commonwealth.

**2.88** As well as modifying GPET's objects, the Amended Constitution also changes elements of GPET's procedural requirements. Changes include: introducing provisions for processes dealing with conflicts of interest (s 6.19) and provisions for reporting on company performance against relevant key performance indicators as set out in the Health and Ageing PBS (s 12.2 (b)); and removing references to the Trust Fund (which is no longer used).

**2.89** The Amended Constitution aligns GPET's stated objects with its current roles. It also provides a basis for GPET to clarify its directions and the alignment of strategies across key corporate documents.

### 3. GPET's Management of AGPT

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*GPET's management of the training program, Australian General Practice Training, is examined in this chapter, including how GPET reviews and reports on AGPT.*

#### Introduction

**3.1** GPET's principal activity is managing AGPT—the program of vocational education and training for medical graduates wishing to pursue a career in general practice in Australia.

**3.2** Prior to 2010, all GPET management activity, directly or indirectly, related to AGPT. From 2010, GPET also manages PGPPP. In 2010, GPET's agreed funding for AGPT was \$114.3 million (some 84 per cent of total program funding), and the remainder relates to PGPPP, which is examined in Chapter 4.

**3.3** AGPT is delivered via a network of RTPs across Australia. In examining how well GPET delivers and reviews AGPT, the ANAO:

- considered the elements of AGPT;
- considered whether GPET had effective procedures to support and manage program delivery; and
- examined GPET's program performance monitoring and reporting—specifically relating to the quality of services provided and the degree to which the program's objectives are achieved.

#### Australian General Practice Training

**3.4** The Australian Government, represented by DoHA, provides GPET with program funds to apply to AGPT. GPET then funds the RTPs to deliver the training. GPET is responsible for managing and marketing AGPT, as well as the selection process applicants follow to enter the program.

**3.5** Applicants for AGPT elect to train in either a general<sup>53</sup> pathway or a rural<sup>54</sup> pathway. The two relevant professional colleges, RACGP and ACRRM, set the curricula and standards for the two training pathways as well as the assessment requirements. The colleges arrange all training, examinations and assessments. The RTPs are accredited against training quality standards jointly by the two colleges and GPET.

**3.6** AGPT involves GP registrars in a three-year full-time (or equivalent) commitment, or four years for training in rural and remote medicine, which can be reduced with recognition of prior learning. The program may be taken part-time. Training is conducted within accredited medical practices and hospitals and is supervised and assessed by experienced medical educators. The training includes self-directed learning, regular face-to-face educational activities and in-practice education.

**3.7** The RTPs deliver training towards two GP vocational qualifications recognised by Medicare Australia<sup>55</sup>: fellowship of ACRRM; and/or fellowship of RACGP. Rural RTPs also deliver training towards the RACGP's Fellowship in Advanced Rural General Practice.

## Training places

**3.8** The Australian Government places a quota on the number of new AGPT positions it funds through GPET each year. Entry into the program is therefore competitive. The 2009–10 Budget announced an expansion of the program over future years with 675 entry training positions funded for prospective GP registrars in 2009, and 700 entry training places for 2010. The annual quota since 2004 had been 600 entry training places. The 2010–11

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<sup>53</sup> The general pathway is for doctors who wish to train in urban areas. After consultation with the Minister and DoHA, GPET amended AGPT rules around training pathway structures so that, from 1 January 2010, general pathway registrars undertake a minimum of 12 months training in a rural and/or outer metropolitan location.

<sup>54</sup> The rural pathway is designed for doctors who wish to undertake the majority of their training in rural and remote areas of Australia. From 2010 the Minister requires GPET to ensure that a minimum of 50 per cent of GP registrars train in rural pathway locations. Accordingly, the DoHA GPET Funding Agreement 2010–12 requires GPET to manage the distribution of GP registrars so that 50 per cent of registrar training activity occurs in such locations.

<sup>55</sup> As noted in Chapter 1, the training programs offered by RTPs are recognised training placements for Medicare purposes. Therefore medical services provided by GP registrars while on AGPT can also attract Medicare benefits.

Budget further provided for ‘stepped’ increases in the number of funded entry training to 1200 places by 2014. This is detailed in Table 3.1.

**Table 3.1**

**AGPT annual intake of funded places**

|                                  | 2010<br>Training<br>year | 2011<br>Training<br>year | 2012<br>Training<br>year | 2013<br>Training<br>year | 2014<br>Training<br>year |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Budgeted annual intake of places | 700                      | 900                      | 1000                     | 1100                     | 1200                     |

Source: Portfolio Budget Statements 2010–11, Health and Ageing Portfolio, p. 655.

**3.9** GPET reports that there were 2489 GP registrars enrolled in AGPT in the 2009 training year, compared to 1929 GP registrars in 2005, the training year in which AGPT first reached its full complement (three program intakes).<sup>56</sup> Table 3.2 details, for each training year from 2005 to 2009, the entry training places, total enrolled GP registrars and the number of AGPT participants who have successfully completed training and all assessment and who are therefore eligible for fellowship (that is, vocational recognition as GPs).

**Table 3.2**

**AGPT annual funded entry places, total enrolments and completions**

|   | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|------|------|------|------|------|
| Annual funded entry places  | 600  | 600  | 600  | 600  | 675  |
| Total enrolled GP registrars  | 1929 | 2047 | 2188 | 2315 | 2489 |
| GP registrars who completed AGPT and became eligible for fellowship | 383  | 397  | 397  | 434  | 447  |

Source: GPET.

**3.10** According to the 2009–10 PBS, AGPT funding from government totalled \$85 million in 2008–09 and was budgeted to total approximately \$91 million in 2009–10. Estimated actual funding for AGPT in 2009–10 was \$113.6 million as reported in the 2010–11 PBS and is budgeted to total approximately \$151 million in 2010–11.

<sup>56</sup> A training year is broadly aligned with a calendar year, covering a period commencing in January of one year and finishing in January of the next.

**3.11** In addition to this direct funding to GPET for GP training, the cost of training GP registrars also involves, among other things, the cost of Medicare Australia funding in respect of the services provided by the GP registrars while on the training program.

## **Indigenous health training**

**3.12** IHT is an important component of the general practice vocational training that GPET manages.<sup>57</sup> The Minister's Statement of Expectations of August 2009 nominated IHT as an Australian Government priority.

**3.13** GPET's IHT has two components: learning activities specific to Indigenous health training, as part of the colleges' Aboriginal health curricula for all GP registrars; and 'IHT posts' whereby GP registrars undertake general practice training placements (posts) at Aboriginal Medical Services (AMS).<sup>58</sup>

**3.14** Completion of an IHT post is not mandatory, and between 2003 and 2008 only five per cent of GP registrars per year undertook training at an AMS, rising to six per cent in 2009. Over the same period (2003 to 2009), three per cent of full-time equivalent weeks of GP training per year were undertaken in AMS.

**3.15** According to GPET's PBS 2010–11, it is intended that GP registrars undertake 3099 full-time equivalent weeks of training in IHT posts in the 2010 training year (compared to 3119 in 2009). The PBS 2010–11 projects strong growth in later years, with 3832 full-time equivalent weeks in IHT posts in 2011 (a rise of over 23 per cent on 2010), and increases of approximately 10 per cent each year for the following three years.

**3.16** In accordance with GPET's management of AGPT, RTPs have a decisive role in the delivery of IHT to GP registrars. Increasing the incidence of GP registrars undertaking an IHT post is not a straightforward objective to achieve. GPET has acted on several fronts since 2008, consistent with

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<sup>57</sup> IHT is designed to provide training to GP registrars in Aboriginal and Torres Strait Islander health matters, access to medical services for Aboriginal and Torres Strait Islander people via the GP registrar and ultimately to provide GPs with appropriate clinical and cultural skills to provide quality services for Aboriginal and Torres Strait Islander people.

<sup>58</sup> An Aboriginal Medical Service (AMS) is a generic term for a health service funded principally to provide services to Aboriginal and/or Torres Strait Islander peoples. An AMS is not necessarily community controlled, and may be a government health service operated by a state or territory government. The latter exist mainly in the Northern Territory and northern Queensland.

government priority and additional Council of Australian Governments funding to boost the numbers of GP registrars taking IHT posts. GPET's measures included:

- commissioning and evaluating in 2008 the report<sup>59</sup> of a wide-ranging evaluation of IHT from its consultants;
- responding to the evaluation, GPET established an expert advisory body to the GPET Board in 2009 (the Aboriginal and Torres Strait Islander Health Advisory Group)—to give broader recognition to Indigenous health training issues in the community than had existed previously. Three members of the Board are on the advisory body;
- developing in 2009 the Aboriginal and Torres Strait Islander Health Training Management Framework 2009–2011—devised in partnership with the advisory group, the framework aims to increase RTP and GP registrar interest in IHT posts;
- giving increased prominence to IHT in its contracts with RTPs post-2009, including requiring RTPs to report on IHT initiatives and expansion; and
- trialling measures with RTPs relating to the funding of salaries of GP registrars at AMSs to improve financial management and accountability.

**3.17** Recognising the substantial challenges involved in improving IHT performance, since September 2009 IHT has become a standing agenda item at all GPET Board meetings.

**3.18** While GPET has been responsive, IHT continues to be an area requiring concerted attention. Given its significance and its complexity, a more proactive approach could include increased attention to the:

- distribution of IHT posts in urban and non-urban locations, given the distribution of the Indigenous population;
- infrastructure constraints and inhibitors (such as housing, communications and transport infrastructure constraints); and

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<sup>59</sup> Urbis, *Evaluation of GPET's Aboriginal and Torres Strait Islander Health Training Framework*, June 2008.

- connections with other parts of the health system to address interconnected aspects of the Government's strategy to 'Close the Gap' in Indigenous opportunity and circumstance compared to that for non-Indigenous people (for example, considering other health workforce issues and other initiatives intended to improve Indigenous health).

## Effective procedures to support and manage program delivery

**3.19** The following sections assess the framework and procedures that GPET applies to manage the delivery of AGPT. The ANAO examined whether GPET had effective processes to:

- support program delivery with the funding agreements with DoHA and contracts with the RTPs;
- ensure training provider quality through accreditation of training providers;
- effectively allocate training places to providers;
- appropriately allocate funding for training to providers;
- ensure the robustness of GP registrar selection; and
- attract and recruit suitable applicants.

### DoHA GPET Funding Agreement

**3.20** DoHA has agreed to fund GPET for AGPT on the terms and conditions set out in the Funding Agreement between the two parties.<sup>60</sup> The agreement for the training period 2007–09 was renegotiated in 2009 to cover the training period 2010–12. The Funding Agreements are also mentioned in Chapter 2.

**3.21** In assessing program management, the ANAO examined the Funding Agreements to determine whether they provided an appropriate framework for the delivery of AGPT by establishing: objectives; funding levels; key

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<sup>60</sup> In full, this is the *Agreement between the Commonwealth of Australia as represented by the Department of Health and Ageing and General Practice Education and Training Limited regarding the Management of a Regionalised Approach to General Practice Vocational Education and Training*.

deliverables for both parties; performance indicators; and a reporting framework for GPET's performance of services under AGPT.

**3.22** GPET's high-level guiding documents communicate different points of emphasis for GPET's purpose and main objectives, with varying degrees of attention to education, meeting community needs and meeting workforce shortages. The Funding Agreement similarly does not have a clear expression of the objectives of AGPT.

**3.23** Table 3.3 sets out the intended performance outcomes for AGPT, key performance indicators (KPIs) for these and the presence of performance benchmarks or targets. This table is not exhaustive in that it does not list all the KPIs in the 2007–09 Agreement.

**Table 3.3**

**AGPT required outcomes and key performance indicators in the Funding Agreement 2007–09**

| Outcome  | Key performance indicator   | Target |
|--|---|--------|
| Efficiency of the training program             | Total cost per registrar  | x      |
|  | Percentage of total expenditure spent on training                           | x      |
|  | Medical educators (staff and contractors) per registrar                     | x      |
| Quality of graduates                           | Registrar pass rate in FRACGP and FACRRM examinations                       | x      |
|  | Accreditation of RTPs, supervisors and practices                            | ✓      |
| Growth in the number of rural and regional GPs | Retention in training program of registrars on the rural pathway            | x      |
|  | Retention of graduating rural registrars who stay in rural and remote areas | x      |
| Compliance with program requirements           | Annual total registrar intake / total number of allocated places            | ✓      |
| Capacity                                       | To be developed   | NA     |
| Community satisfaction                         | To be developed   | NA     |

✓: target included; x: target not included; NA: not applicable.

Source: GPET.

**3.24** As shown in Table 3.3, there are gaps in the AGPT performance assessment framework set out in the Funding Agreement 2007–09, with many KPIs not having benchmarks or targets. The only targets that the Funding Agreement specifies are that 100 per cent of RTPs must be accredited; and



100 per cent of allocated places filled. DoHA advised the ANAO in response to these observations about the Funding Agreement that the targets were not able to be devised for use in the Funding Agreement because reliable baseline data was not available from RTPs. While accepting that data limitations may have prevented the formulation of some targets, their absence means that the Funding Agreement does not set out a clear basis to determine performance in relation to desired outcomes such as efficiency of the training program, or the quality of graduates as indicated by achieving a target pass rate in the college examinations. In the absence of parameters for expected performance regarding efficiency and quality, it is more difficult for GPET to demonstrate that it complies with the Funding Agreement requirement that it provide value for money to the Commonwealth.<sup>61</sup>

**3.25** GPET and DoHA have continued their collaborative work regarding the negotiation and development of the Funding Agreements and both actively participated in redrafting the agreement with DoHA for 2010–12. Schedule 2 of the 2010–12 Funding Agreement outlines services and budgets in relation to GPET's delivery and management of AGPT. Like the 2007–09 Funding Agreement, it includes key deliverables and key performance indicators and targets against strategic aims in relation to accreditation. In an improvement on the previous Funding Agreement, the 2010–12 Agreement specifies a target for GP registrar satisfaction and a target for the distribution of GP registrar training to rural and remote locations.

**3.26** In DoHA's view, although the 2007–09 Funding Agreement contained explicit governance requirements aimed at strengthening GPET's focus on its core activity of delivering AGPT, the 2010–12 Funding Agreement provides for increased emphasis on financial management. It does this with the introduction of a range of reporting templates to secure a higher level of accountability through more detailed financial reporting, while at the same time also rationalising GPET's reporting responsibilities to DoHA.

**3.27** A number of GPET's operational decisions and subsequent performance indicators rely on data to be received from DoHA, such as

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<sup>61</sup> Per Clause 21.2 of the 2007–09 Funding Agreement. An identical clause is included in the 2010–12 Funding Agreement, at Clause 23.2(h).

information regarding districts of workforce shortage<sup>62</sup>, or rates of retention in rural and remote areas for graduating rural registrars.<sup>63</sup> GPET's analytical and other papers to its Board in 2008 and 2009 show that there have been delays in DoHA providing data to GPET relating to areas of workforce shortage and data on Medicare servicing that would indicate the activity and location of GPs (and hence provide indications of GP retention in the profession and retention in the region in which they trained in AGPT). This data represents important performance indicators by which to assess RTP performance (and that of AGPT and GPET) as well as being key inputs into GPET's consideration as to how to distribute AGPT places across RTPs. The training place allocation processes and performance monitoring processes are discussed later in this chapter.

**3.28** Although DoHA is not obliged to provide GPET with this data under the terms of either Funding Agreement, DoHA appreciates that access to the data would provide GPET with a broader context in which to make decisions about GP education and training. During the latter part of the audit, DoHA advised that it had commenced processes to establish standardised reports to be provided to GPET regularly, in line with its business needs.

## Recommendation No.2

**3.29** To improve GPET's management of general practice education and training, the ANAO recommends that GPET explore with the Department of Health and Ageing arrangements for the Department to provide general practitioner workforce information that assists GPET to take into consideration and to report on new and emerging workforce priorities.

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<sup>62</sup> A 'District of Workforce Shortage' is defined by DoHA as a geographical area of Australia in which the population's need for health care has not been met. It is determined by DoHA using both Australian Bureau of Statistics population data and Medicare Australia billing data. In general, a location is deemed a District of Workforce Shortage if it falls below the national average for the provision of medical services.

<sup>63</sup> GPET's capacity to manage AGPT would be assisted by data that is relevant to the management cycle, for example:

- planning (allocation of training places to areas of workforce shortage);
- monitoring performance (ongoing provision of Medicare services); and
- reviewing performance (for example, retention of graduating registrars in the profession and within rural and remote areas). Such information may lead GPET to revise its perception of areas of workforce shortage and can inform its next planning round to allocate training places.

## **GPET response**

**3.30** Agreed. Arrangements have been put in place between GPET and the Department of Health and Ageing for the provision of general practice workforce information.

## **Regional Training Providers and training delivery contracts**

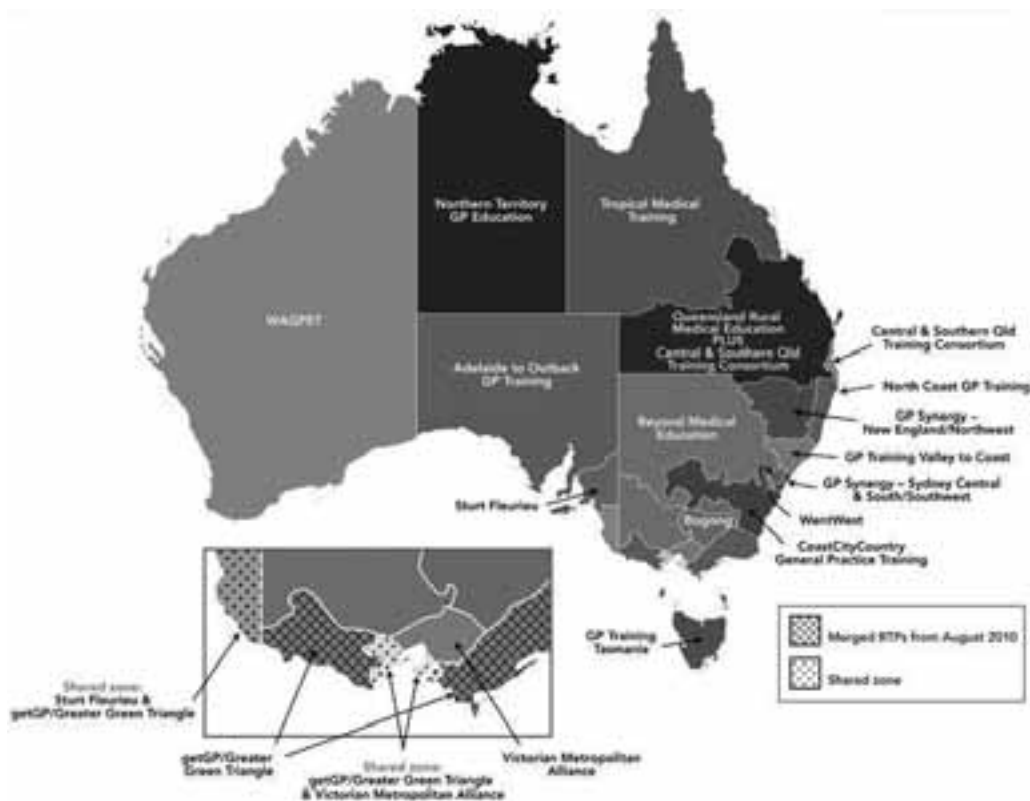
**3.31** The ANAO examined the mechanisms in place to deliver AGPT, to determine whether:

- there was an appropriate contractual basis for the provision of the services purchased by GPET, setting out the program's aims and objectives, financial management and services to be provided;
- there were measures in place, with appropriate performance targets, to enable GPET to determine whether RTPs complied with their requirements under the contract; and
- GPET satisfied itself that training would be provided to an appropriate standard, while recognising that RTPs operate in differing circumstances.

**3.32** RTPs are not-for-profit organisations created to deliver education and training within a specific geographical location. Their distribution is detailed in Figure 3.1 below. As highlighted in Chapter 1, characteristics of RTPs vary and RTPs deliver AGPT using a range of strategies and approaches tailored by them to their regions. RTPs receive most of their funding from GPET.

**Figure 3.1**

**Regional training providers by state 2010**



Source: GPET.

**3.33** GPET's stated aims are to 'establish broad principles and strategic aims for AGPT that empower RTPs to deliver a program that meets community needs and Government policy objectives'. In reviewing delivery of AGPT by RTPs, the ANAO examined whether GPET's contracts with RTPs reflected this approach.

**3.34** GPET manages its relationship with RTPs through contracts setting out the terms and conditions for their provision of vocational training for general practice, in exchange for funding. The contracts set out the program's overall objective as 'to enable the Provider to manage a high-quality program of general practice vocational training during the Program Period'. The contracts require the RTPs to undertake specified tasks to achieve this objective, to standards established by the colleges. They specify obligations in relation to such matters as funding, recordkeeping and reporting, intellectual property, compliance with GPET's quality framework, and governance aspects. They do

not, however, specify the operational nature, content or extent of the training to be provided. This is consistent with the flexibility that the program design is intended to allow.

**3.35** GPET has renegotiated contracts with RTPs twice in the life of the program—for the 2007–09 triennium and for the 2010–12 triennium.

*Development of 2010–12 GPET RTP contracts*

**3.36** The 2007–09 contracts between GPET and individual RTPs detailed the purchaser–provider relationship. However, the 2007–09 contracts did not provide RTP performance indicators or targets, making it difficult to determine the extent to which RTPs contributed to the program's aims. Recognising this shortcoming, GPET introduced processes to develop improved contracts in a timely, transparent and collaborative way.

**3.37** GPET initiated its strategy for developing RTP contracts for the 2010–12 triennium in late 2008. Consultations with the RTPs were conducted in relation to key elements of the new contract, particularly the inclusion of KPIs.

**3.38** In 2009, GPET managed a process of consolidation amongst RTPs designed to reap economies of scale. This required RTPs, as part of the contracting process for 2010–12, to provide to GPET strategic 'collaboration plans', including scope for mergers. GPET then initiated mergers through the consolidation of RTP contract offers.

**3.39** Significant improvements over the 2007–09 RTP contracts include:

- the inclusion of a schedule of KPIs mapped to GPET's strategic aims, with RTPs required to report against the individually tailored performance indicators and targets; and
- obligations for the RTPs to cooperate with an annual performance review and to implement reasonable GPET requirements in relation to performance.

**3.40** The new contracts and collaboration plans provide the basis for a more effective mechanism for GPET to manage AGPT actively. GPET is now better placed to measure and assess the delivery of selected key aspects of AGPT by the RTPs. GPET intends to use the performance reporting information generated under the contracts in its RTP accreditation process. Although the new contracts are an improvement, there remains scope for GPET to develop further RTP-level KPIs, while keeping reporting obligations to the minimum

necessary. This is considered under monitoring and reporting, later in this chapter.

## **RTP accreditation**

**3.41** The accreditation of RTPs and their networks of training practices against college standards is the main means available to GPET to gain assurance that the training delivered will be of an acceptable quality.

**3.42** The ANAO examined whether GPET had processes in place to: assess that training is delivered against college standards and GPET quality criteria; and promote quality improvement.

**3.43** GPET manages the accreditation of RTPs. While the accreditation of participating general practices is not a GPET responsibility, GPET maintains an active monitoring interest in the process undertaken by the RTPs, as the outcome is fundamentally important to the overall success of AGPT.

### ***RTP accreditation***

**3.44** In reviewing the accreditation of RTPs, the ANAO assessed whether: GPET had an appropriate system in place to undertake such accreditations; it covered all RTPs; reviews were carried out by experts; and they built progressively on reviews carried out over time.

**3.45** Under its funding agreement with DoHA<sup>64</sup> GPET must assure itself that RTPs can deliver AGPT training in accordance with the standards set by the colleges. Accordingly, GPET accredits the RTPs against a Quality Framework agreed by the GPET Board in May 2003 to span a ten-year period to 2012. The review can result in accreditation, but primarily gives feedback to RTPs as to how they can improve. Accreditation can be subject to conditions that must be fulfilled by the RTP.

**3.46** Accreditation is for a period of three years. GPET has a rolling program of accrediting six to seven RTPs per year, so that all are completed by the end of the cycle. All RTPs have been accredited over two rounds. The accreditation was undertaken by multi-disciplinary teams with representatives from the colleges to monitor compliance with college standards; GPET staff; peer RTP chief executive officers; medical educators and recent graduates of AGPT.

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<sup>64</sup> DoHA GPET 2007–09 Funding Agreement Schedule 2A, Objective 7.1.

**3.47** A third accreditation round is to run between 2010 and 2012. The reviews will be conducted by smaller teams, while maintaining representation from relevant stakeholders, and will be more focused on the new performance management and reporting process for RTPs.

**3.48** The ANAO found that GPET's processes for the accreditation of RTPs are sound. GPET has an appropriate framework in place to undertake accreditations against defined standards. Accreditations are carried out progressively for all RTPs.

#### *Practice accreditation*

**3.49** GPET actively monitors the accreditation of general practices by RTPs because AGPT depends as much on the availability of accredited training practices to train GP registrars as on the number of applicants to fill GP registrar positions.

**3.50** RTPs deliver general practice training through local networks of GPs who are able to provide experience and support to the GP registrars. All the practices participating in AGPT must be accredited with RACGP and/or ACRRM to ensure the practices meet college performance standards and expected quality of outcomes.

**3.51** As noted above, GPET itself is not responsible for practice accreditation. Until the end of 2009, accreditation was carried out by the colleges. The colleges delegated practice accreditation to RTPs from February 2010, for an initial period of three years. This was done, in part, to respond to the shortfalls in accreditation by the colleges of practices used or expected to be used by GP registrars—a significant risk to AGPT. The change will enhance RTPs' capacity to manage the increasing demand for high quality training in an effective and timely manner and help to make sure that there are sufficient accredited practices to take GP registrars.

**3.52** GPET has recognised the need to focus on aspects of training capacity to meet the significant increases in GP registrar numbers expected over the coming years. GPET undertook an assessment in early 2010 and found that work needed to commence on increasing the capacity of practices to provide for the additional allocations of AGPT training places beyond 2012.

**3.53** As well as modifying its formal Business Plan framework with the introduction of a new sub program to give specific attention to driving growth in training capacity, GPET also enhanced its focus on the importance of training capacity in managing RTPs. GPET introduced a KPI in its regular

performance monitoring of RTPs that measures the annual number of new training facility accreditations per RTP, compared with total accredited facilities. The GPET Board monitors these, and other, RTP KPIs. (See the later section of this chapter on GPET monitoring RTPs.)

**3.54** However, this measure of proportionate growth may be less appropriate as the scope for engaging new training facilities plateaus. RTPs have expressed concern to GPET in comments on their annual performance reports, and to the ANAO during fieldwork, that the existing KPI does not reflect their ability (and practical necessity) to *retain* practices by maintaining good relations, and expanding the capacity of *existing* training practices. Although the current KPI should continue to be measured, additional indicators relating to each RTP's ability to retain practices, or to reduce the rate of practices leaving the program, may also be worth consideration.

### **Allocation and distribution of training places**

**3.55** As mentioned above, the Australian Government places a quota on the number of new AGPT positions it funds each year. GPET determines how these places are allocated to each RTP. The ANAO examined whether GPET had a transparent and appropriate methodology for allocating new places to facilitate achievement of the program's objectives. It would be expected that this methodology would take into account changing circumstances within the RTPs, as well as current views of areas of workforce shortage, given GPET's stated objectives in the PBS and Strategic Plan. A robust model would ensure that all available places were used in accordance with the program design.

**3.56** GPET stated that, in allocating places to RTPs for 2011, it would distribute the additional budgeted training places to 'areas that have a demonstrated GP workforce shortage and are likely to receive sufficient applications to ensure that the positions are filled'—that is, there were two specific criteria: shortage and demand.

**3.57** GPET advised that it bases the overall allocation of training places provided annually by the government on the findings and recommendations of the 2005 AMWAC Report<sup>65</sup>, adjusted each year to take account of medical

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<sup>65</sup> The Australian Medical Workforce Advisory Committee (AMWAC) completed a study in 2005 into the supply and demand of GPs, taking into account such factors as expected retirements and changing demographics.



graduate numbers, changes to 'pathway' structures and government policy, such as the Minister's stated expectation that 50 per cent of GP registrars train in rural locations. GPET also takes into account the supply of training practices and the historic and projected preferences of GP registrars for a given area. GPET has refined its allocation model over time, comparing the effect of different assumptions, and adjusting the model as more data becomes available.

**3.58** GPET is not regularly provided with comprehensive information by DoHA regarding locations of workforce shortage, despite this information being crucial to an effective allocation of places to achieve the program objective of addressing workforce shortages.

**3.59** In late 2009, however, DoHA provided GPET with GP workforce distribution and participation data that compared the ratio of full-time workload equivalent (FWE)<sup>66</sup> GPs to population for each RTP, thereby giving GPET a very broad estimate<sup>67</sup> of workforce shortage. GPET used this information to revise its distribution analysis of AGPT training places for 2011, which was presented to the Board as a late paper in February 2010. However, the Board papers did not set out the basis for the precise allocation of places for 2011.

**3.60** Once GPET allocates places to RTPs, the RTPs determine the placement (distribution) of GP registrars in particular locations. The Government recently streamlined its allocation policy, with effect from 2010, by adjusting the various 'pathway' models and rationalising the classification of geographic regions, as discussed earlier. For the 2010 and future training years, GPET sets distribution targets by geographic region for each RTP through the new KPIs incorporated into the 2010–12 contracts, reflecting the Minister's 50 per cent objective for rural placements.

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<sup>66</sup> As noted in Chapter 1, FWE measures medical practitioner supply based on claims processed by Medicare in a given period. It is calculated by dividing the practitioner's Medicare billing by the mean billing of full-time practitioners for that period. To illustrate, a full-time workload equivalent value of 'two' indicates that the practitioner's total billing is twice that of the mean billing of a full-time practitioner.

<sup>67</sup> When interpreting what an analysis of GP distribution means for dealing with workforce shortage, it is important to note that workforce shortage is also affected by other factors, such as population density (linking to access issues) and levels of community health (linking to demand issues).

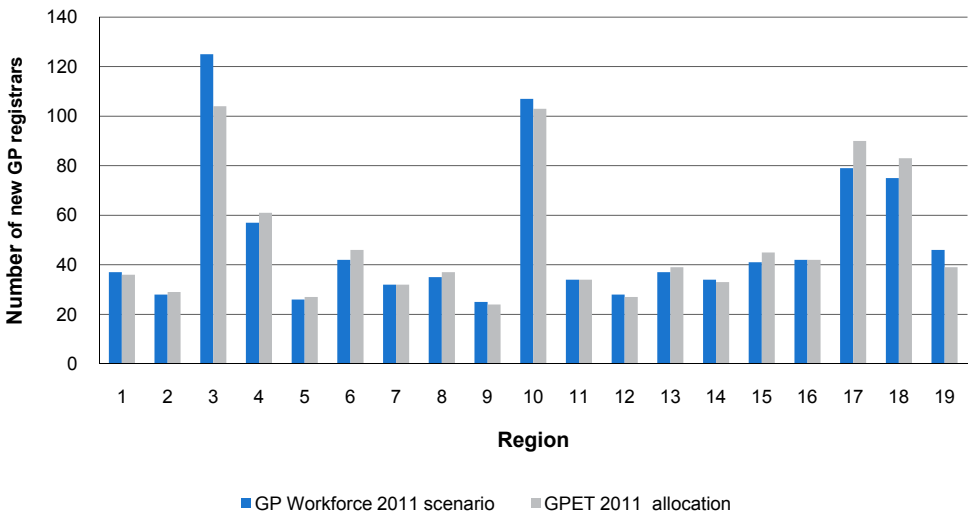
**3.61** The ANAO assessed GPET’s approach to allocating and distributing AGPT training places via several pieces of analysis, finding, in broad terms, that GPET’s approach was appropriate.

**3.62** The first piece of analysis applies the ‘workforce shortage’ data DoHA provided to GPET in late 2009 to examine the results of a particular training place allocation cycle.

**3.63** Figure 3.2 compares the actual allocation of new GP registrars for 2011 with the scenario of allocating the new training places based on GP workforce data provided by DoHA. As highlighted in Figure 3.2, GPET’s actual allocations of new training places for 2011 follow the ‘workforce need’ pattern quite closely. This reflects well on the merit of GPET’s approach to allocating new training places, given GPET’s objectives. The relatively more significant variances in allocations only appear in relation to allocations for Region 3 (which is under-allocated compared to the allocation that would have resulted from applying data illustrating GP workforce shortage) and Regions 17 and 18 (which are over-allocated on that same basis).

**Figure 3.2**

**Comparison of GPET’s allocation of GP registrars for 2011 with allocations based on GP workforce data**



Source: ANAO presentation of GPET data.

**3.64** As well as assessing GPET’s allocation process by examining its outputs for a particular cycle, it is also instructive to assess GPET’s allocation process by looking at the situation reflecting the results of GPET’s previous

allocations. The second piece of analysis involves examining the relationship, at a point in time, between the distribution of FWE GPs (as at 2008) and the enrolled GP registrars (as at 2009) per 100 000 persons, to highlight whether GPET has successfully allocated training places over time to areas where GPs appear to be under-represented.

**3.65** Recognising GPET's difficulty in obtaining relevant GP workforce data, and that DoHA provided some data to GPET in late 2009, such analysis gives a useful idea of how GPET's historic allocation of training places relates to imbalances in GP distribution. In making this assessment about relative imbalances in the distribution of GPs as a possible pointer to 'workforce shortage'<sup>68</sup>, as noted earlier workforce shortage is also affected by factors other than workforce distribution—such as factors bearing on access to GP services (for example, population density) and factors bearing on the need for GP services (for example, health status).

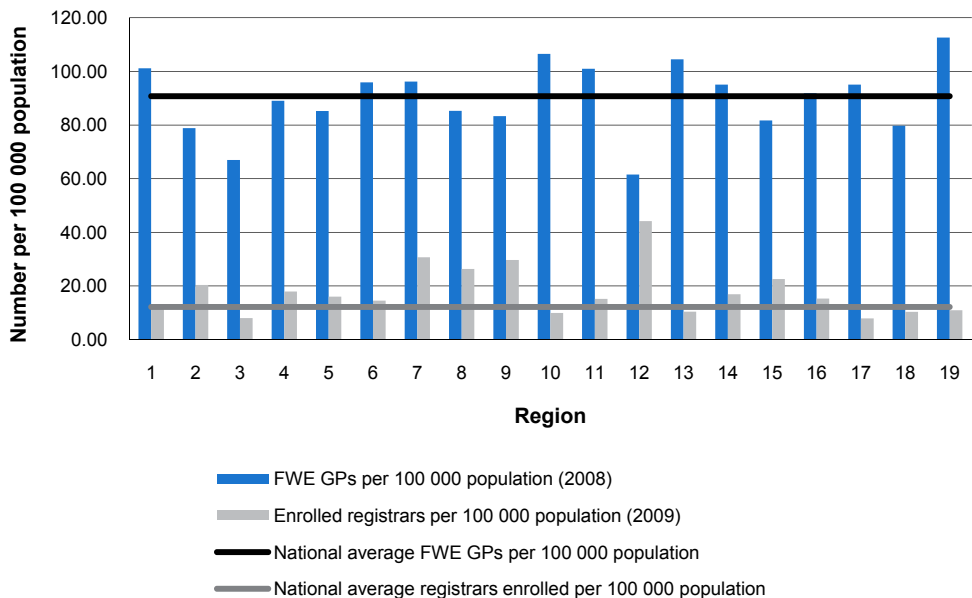
**3.66** Plotting the regional distribution of GPs and the national average figure for this statistic and the regional distribution of enrolled registrars and the national average for this statistic, Figure 3.3 depicts the incidence of FWE GPs in practice and GP registrars undergoing AGPT training in each region.

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<sup>68</sup> DoHA takes variations from the national average (of full-time workload equivalent GPs per 100 000 population) as a rough indicator of workforce shortage.

**Figure 3.3**

**Comparison of full-time workload equivalent GPs in practice and enrolled GP registrars per 100 000 population**



Source: ANAO analysis of GPET data.

**3.67** Figure 3.3 shows that some RTPs are below the national average in respect of FWE GPs per 100 000 population, indicating a relative workforce shortage in those regions. One approach to addressing the imbalances would involve GPET enrolling in these regions more than the national average number of enrolled registrars per 100 000 population. However, the feasibility of this approach must be considered in light of the practical limitations in GPET being able to achieve such extra enrolments in areas of workforce shortage. For example, GP workforce shortages may mean shortages of potential GP supervisors for AGPT in some regions and this effectively constrains enrolments in these regions.

**3.68** Although the analysis depicted in Figure 3.3 is broadly reassuring as to the merit of GPET's training place allocation approach, it shows that there are some regions in which the relative regional endowment of GP registrars does not offset or 'mirror' the relative regional under-endowment of GPs in practice. In other words, Figure 3.3 shows that the historic allocation of registrars (reflected in enrolled GP registrars), does not fully mirror the pattern of GPs in practice.

**3.69** For example, two regions<sup>69</sup> with below average numbers of FWE GPs per 100 000 population also have below average numbers of enrolled GP registrars per 100 000 population. Similarly, four regions<sup>70</sup> with above average numbers of FWE GPs per 100 000 population have above average numbers of enrolled GP registrars per 100 000 population.

**3.70** This analysis suggests that although GPET's place allocation approach is sound overall, the pattern of training place allocations by GPET up to 2009 has not addressed all areas of workforce shortage (as defined by the numbers of FWE GPs in practice in those regions).

**3.71** The third piece of analysis of GPET's allocation and distribution processes was undertaken by DoHA. GPET obtained some broad reassurance about the merit of the allocation and distribution processes from this analytical exercise.<sup>71</sup> GPET management advised its Board in March 2010 that DoHA had recently conducted a statistical analysis of towns outside major cities that were experiencing low levels of GP services for the population size, and compared this to the allocation of AGPT registrars in Semester 1 of 2010. DoHA undertook this analysis to inform the Minister of the impact on such towns of training place allocations to RTPs. GPET advised its Board that:

the analysis indicated the allocation of registrars, which is undertaken by RTPs at the regional level against GPET-set distribution targets based on ASCG RA categories, broadly addresses the needs of the identified towns.

### *Comment regarding allocation and distribution*

**3.72** GPET's approach to allocating new training places to RTPs distributes all funded training places; and appropriately considers a wide range of factors such as changes to program parameters, applicant preferences, training capacity and dimensions of workforce shortage. The Board papers do not set out GPET's rationale for the precise allocation of places, but analysis of the results of GPET's allocation processes suggests that the approach is appropriate.

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<sup>69</sup> Identified in Figure 3.3 as regions 3 and 18.

<sup>70</sup> Identified in Figure 3.3 as regions 6, 7, 11 and 14.

<sup>71</sup> The ANAO did not examine DoHA's analysis.

## Program funding to RTPs

**3.73** In reviewing GPET's management of AGPT, the ANAO assessed whether GPET used appropriate mechanisms to determine the annual funding allocations for RTPs. Such a funding model should be transparent, defensible, based on reasonable data, adequate to RTP needs, and flexible enough to facilitate efficiencies.

**3.74** Total AGPT funding is based upon the number of GP registrars commencing AGPT each year, over the anticipated length of their training. However, determining the annual allocation of funding to RTPs is a more complex task than a straight apportionment on the basis of a head count of trainees. Under the funding model applying prior to the 2010 training year, GPET calculated the distribution of training funds across the RTPs using a weighted funding model. The model applied relative weightings to each GP registrar activity type (basic training, advanced training and trainees on leave); the geographic location of training as an approximation for financial 'need' (that is, the level and nature of expenses incurred); the relative size of each provider as an approximation of efficiency; and comparative consumer price index movements.

### *Funding model review*

**3.75** In early 2009, GPET engaged the consultants Access Economics to review and strengthen the funding model, and to provide advice on alternative approaches aligned with the overall objectives of AGPT. Access Economics identified shortcomings with the funding model<sup>72</sup>, and found that the relative distribution of AGPT funding over past years of applying the funding model was skewed significantly towards smaller RTPs.

**3.76** Access Economics reported in March 2009 and recommended revised funding mechanisms, including weightings, to enhance the basis of the funding model. GPET implemented these recommendations in making its funding allocations to RTPs in 2010. However, it was agreed as part of contract renegotiations with the RTPs, that in order to provide a measure of financial continuity, the funding allocation for 2010 was to be not less than that provided in 2008 for the same level of activity.

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<sup>72</sup> Identified shortcomings included: flaws with the use of stepped rather than continuous weightings; the arbitrary nature of the financial 'need' factor allocated to RTPs; and the inequitable spread of costs between RTPs, associated with the lack of competitive market pressure for them to identify efficiencies.

## GP registrar selection

**3.77** The ANAO examined whether the process of selection and placement of doctors as GP registrars with RTPs was transparent and defensible against publicised selection criteria, ensuring that suitable applicants were selected to fill all available AGPT places in a fair and equitable manner.

**3.78** AGPT is competitive. Not all applicants are successful. GPET undertakes a multi-phased selection process to determine that the successful GP registrars are suitably qualified. Applicant guides and handbooks are available to prospective applicants on GPET's public website. Prospective GP registrars are required to complete an online application. These applications are assessed by GPET to determine eligibility against nationally consistent selection criteria underpinned by the Australian Medical Council<sup>73</sup> as well as the college standards for selection. Eligible applicants are then allocated to interviews with RTPs based on their ranking and training preferences. GPET's Selection Review Committee, comprising representatives of stakeholders, reviews and evaluates the GP registrar selection process after every annual cycle.

**3.79** In accordance with the DoHA Funding Agreement 2007–09, GPET commissioned an expert, independent review of the selection processes for AGPT. Allworth Juniper Pty Ltd reported on its review of the AGPT selection process in February 2009. The review reported that GPET's existing process was robust, time and cost effective and consistent with international best practice.<sup>74</sup>

**3.80** The review made a number of recommendations, including increasing the involvement of RTPs in the selection process. GPET endorsed the review's recommendations and has in place a selection process that appears to be transparent, defensible and equitable.

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<sup>73</sup> The Australian Medical Council is an independent national standards body for medical education and training. One of its core functions is to assess medical courses and training programs (both medical school courses and the programs for training medical specialists) and to accredit programs that meet AMC accreditation standards.

<sup>74</sup> Positive features were:

- processes were documented and accessible to applicants;
- stakeholders reviewed the selection processes after the event annually for GPET; and
- GPET implemented a well-documented complaints and appeals procedure for GP registrar selection.

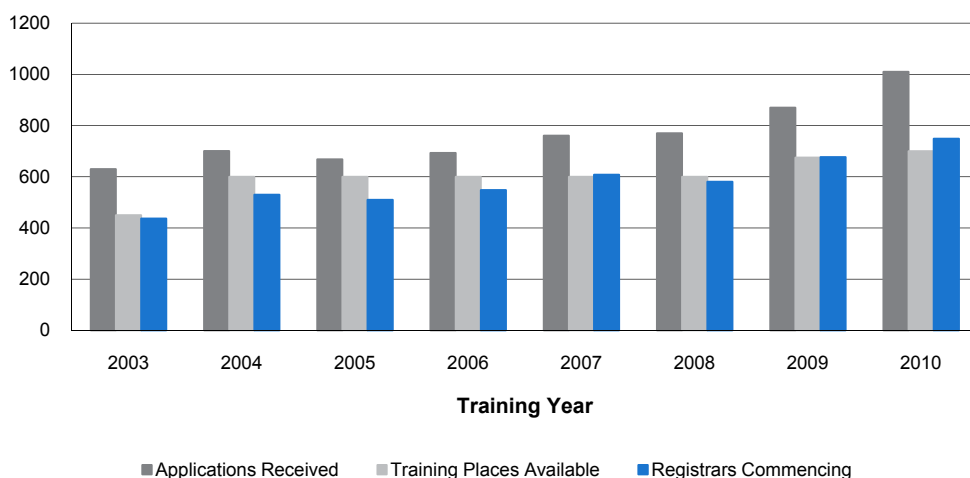
## Attracting applicants to AGPT

**3.81** Attracting AGPT applicants, that is, GP registrar recruitment, is at the heart of GPET's strategic aim to address Australian medical workforce needs in relation to training numbers, distribution and retention of GPs.

**3.82** GPET has sometimes in the past been unable to identify sufficient, suitable applicants to accept and commence in available places. Although GPET has been able to fill on average 98 per cent of places awarded by the Minister annually to AGPT, only in 2007, 2009 and 2010 were all available places filled. This is illustrated in Figure 3.4 for the program as a whole. In 2005 as few as 85 per cent of places were filled.

**Figure 3.4**

### New GP registrars accepted and places available



Source: ANAO analysis based on GPET data.

**3.83** Success in filling the annual quota of places is not consistent between RTPs. While most RTPs filled their allocation of places for the 2010 training year; three did not—with one RTP achieving only 78 per cent of its allocation.

**3.84** In order to manage the process better, GPET introduced a KPI (KPI-1) under the 2010–12 contract to measure the ratio of accepted applicants to available places for each RTP. Although a reasonable indicator, this ratio does have some limitations in terms of assessing RTP performance. This is because although RTPs can influence aspects bearing on the incidence of acceptable applications from GP registrars, there are other factors outside RTP control affecting this indicator.



**3.85** Furthermore, both GPET and the RTPs are aware, and have mentioned to the ANAO in fieldwork, that simply accepting any qualified applicant who expresses an interest in a post in order to satisfy a quota may be detrimental to the program. This is because choosing an inappropriate person to fill a vacant AGPT place in order to fill a quota may necessitate expensive remedial action for the GP registrar later when training problems emerge, without a guarantee of a successful outcome at the end of the training period. It is preferable to select applicants deemed to have the potential to become competent and confident GPs.

### *Australian medical graduates*

**3.86** GPET pays particular attention to attracting applications from Australian medical graduates (AMGs) and it has set targets and it monitors performance in that regard. This is because attracting applications from AMGs is a priority outlined in the Minister's SoE.

**3.87** The Minister's SoE indicates that to enhance the future GP workforce GPET is expected to market and promote general practice as a career choice to increase registrar recruitment to AGPT amongst AMGs. Therefore GPET recognises as a priority the need to increase both the proportion of recent AMGs who apply for AGPT and to increase the number of AMGs applying for AGPT over time, in order to address Australian medical workforce needs (one of GPET's strategic aims).

**3.88** Accordingly, GPET has set a target to increase the proportion of recent AMGs that apply to AGPT, aiming to increase the proportion from the 27 per cent achieved in 2007 to 35 per cent by 2013.

**3.89** In addition, and consistent with its priority to increase the number of AMGs applying to AGPT over time, one of the 2010–12 KPIs for RTPs (KPI-2) requires RTPs to report on the number of AMGs applying to the program compared to previous years.

## **Monitoring and reporting AGPT activity and performance**

**3.90** The ANAO examined whether GPET undertook timely, comprehensive, relevant and measurable monitoring and reporting of program performance, including the quality of services provided under the program and the degree to which the program's objectives are achieved. Such monitoring would allow GPET to identify and implement program improvements and manage risks to the effective achievement of the program's aims. The ANAO examined GPET's processes to monitor and report AGPT

activity and RTPs' operations, as well as further possible ways by which GPET might monitor RTPs' operations (including effectiveness).

## **Board monitoring and reporting of AGPT**

**3.91** The GPET Board is kept informed of centrally managed aspects of AGPT<sup>75</sup> via Quarterly Program Performance Reports. However, in terms of monitoring AGPT as a whole and assessing overall AGPT performance against GPET's strategic aims, the GPET Board focuses on the annual performance report compiled for DoHA in relation to the AGPT program.

**3.92** The first such AGPT performance report was published in June 2008 for the period 2002–07. Other annual AGPT performance reports were provided, as required, for 2008 and 2009.

**3.93** In addition to the annual consolidated AGPT program reports, the GPET Board also receives data reports and reports on policy issues on a quarterly basis. These AGPT reports are required to be provided to DoHA under the terms of the DoHA GPET Funding Agreements (2007–9 and 2010-12). The reports are provided to the Board before being provided to DoHA.

**3.94** Since the formulation in late 2009 of KPIs relating to RTP activity, the Board has received reports on the performance of individual RTPs. This is presented to the Board via RTP Performance Reports ('RTP Dashboard' reports), highlighting each RTP's activity against each KPI (for example, numbers of practices newly accredited, cost efficiency and training effort). At the time of the audit fieldwork, the GPET Board had received one set of such annual RTP performance reports.

## **Monitoring and reporting to DoHA under the Funding Agreements**

### ***AGPT***

**3.95** Under the 2007–09 funding agreement with DoHA, GPET was required to provide a quarterly policy report to DoHA on key policy and operational issues impacting on AGPT. Every six months the report to DoHA was to include a data report covering the information specified in Schedule 6 of the

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<sup>75</sup> Centrally managed aspects of AGPT include RTP accreditation, selection of GP registrars and marketing.

contract. This included performance indicators against the specified outcomes as outlined in Table 3.3.

**3.96** As noted earlier, under the 2007–09 DoHA GPET Funding Agreement, GPET had few targets by which to assess performance aligned with the Funding Agreement outcomes. There were also no AGPT program aims or objectives that would enable GPET to measure the extent to which program performance was successful. In the same period, the contracts between GPET and the RTPs did not specify comparable performance indicators or targets that would facilitate GPET's review of individual RTPs or an overall assessment of the program. GPET reported absolute results and trends, but did not express a view on performance (satisfactory or otherwise) against expectations.

**3.97** The DoHA GPET Funding Agreement 2010–12 provides a broadly similar framework to the earlier Funding Agreement in specifying particular provisions regarding services and reports and the management of funds, this time for PGPPP as well as AGPT, but still does not specify the objectives for AGPT. GPET met its reporting obligations evident at the time of the audit.

#### *Other reporting to DoHA*

**3.98** The bulk of GPET's monitoring and reporting activity under the Funding Agreement 2007–09 related to AGPT. However, GPET was also required to report to DoHA on its corporate responsibilities, such as organisational planning and annual reporting and the Annual General Meeting.

**3.99** The review of GPET's management of AGPT and GPET's corporate responsibilities shows that GPET complies with the activity and reporting requirements of the Funding Agreements.

### **GPET's monitoring of RTPs**

**3.100** In late 2009, GPET developed RTP profiles to collate key information to enable it to monitor and quickly assess the comparative and absolute performances of RTPs and AGPT over time, while taking into account each RTP's specific characteristics such as remoteness and registrar demographics.

**3.101** At the same time, GPET was developing KPIs as part of the process of negotiating the 2010–12 RTP contracts. These new RTP-level KPIs have been mapped against the strategic aims and objectives for the AGPT program. Some

KPIs have been referred to already in this chapter. The complete list of KPIs is shown at Table 3.4.

**Table 3.4**

**Key performance indicators in the GPET RTP contract 2010–12**

| KPI | KPI name                                  | KPI formula   |
|-----|---|---|
| 1   | Annual intake quota filled                | Total number of accepted applicants / total number of available places  |
| 2   | Future General Practice workforce         | Total number of AMGs applying to AGPT/RTP compared to historic  |
| 3   | Registrar workforce distribution          | FTE weeks provided by category grouping (RRMA, GPARIA, ASGC/RA) / total FTE weeks provided  |
| 4   | Effective management of training capacity | New training facility accreditations: lapsing accreditations ratio  |
| 5   | Sustainable GP educator workforce         | Number of Registrars receiving training in approved teaching skills / total number of Registrars  |
| 6   | Cost efficiency                           | RTP total expenditure / sum FTE weeks training undertaken   |
| 7   | Exposure to wide scope of practice        | Number of registrars undertaking extended or advanced skills training / total number of registrars  |
| 8   | Registrars' satisfaction                  | Number of registrars that expressed overall satisfaction (satisfied and very satisfied) with AGPT or RTPs / total number of Registrar respondents |

Source: GPET.

**3.102** GPET based the 2008<sup>76</sup> and 2009<sup>77</sup> AGPT performance reports due under the 2007–09 contract on performance requirements set out in the 2010–12 contract. Although this does not provide trend comparisons across 2007–09, it does facilitate comparisons going forward.

**3.103** GPET has established trigger events that would suggest underperformance, namely:

- a significant variance from target;
- a high number of KPIs being off target;

<sup>76</sup> Delivered September 2009.

<sup>77</sup> Delivered April 2010.

- a worsening situation;
- continuing under-performance despite intervention; or
- that the RTP cannot explain drivers for under-performance.

**3.104** Although identifying trigger events to alert GPET to possible RTP underperformance is good practice, GPET has not set benchmarks to determine consistently when intervention would be required.

**3.105** As is apparent from Table 3.4, and as GPET acknowledges, 'quantity' is the current focus of the KPIs. GPET acknowledges that 'quality' measures of performance are more difficult to determine than 'quantity' measures and it is working with an advisory group in an effort to devise better 'quality' KPIs for the future. However, GPET does monitor and report GP registrar satisfaction as an indicator of 'quality', as KPI 8.

#### *Monitoring GP registrar satisfaction*

**3.106** GPET employed contractors to conduct annual GP registrar satisfaction surveys. The survey results are positive. In 2009, 89 per cent of GP registrars responding to the survey reported overall satisfaction with their training, while 86 per cent expressed overall satisfaction with their RTP.

**3.107** However, the surveys have not been compulsory and response rates have been modest at times. Response rates ranged from 34 per cent of GP registrars in 2007 to 48 per cent of GP registrars in 2009, and these rates bear on the accuracy of the survey results. The ANAO suggests that GPET consider making future surveys compulsory—perhaps as a condition of continuing enrolment in the program—in order to provide a more representative picture of GP registrar satisfaction with the program. The registrar satisfaction surveys are discussed in Chapter 5.

#### *Monitoring cost efficiency*

**3.108** GPET's method of allocating funding to RTPs was examined in a previous section on Program funding to RTPs. The level of funding allocated by GPET to each RTP varies between RTPs from approximately \$21 000 to \$41 000 per GP registrar. This variation in funding levels is significant.

**3.109** Not only does funding per registrar vary between RTPs, but also levels of training per GP registrar vary from RTP to RTP. To allow comparisons across RTPs, GPET monitors the full-time equivalent (FTE) weeks of training effort provided by each RTP. GPET then measures (as RTP-level KPI 6) RTPs'

cost efficiency by comparing total expenditure for the RTP with the amount of FTE weeks' training it provides.

**3.110** On this basis, the cost efficiency of RTPs for the 2009 training year varies considerably between RTPs—from \$721 to \$1 661 expenditure per FTE training week. The variation is largely explained by factors such as geographical location and the size of the RTP.

**3.111** Given that the level of training provided to each GP registrar varies, it is important that GPET examines *efficiency indicators* such as that above *in combination with effectiveness indicators*, for example exam results, to obtain an indication of 'value for money'. Some possible ways GPET might monitor AGPT effectiveness are outlined in the next section.

### ***Monitoring effectiveness***

**3.112** One indicator of RTP effectiveness is the proportion of active GP registrars completing their training each year, thereby giving an indication of 'throughput'—the average time it will take a GP registrar to undertake AGPT. In its performance report for the 2009 training year, GPET states:

Since 2005 the average number of registrars completing the AGPT program has been 397 per year. This represents a decrease in the proportion of registrars completing the AGPT program annually from 20% in 2005 to 16% in 2009.

**3.113** Closely linked with this notion of completing training, is the notion of passing exams or other required assessments (and being awarded college fellowship). The ratio of fellowships awarded each year compared to active GP registrars in that year can be an indicator of the success of the program, both nationally and by RTP.

**3.114** The rate of successful fellowships awarded in 2009 per active GP registrar (that is, excluding those taking leave of absence) varied considerably between RTPs, ranging from three per cent to 25 per cent. However, this wide variation needs to be considered in the context of individual registrars' circumstances and would only be meaningful if measured over a number of years before inferences are drawn as to RTP performance.

**3.115** A further useful indicator of the effectiveness of AGPT would be a comparison of the examination pass rates for AGPT participants with pass rates for non-AGPT candidates ('practice-eligible' candidates). While appreciating that the circumstances and demographics of AGPT candidates and practice-eligible candidates differ, information provided by RACGP to the ANAO for analytical purposes indicated that, for the period 2002–09, the

majority of AGPT candidates passed the RACGP exams, a significantly higher proportion than the proportion of practice-eligible candidates who passed the exams. This comparative result might highlight the merit of AGPT, as a training and education program that makes passing college exams more likely. However, it is difficult to draw firm conclusions about the effectiveness of AGPT without understanding the context and performance benchmarks of the two streams of candidates.

**3.116** GPET, in establishing RTP-level KPIs, created useful tools to measure RTP performance and to enable comparisons over time. There is merit in GPET continuing to consider and to develop additional indicators such as exam results, in order to determine the success of AGPT, and of individual RTPs, in achieving the program's aims. The difficulty GPET has obtaining access to all the data that it requires for this purpose is recognised, when custody of the data is with other parties—the colleges, for example, in the case of examination or other assessment results. While recognising the organisational challenges, GPET is making progress in working with stakeholders, given their mutual interests in GPET successfully implementing the program, including pressing its case for access to data that provides insights or perspectives on AGPT performance, and especially program effectiveness.

## 4. GPET's Management of PGPPP

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*GPET took over responsibility for the management of the Prevocational General Practice Placements Program from the colleges as of 1 January 2010. This chapter examines how well GPET managed the transition process and the program's subsequent implementation at its very early phase.*

### Introduction

**4.1** PGPPP provides general practice placements for junior doctors, as depicted in Figure 1.1 describing the training undertaken by a GP. The placements are of varying duration of approximately 10–12 weeks.

**4.2** PGPPP is essentially a 'short-term work-experience program' for junior doctors working in the hospital system.

**4.3** PGPPP has two key aims that support the delivery of primary health care in Australia:

- to provide junior doctors with clinical training experience in primary care settings, enhancing their understanding of generalist medicine and integrated care; and
- to encourage junior doctors to take up a career in general practice.

**4.4** From 1 January 2010, the management of the program became the responsibility of GPET, which already managed the network of RTPs through which the majority of PGPPP placements are administered.

**4.5** In reviewing GPET's management of this measure in its initial phases, the ANAO examined whether:

- GPET conducted appropriate preparation and handover processes so that PGPPP was provided in 2010, as required by the Government;
- appropriate transitional arrangements were in place for the delivery of the program; and
- GPET had an appropriate focus on future reform of the program.



## Preparation and handover processes

### Administration of PGPPP by the colleges

**4.6** PGPPP was announced by the Australian Government in late 2003, with funding from government provided via DoHA and its predecessors. The program offered prevocational trainees voluntary, supervised and supported placements for a nominal 12 weeks in outer metropolitan, regional, rural and remote areas in accredited training environments.

**4.7** Program placements in rural, remote and small regional areas were administered on behalf of DoHA by ACRRM. RACGP administered the placements in larger regional and outer metropolitan areas.

**4.8** The financial and administrative arrangements for program placements were managed on the colleges' behalf by RTPs and some other providers.<sup>78</sup> As discussed in Chapter 3, RTPs have played a significant role in the delivery of vocational training for GPs via AGPT since 2002.

**4.9** Overseeing the conduct of the program, the PGPPP National Advisory Committee (NAC) provided policy advice to DoHA, program guidance to the colleges, and managed the PGPPP applications approval process on behalf of DoHA. The NAC was disbanded in July 2009 as part of the transition of passing responsibility for PGPPP to GPET.

**4.10** The first placements under the program commenced in January 2005, with varying levels of take-up across the jurisdictions. Placements grew over subsequent years, with 111 placements completed in 2005–06, 173 in 2006–07 and 248 in 2007–08. Table 4.1 shows placements completed to 30 June 2008. As illustrated in Table 4.1, program activity was low in the Australian Capital Territory, New South Wales and Tasmania.

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<sup>78</sup> RTPs administered 77 per cent of PGPPP placements in 2010. The balance of placements was administered by a range of other providers such as universities and divisions of general practice. As noted earlier, divisions of general practice are professionally led and regionally based voluntary associations of GPs that seek to provide professional support for GPs and to coordinate and improve local primary care services, including by running some programs.

**Table 4.1****Completed PGPPP placements from January 2005 to June 2008**

|   | ACT | NSW | NT | QLD | SA  | TAS | VIC | WA | Total |
|---|-----|-----|----|-----|-----|-----|-----|----|-------|
| Placements<br>January 2005 to<br>30 June 2008 | 0   | 38  | 61 | 85  | 276 | 12  | 69  | 48 | 589   |

Source: GPET.

**Transfer of PGPPP to GPET**

**4.11** The 2009–10 Budget announced that, from 1 January 2010, the management and delivery of PGPPP would transfer from the colleges to GPET, which also managed AGPT. The change was designed to integrate prevocational general practice training for junior doctors with GPET’s pathway links to training for GP registrars via AGPT. The move of PGPPP to GPET was also designed to facilitate the recognition of prior learning for PGPPP participants who pursue a career in general practice. The change was expected to generate efficiencies in program delivery and allow cost savings, with the 2009–10 Budget measure for PGPPP identifying savings of \$2.6 million over the four years 2009–10 to 2012–13.

**4.12** At the same time, the Australian Government also expanded PGPPP with a specific commitment to increase the number of junior doctors accessing general practice experience in New South Wales, the Australian Capital Territory and Tasmania. The Government allocated an extra \$41.2 million funding (over four years) to the program in the 2009–10 Budget to allow the increase in placement numbers from 2009–10 to 2012–13.

**4.13** The Minister for Health and Ageing’s 2009 SoE indicated that it would be important that GPET worked closely with the colleges and current non-RTP providers to put in place realistic and smooth transitional arrangements for PGPPP and to ensure that existing training arrangements were maintained for 2010. DoHA’s briefing to GPET on the PGPPP measure indicated that GPET was required to maintain current fundholder and placement arrangements during 2010 to facilitate the transition, but GPET would be able to make changes to the arrangements from 2011.

**4.14** The 2010–11 Budget further provided \$149.6 million over four years to deliver by 2012–13 approximately 575 additional places per year in PGPPP. According to the 2010–11 PBS, the minimum number of placements for PGPPP is 380 in the 2010 training year, 910 in the 2011 training year and 975 from the

2012 training year onwards. The Budget document indicated that, when combined with existing initiatives, it was expected to bring the total number of annual places up to 975 by 2013.

## Transitional arrangements

**4.15** In October 2009, GPET entered into a Standard Funding Agreement with DoHA to implement and manage the allocation of general practice placements for 2010 for PGPPP. The ANAO assessed whether the existing training arrangements were maintained for 2010, as required by the Minister, and whether appropriate transition arrangements were in place to ensure the continuous, smooth delivery of the program.

**4.16** In mid-2009, as part of its preparation for managing PGPPP, GPET engaged consultants Business Essence to map the separate business processes used by the two colleges in the administration of PGPPP. This was to gain a full understanding of the processes used to support the program and assist GPET to integrate PGPPP into its business operations.

**4.17** The report contained a comprehensive set of flowcharts, documents and processes, together with discussion on possible risks and issues for GPET to consider in its implementation of PGPPP. Potential risks were identified in funding arrangements, contracts and stakeholder relationships. GPET considered and acted on these areas in the context of developing the PGPPP transition arrangements in 2009 and the management arrangements from 1 January 2010—evident, for example, in the terms of GPET's contracts with training providers and work with stakeholders.

**4.18** PGPPP was incorporated into the work of GPET's Quality and Education Section. (See Appendix 3 for GPET's organisational structure.) GPET plans that from 2011 the program will be fully integrated into its business processes.

**4.19** GPET and the colleges worked together in 2009 to arrange and finalise the 2010 placements, assembling information on providers and practice

placements. GPET allocated \$21.6 million to PGPPP for the 2010 calendar year, with 484 placements allocated in total.<sup>79</sup>

**4.20** GPET Board material in February 2010 indicated that funding for the 2010 placements had been as per the 2009 funding allocations. It also acknowledged that PGPPP is a high-cost program and indicated that GPET would review the funding arrangements. The funding review is discussed later in this chapter.

**4.21** Except in New South Wales, the Australian Capital Territory and Tasmania, GPET did not make any changes to the placement numbers or fundholder arrangements for the program in 2010. GPET planned to use the year to scope the program and identify any opportunities where it might be able to expand the program (within budget) across all states and territories. This was to involve an extensive stakeholder consultation process to enable GPET to establish the potential demand for PGPPP and to identify the best and most cost-effective way of managing the program to meet the needs of the states, territories and the Australian Government.

## **Fundholder arrangements**

**4.22** Fundholders (now known as ‘providers’) were required to enter into a new fundholder agreement with GPET by December 2009, to enable the program to commence with the first round of placements in early January 2010. This agreement generally followed the previous arrangements, with program performance and Medicare Australia reporting arrangements continuing so that GPET could monitor the program and provide for the ongoing collection of program data. The new provider agreement consolidated the previous two separate, and different, college contracts for PGPPP providers and strengthened the funding acquittal and recovery provisions for providers compared to the previous arrangements with the colleges.

## **Procedures**

**4.23** GPET’s documentation shows that it sought to ensure that the existing program processes and procedures continued to apply in 2010. The program

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<sup>79</sup> GPET was able to allocate more placements than the minimum of 380 specified in the GPET’s Health and Ageing PBS 2010–11 by it offering somewhat shorter placement terms than the 12 weeks which was the basis of funding from DoHA. GPET offered additional placements to New South Wales, the Australian Capital Territory and Tasmania as intended by government.

guidelines of the former NAC continued to operate in 2010, where they were not inconsistent with the new agreements GPET entered into with all fundholders. For example, the re-application process for all practices wishing to participate in the PGPPP in 2010 followed the process used by the NAC and required practices to confirm the details of their original application (advising any changes) and submit a fresh budget for the 2010 placement program.

**4.24** This part of the process was managed by the colleges, which agreed to undertake it in order to facilitate the transition of the program to GPET. New practices (in the Australian Capital Territory, New South Wales and Tasmania) were approved for PGPPP placements by GPET.

*Program standards for training, supervision and support*

**4.25** The NAC guidelines around the supervision of junior doctors undertaking PGPPP placements continued to operate in 2010. GPET Board documents indicated that the colleges had signalled some areas for review and improvement and that these would be reflected in any changes introduced to the program requirements from 2011.

**4.26** GPET intended to review the NAC guidelines fully during 2010.

**4.27** Representatives of the RTPs and the colleges consulted during the audit highlighted the activities undertaken during the handover and transition phases. Staff in the RTPs involved in running PGPPP were supportive of GPET's preparation and handover processes so that PGPPP was provided in 2010, as required by the government. Staff were also supportive of GPET's measures to encourage the consideration and adoption of specific administrative processes in the early operational phases once it had assumed responsibility for PGPPP.

**4.28** GPET has demonstrated sound overall management of the transition of PGPPP and of the processes and procedures applying to the program in 2010 to ensure its continuous, smooth delivery.

## Future reforms

**4.29** The PGPPP reform was nominated in the 2009–10 Budget as a savings measure that would improve the alignment between AGPT and PGPPP and create a comprehensive pathway for general practice training. Although GPET's management of the PGPPP was in its very early days at the time of the audit fieldwork, the ANAO assessed the progress being made by GPET in delivering against the Budget measures.

## **Advisory committee**

**4.30** Having reviewed the role of the disbanded NAC, GPET set up a new advisory group, the Prevocational Training Policy Advisory Committee (PTPAC), to play an important role in future reforms of the program. The committee's membership is representative of key stakeholders. The committee will provide:

- advice on the development of training pathways for medical students and junior doctors between undergraduate, prevocational, and vocational education and training in general practice;
- advice on the review and evaluation of prevocational medical education and training programs in general practice; and
- a forum for the development and review of new initiatives in prevocational medical education and training in general practice.

The committee met for the first time on 25 February 2010.

## **PGPPP provider selection**

**4.31** At its first meeting, the PTPAC noted the need for improved co-ordination for vertical integration from post-university education through to vocational training programs such as AGPT. It also noted that a review of provider pre-requisites would provide a foundation for further development of the vertical integration pathway. The PTPAC proposed the following selection criteria for all PGPPP providers:

- the provision of training, and management of training posts in accordance with college standards, must be clearly defined as core business in the provider's strategic objectives;
- each provider must hold current accreditation as an AGPT provider or higher education provider so that all training and education is in accordance with college standards;
- the increased demand for education and training after university will require increased use of provider resources and a capacity to manage this increased activity effectively; and
- each provider must have the capacity to provide a range of post-graduate medical education and training opportunities at varying levels of the vertical integration pathway.

**4.32** The application of the proposed selection criteria will reduce the number of PGPPP providers able to contract with GPET in 2011 to provide PGPPP services. At the time of the audit fieldwork, GPET was developing a single accreditation model for the AGPT program and PGPPP that addresses broader GP training.

## **Provider funding**

**4.33** Funding for the 2010 placements for PGPPP followed the established allocation formula—that is, it was provided using a ‘bottom up’ approach whereby every PGPPP funding application identified specific amounts to be spent on specific line items, prescribing payments to practices, providers, hospitals and prevocational doctors. This funding approach is significantly different from the funding allocation process undertaken for AGPT. In early 2010 GPET’s Board reviewed the PGPPP provider funding arrangements and found that the inflexibility in the PGPPP funding approach had significantly limited the capacity of providers to innovate and to improve the effectiveness and efficiency of the program.

**4.34** In March 2010, GPET’s Board approved changes to the provider and funding arrangements for PGPPP for 2011. It decided that PGPPP provider funding would be allocated on a ‘per placement weeks’ basis, with guidelines for allocation, underpinned by performance requirements. GPET intends to remove the line item requirement from the funding application process and allow providers the flexibility to negotiate the allocation of funds to the hospitals providing PGPPP trainees and/or training practices, as required. GPET anticipates that this less rigid approach will enable increased PGPPP participation without requiring additional funds.

## **Future demand and issues**

**4.35** As noted in Appendix 2, as a result of the Council of Australian Governments decision in 2006 to increase the number of medical school places, there will be significant increases in coming years in the numbers of medical students graduating from universities and seeking to enter the hospital training system. The increasing number of medical graduates (domestic and international) places increased demand on the hospital training system.

**4.36** One of the factors affecting GPET’s ability to increase the take-up in the number of prevocational general practice placements is the number of junior doctors engaged with hospitals who are released to undertake the placements. It is expected that constraints will arise in the training capacity of hospitals in

the near future in some jurisdictions which will affect their ability to train interns. This will affect the demand for PGPPP placements, both negatively and positively; internships (the source of PGPPP participants) may be constrained, but PGPPP placements will be sought-after as attractive and positive training opportunities for hospitals and junior doctors.

**4.37** The review of the early stages of GPET's assumption of responsibility for PGPPP highlights that a range of factors needs to be considered in designing PGPPP for the future. These factors include the time it takes a teaching practice to build expertise in training prevocational doctors; the effectiveness of existing arrangements and networks; practice capacity and availability; impact on service provision in hospitals; and junior doctor training requirements. Board papers show that GPET is giving thought to these issues.



## 5. GPET's Supporting Processes

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*Information management, communications and marketing, and stakeholder engagement are key capabilities which GPET relies on to support its administration of general practice training. This chapter examines the effectiveness of these support processes.*

### Introduction

**5.1** An important element of program management is ready access by managers and other entity staff to relevant and high-quality information on which they can base program management and reporting.

**5.2** The ANAO examined GPET's supporting processes to assess the suitability of these systems and arrangements to support program delivery and accountability. The ANAO examined the:

- information management systems;
- communications and marketing strategy; and
- arrangements for stakeholder engagement.

### Information management systems

#### Information management

**5.3** GPET's information management framework involves relevant IT systems, data sets, data flows, analysis and reporting work. IT systems, data sets and analytical tools are crucial for GPET to assess the appropriateness and quality of training services purchased from RTPs, and are also crucial to internal management activities in planning, shaping, supporting, reviewing and reporting on its training programs. This work is undertaken collectively by three sections within GPET's Program Improvement and Workforce Branch. (See Appendix 3 for GPET's organisational structure.)

#### GPET's IT systems

**5.4** Until late 2009, GPET's two main systems relevant to its management of AGPT were the Selection Information Management System (SIMS) and the Interactive Registrar Information System (IRIS). GPET used these IT systems, plus associated databases and business intelligence analysis tools, to collect,

analyse and report on activities relating to the training and education of GP registrars.<sup>80</sup>

**5.5** GPET used SIMS to manage the application and selection of potential GP registrars for AGPT. SIMS allowed a suitably qualified medical graduate to apply for AGPT online, and it stored details of their staged selection process and results. Once the applicant was accepted and allocated to an RTP, relevant information for the accepted applicant was migrated from SIMS into IRIS, to form the RTP's basic registrar record. RTPs connected to IRIS via the internet to record training information for each GP registrar.

**5.6** In 2009, GPET recognised two strategic IT-related issues:

- the process of data migration from SIMS into IRIS was 'non-precise and cumbersome' and one that would be improved with better integration of SIMS and IRIS; and
- the issue of data quality and IRIS system functionality (especially the need to enter data multiple times, the amount of system support regularly required of RTPs and GPET to undertake tasks and introduce minor changes) and reporting capability.

**5.7** For these reasons, GPET decided in the latter part of 2009 to replace the two systems and to redesign its approach to managing IT.

## **Problems with IRIS and GPET responses**

**5.8** Despite changes to IRIS over time in an attempt to improve its functionality and reliability, with changes to better record, manage and report on AGPT information, in 2009 IRIS was still not fulfilling RTPs' or GPET's requirements.

**5.9** The RTPs visited in the first quarter of 2010 as part of the audit consistently reported frustrations and operational difficulties with (the various iterations of) IRIS over time, complaining of a lack of training and system

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<sup>80</sup> The ANAO broadly tested whether GPET's training data was 'reasonable', including comparing GPET data with data from external sources, such as government announcements on the numbers of training intake places being funded, the number of medical students graduating from medical school and thus possibly entering the training program, and the number of GP registrars sitting exams to seek college fellowship. The results of these broad 'input and output' checks on the numbers of training places offer very broad reassurance as to reasonableness and accuracy of GPET places data. The ANAO found that the data was largely internally consistent and the data was broadly consistent with independent external sources.

support from GPET, and inconsistencies in the data that RTPs had entered and the data then apparent to GPET in the IRIS system. To rectify these problems, GPET established minimum data requirements with the RTPs and initiated changes to the IT system.

#### *Minimum data set from regional training providers*

**5.10** In 2009, GPET and RTPs agreed a minimum data set to be provided to GPET on a routine basis. This was the minimum set of data elements agreed for mandatory collection and reporting at a national level, to satisfy GPET's reporting requirements to key stakeholders. The minimum data set covered items relating to GP registrar information, RTP training performance, RTP activity and financial performance.

#### *IT system changes*

**5.11** In 2009 GPET commissioned a series of analyses of IT system requirements, particularly to redevelop IRIS, and then tendered for the redevelopment of SIMS and the replacement of IRIS.

**5.12** The GPET Board decided in late 2009 to redevelop SIMS and develop a new data storage and retrieval system for AGPT's minimum data set. In developing the new data storage and retrieval system, GPET decided to adopt a quite different strategic approach to managing its and RTPs' interactions regarding AGPT. RTPs continue to record the registrar training history and outcomes in their own systems, but GPET extracts a subset of this data (the minimum data set) into a GPET database in a form prescribed by the needs of GPET's data warehouse. The revised IRIS system extracts this data from the RTPs. One of the major advantages of this approach is that it removes the need for RTPs to duplicate data entry into their own systems and again into IRIS.

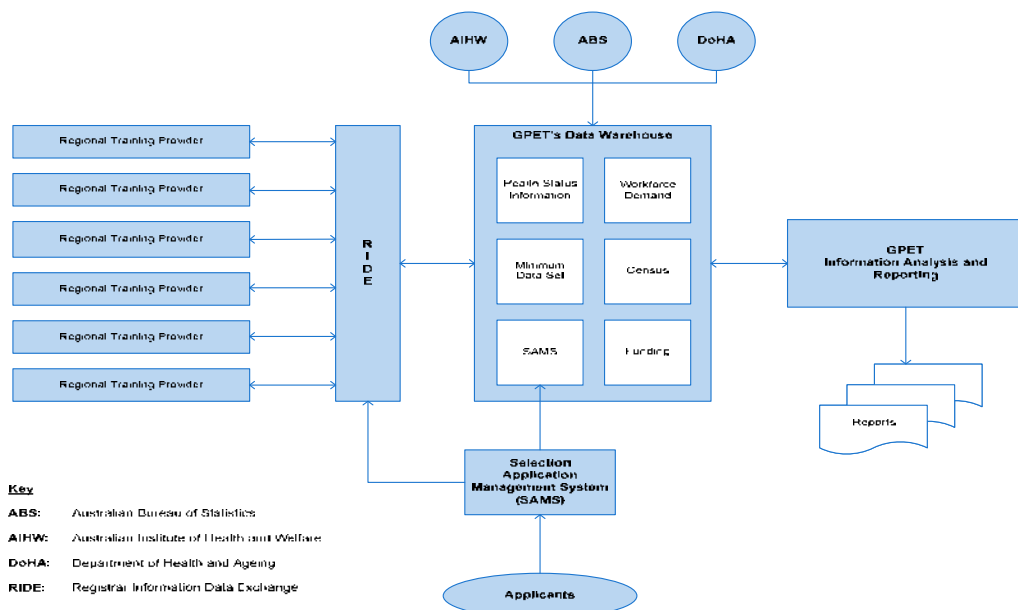
**5.13** The 'revised IRIS' became known as the Registrar Information Data Exchange (RIDE). The redeveloped SIMS became known as the Selection Application Management System (SAMS).

### **GPET's current information management processes**

**5.14** GPET's information management processes are depicted in Figure 5.1. Implementation of the revised IT systems and new IT architecture was underway at the time of audit fieldwork in the first quarter of 2010.

**Figure 5.1**

## GPET's information management processes



Source: ANAO depiction of GPET information.

**5.15** GPET's current training program information management processes broadly involve the processes relating to the capture of information via IT systems as well as analytical and reporting processes. The information management processes underpin GPET's own allocation of training places and the monitoring and evaluation of RTPs' performance and the collective results for AGPT (and PGPPP as of 2010).

**5.16** GPET's data warehouse is the repository for data from many sources (such as SAMS, the minimum data set from RTPs, census data from the Australian Bureau of Statistics, information on population health status and health needs from the Australian Institute of Health and Welfare and funding information from DoHA). GPET uses analytical tools to interrogate the data warehouse, undertake analysis and then prepare reports. This analysis and reporting process underpins much of the work done to support the planning, review and reporting on AGPT, outlined in Chapter 3.

**5.17** Reflecting the changes GPET has made to address its IT problems and to improve its administrative arrangements, GPET's information management processes offer a comprehensive platform supporting GPET's general practice training.

## Communications and marketing

**5.18** Managing training programs for GP registrars and junior doctors on AGPT and PGPPP, delivered via RTPs and other providers around Australia, requires GPET to engage and communicate with a wide range of stakeholders (outlined later in this chapter), with widely differing needs, interests and responsibilities. Communications and marketing are important support tasks in GPET's administration of its training programs and are all the more important in the context of growing general practice training programs that must 'compete' for candidates with other medical specialisations. Communications and marketing tools can support the effective design, delivery and enhancement of the programs by disseminating information and targeting research to assess and address particular communication needs among stakeholder groups.

**5.19** The ANAO examined whether GPET had a communications strategy to guide its approach and used a range of communications media. A well-scoped, well-documented communications strategy assists an entity to recognise and respond to its various stakeholders and provides for the evaluation of its communications activities over time.

### Communications strategy

**5.20** The Marketing and Communication Strategy 2009–11 is a structured way by which GPET documents its approaches to communications. Appropriately, the strategy gives particular attention to marketing and communications to support AGPT.<sup>81</sup> The AGPT strategy identified target groups and broad marketing strategies and specified three performance indicators to judge the success of the AGPT marketing strategy. These performance indicators were:

- increases in the number of AGPT applicants over the previous year;
- increases over the life of the plan in the proportion of Australian Medical Graduates (AMGs) applying for AGPT, rising from 29 per cent of AMGs applying (in 2008) to 35 per cent of AMGs applying (by 2013); and

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<sup>81</sup> AGPT at the time the strategy was formulated was the only GP training program that GPET managed. Therefore the delivery of AGPT, with all its associated activities and processes, represented GPET's corporate purpose.

- applicant survey feedback on marketing materials—but the plan did not specify any targets.

**5.21** Although the AGPT performance indicators are a useful focus for GPET's attention, they are not particularly useful indicators of the success of the AGPT marketing program, as such. Illustrating the indirect connection between the marketing and the performance indicator cited, the annual increases in the numbers of applicants, for example, could be more closely related to increases in the number of medical graduates completing medical school and increases in the number of AGPT training places funded by government than to improved AGPT marketing. GPET's one indicator most closely related to testing perceptions on marketing materials could be strengthened if it specified a performance benchmark. Such a benchmark would allow judgement on whether feedback indicated success in advertising or otherwise.

**5.22** The relative strength of GPET's Marketing and Communication Strategy 2009–11 is its recording, as corporate knowledge, information on matters such as:

- GPET's and DoHA's agreed procedures to guide external communications;
- a corporate perspective on GPET's key messages relating to GP registrar training; and
- the important links between communications and stakeholder relationship management.

## **Range of activities**

**5.23** Consistent with its Marketing and Communications Strategy 2009–11, GPET's marketing program involves conducting market research, devising and delivering the AGPT marketing campaign to communicate the benefits and features of AGPT, providing financial support for student and GP trainee networks and conducting events and conferences, including the annual GPET Convention.

**5.24** The support for students and trainees occurred across each part of the training cycle, with:

- support for the GP Students Network with its GPSN Ambassadors and the GP Student Club geared to providing marketing to medical students as they transition from medical school to hospitals;

- the General Practice Registrar Association delivering its GP Compass program (hospital-based marketing and prevocational liaison to potential AGPT candidates); and
- National GP Supervisors Association to support supervisors' information provision, advocacy and pastoral care functions.

**5.25** In 2009–10, GPET budgeted to spend approximately \$1.5 million on these marketing and communications activities. The bulk of this amount was allocated to supporting the GP Students Network, GP Compass and the National GP Supervisors Association secretariat.

**5.26** Based on its review of the program planning and monitoring mechanisms, including Board review processes, the ANAO considers that GPET conducts its marketing and communication activities with appropriate attention to process.

## Evaluation

**5.27** As evident in GPET's evaluation conducted as part of its late 2008 web-based survey of some 900 applicants for the 2009 AGPT program intake, GPET evaluates its marketing and communication methods and acts on these evaluations.

**5.28** The survey indicated applicants' primary sources of information about general practice training (for example, source organisation and method of provision) and the penetration and effectiveness of the AGPT marketing materials used. Survey results prompted GPET to discontinue its attendance at one promotional activity and to initiate collaborative action with RTP-based marketing contacts around Australia.

## Engagement with stakeholders

**5.29** Engaging with stakeholders is an important support process when managing training programs. Effective stakeholder engagement is also a key element of corporate governance, because effective communication with stakeholders—both internal and external—together with good information and decision support mean that an organisation can plan and deliver required programs and outcomes, as well as meet the requirements for compliance and accountability.

**5.30** In assessing GPET's stakeholder engagement, the ANAO examined whether GPET actively engaged with a wide range of stakeholders relevant to

general practice training and whether the nature, timing and scope of these interactions (formal and informal) reflected the circumstances required, in a professional way.

## **Stakeholder engagement activities**

**5.31** GPET's role as a Commonwealth company managing the provision of general practice training requires it to engage actively with a wide range of stakeholders. These include:

- government—the Minister for Health and Ageing, DoHA, Health Workforce Australia and state and territory governments;
- the medical profession and academics—the professional colleges; representative groups, including representatives of Aboriginal Community Controlled Health Organisations, the Rural Doctors Association, Australian divisions of general practice, hospitals, and Medical Deans of Australia and New Zealand;
- training providers—RTP Board Chairs and CEOs, third party contractors such as universities, medical educators, supervisors and mentors;
- clients—the trainees in the training systems that GPET oversees (namely the representatives of GP registrars, applicants and prospective applicants, and international medical graduates); and
- community—general, rural and remote, Aboriginal and Torres Strait Islander communities.

**5.32** Board papers, program development and implementation documents and audit fieldwork discussions demonstrated that GPET has ongoing and productive engagement with a wide range of parties with an interest in general practice training.

**5.33** Two cases in 2009 demonstrated how GPET and the RTPs worked with professionalism to manage differences and to maintain working relationships. These were:

- a long-running contract and funding issue with one RTP; and
- the management of processes to reduce the number of RTPs following the announcement of the Government's 2009–10 Budget measure to consolidate the number of RTPs to improve the efficiency of AGPT.



## **Stakeholder survey—the annual GP registrar satisfaction survey**

**5.34** Stakeholder surveys, undertaken at regular intervals, are a good way of assessing an organisation's performance (including performance over time), as perceived by stakeholders. Surveys can highlight areas of relative strength and areas perceived to need improvement.

**5.35** GPET conducts an annual online satisfaction survey of GP registrars undertaking AGPT. Run well, it would be expected that GPET would have appropriate processes around the conduct of the survey (for example, it would be run in a rigorous way and GPET would take account of survey results) and ideally, the survey would reassure GPET that GP registrars were satisfied with AGPT.

**5.36** GPET engaged professional survey firms to conduct its National GP Registrar Satisfaction Surveys and adapted the questionnaire in 2009 to accommodate changes in the general practice regional training environment, after consultations with the representatives of RTPs and GP registrars. The survey seeks registrars' feedback on their level of satisfaction with the quality of training and supervision provided by RTPs. The survey seeks responses from all GP registrars on, among other things, the activities and conduct of the RTP, education resources and support, and overall satisfaction with training received so far.

**5.37** GPET uses the information from the national surveys to assess the national consistency of the delivery of AGPT training. Disaggregated survey information helps individual RTPs gauge their own GP registrars' satisfaction against a national average and assists RTPs to identify relative strengths and matters for improvement. The Board actively considered the results of each year's survey and GPET conducted follow-up sessions with RTPs regarding survey results.

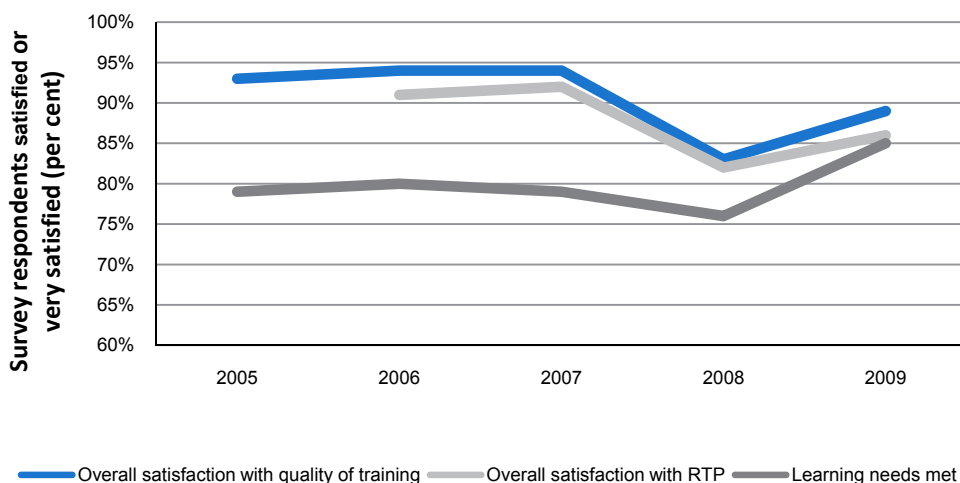
**5.38** As highlighted in Figure 5.2, the results of the surveys have been positive. In 2009<sup>82</sup>, for example, 89 per cent of respondents indicated that they were satisfied or very satisfied with the quality of their individual training, 86 per cent were satisfied or very satisfied with the quality of their RTP and 85 per cent were satisfied or very satisfied that their learning needs were met.

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<sup>82</sup> The 2009 survey had 1197 survey responses, a survey response rate of 56 per cent.

**Figure 5.2**

**GP registrar satisfaction survey results**



Source: ANAO depiction of GPET data.

Notes: 2008 was the first year that the survey was conducted electronically, resulting in improved response rates.

The 2009 survey had a different content and structure from earlier surveys, making it inappropriate to compare data directly with earlier periods.

**5.39** As well as offering comments on the positive aspects of their training, respondents also suggested areas for improvements. The most common suggestions were that RTPs should provide more training and workshops tailored to real situations, and RTPs should improve communications and consistency of information from RTPs and practices to GP registrars.

**5.40** The GP registration satisfaction surveys and their results reflect well on GPET's use of supporting processes, including engagement with key stakeholders, and the perceived effectiveness of GPET's activities managing general practice education and training.

Ian McPhee  
Auditor-General

Canberra ACT  
24 March 2011

# Appendices



## Appendix 1: GPET's response

The Australian Government has made significant investments in general practice education and training over recent years, with entry places in the AGPT program rising from 600 in 2008 to 1200 in 2014. Placements in the PGPPP have increased from 380 in 2010 to 975 in 2012. This growth in general practice training is an important component of the Government's health reform and workforce strategies. As noted by the ANAO, GPET has successfully established and administered the AGPT program and successfully managed the transition and early implementation of the PGPPP.

Throughout its short history GPET has applied the highest standards of corporate governance. GPET's strategic and business planning has successfully supported the establishment of a network of regional training providers, the implementation of a regionalised approach to general practice training, and the subsequent expansion of the AGPT program and the PGPPP. GPET's high level corporate guidance materials and plans have reflected the strategic priorities of the Company at each stage during the transition from the establishment and start-up phase of the training programs through the consolidation of the regional training provider network and on to the current growth phase.

The changes to the Company Constitution in 2010 have provided the basis for a clear alignment between the Company's objects, its strategic planning, and the key performance outcomes set out in the Health and Ageing Portfolio Budget Statements, in the current context of an unprecedented growth phase in general practice training.

## Appendix 2: The growth of the prevocational and vocational general practice training programs

### Australian General Practice Training program history—context for the increased training places over time

The 2000–01 Budget contained a range of measures under the *Regional Health Strategy* that aimed to attract more doctors to rural and regional areas and strengthen the rural medical workforce. The package included funding for 50 additional general practice vocational training places from January 2001 to be allocated to rural and regional locations. This raised the annual quota for general practice vocational training then delivered through the Royal Australian College of General Practitioners' training program from 400 to 450 places. Incentive payments were also made available to doctors who trained in rural areas.

Since January 2002, general practice vocational education and training has been offered through the Australian General Practice Training (AGPT) program, managed by General Practice Education and Training Limited (GPET). The initial quota for training places on AGPT was 450 places per new intake.

The 2003–04 Budget measure: *A Fairer Medicare: Better Access, More Affordable* provided funding for an additional 150 training places on AGPT. Training places were targeted at outer-metropolitan and other areas of workforce shortage and complemented the *More Doctors for Outer Metropolitan Areas* measure contained in the 2002–03 Budget, which required registrars on AGPT's general pathway to train in designated outer metropolitan areas to reduce pressure on GPs caused by the extensive population growth in these areas.

In April 2006, the Council of Australian Governments (COAG) approved an increase in the number of medical school places to help address medical workforce shortages. An additional 400 medical places were funded with 200 places commencing in 2007 and the full 400 available by 2009 with over 1800 new medical places expected to be funded by 2013. A proportion of the new medical school places were bonded to areas of medical workforce shortages.

Australia is now starting to experience the flow-on effect of this decision and is seeing an unprecedented increase in the number of graduates from Australian medical schools. The number of graduates from medical courses across

Australia is expected to increase from 2243 graduates in 2008 to approximately 3790 in 2014. This includes domestic and international students and represents a projected growth of almost 69 per cent.

This increase in the number of medical graduates resulted in GPET receiving a record number of applications for the 2009 new intake for AGPT—870 applications for 600 new intake training places. To help meet the immediate demand for GP vocational training, on 5 November 2008 the Australian Government announced a one-off increase of 75 places in 2009 and an extra 100 places in 2010, bringing the total number of training places per intake of the AGPT program to 675 in 2009 and 700 in 2010.

The Australian Government announced on 29 November 2008 a further increase of 212 on the base number of ongoing general practice training places from 2011, as part of the Commonwealth's contribution to the Health Workforce Partnership through the COAG agreement. This brought the total number of general practice training places per new intake to 812 per year from 2011 onwards.

On 15 March 2010, the Australian Government announced funding for a further expansion in general practice training, which, combined with previous increases, provided for 900 new intake places in 2011, 1000 places in 2012, 1100 places in 2013 and 1200 places ongoing from 2014. This doubles the places in AGPT from 600 new intake training places in 2008 to 1200 new intake training places in 2014.

The Government also supported 22 general practice training places ongoing from 2011 on the Remote Vocational Training Scheme, and has funded an additional 38 Indigenous Health Training posts for four years from 2010 through the COAG Indigenous Chronic Disease package. GPET does not manage the Remote Vocational Training Scheme.

### **Prevocational General Practice Placement Program history—context for increased training places**

The Prevocational General Practice Placement Program (PGPPP) is a prevocational training program that provides junior doctors with an opportunity to undertake voluntary, well-supervised placements in general practices in outer metropolitan, regional, rural and remote areas. The program is designed to enhance junior doctors' understanding of the links between primary and secondary healthcare (that is, the relationship between the primary care by general practitioners and care by other medical specialists,

including in a hospital situation) and to encourage junior doctors to consider general practice as their preferred medical specialty.

In the 2009–10 Budget, the Australian Government increased funding for the program to provide for 380 placements (averaging 12 weeks) in 2010, building to 410 placements by 2013. This is designed to boost the number of placements in NSW, Tasmania and the ACT to achieve a more even distribution across Australia.

The management of PGPPP was transferred to GPET from 1 January 2010, with the objectives of better aligning PGPPP and AGPT, and creating a comprehensive pathway with greater opportunity for coordinated linkages and activities in the delivery of general practice training.

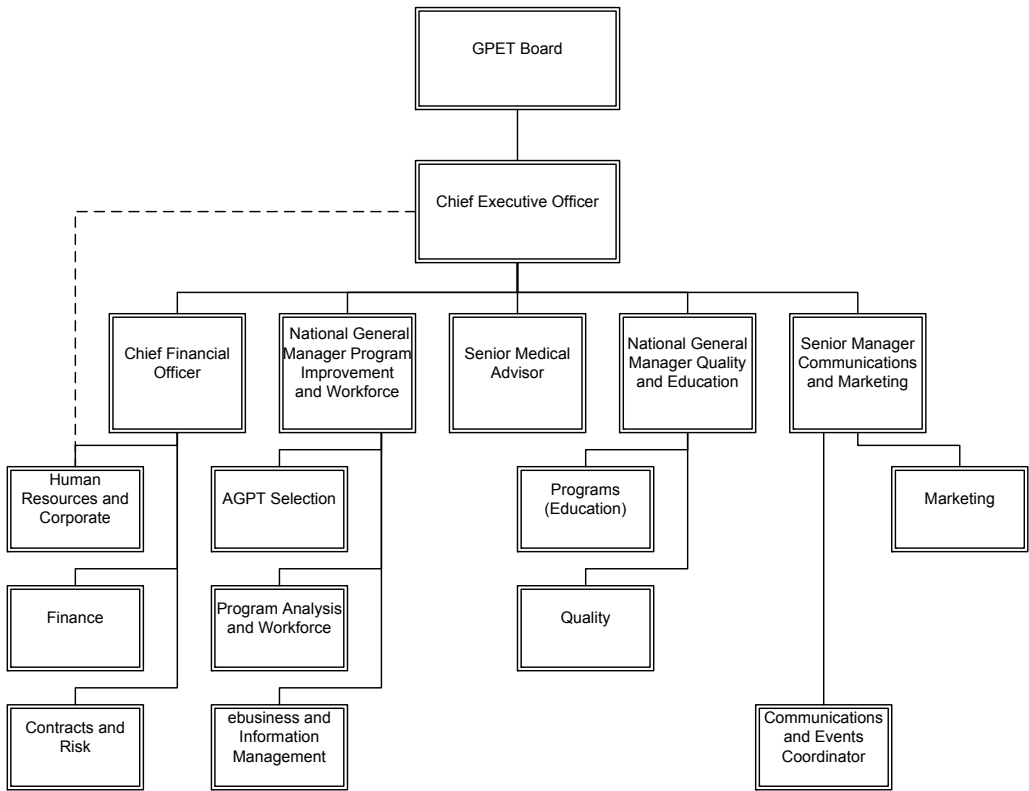
On 15 March 2010, the Australian Government announced that it will more than double the number of placements from 380 in 2010 to 975 placements in 2012 onwards. Providing additional general practice training rotations for interns and junior doctors in primary care and community settings via the expanded PGPPP program increases the capacity of the hospital system to train the rising number of medical graduates entering the system.



# Appendix 3: The GPET organisation

Figure A 1

GPET’s organisational structure as at 30 June 2009



Source: GPET.

GPET’s organisational structure as at 30 June 2010 was largely similar to that in mid-2009. However, over the year two sections under the Chief Financial Officer were amalgamated into one section (the new section being Finance and Contracts) and an additional section was created under the National General Manager Program Improvement and Workforce (the new section being Training Capacity and Resources).

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