



Government involvement in general practice

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In an increasingly regulated society it is hardly surprising that the important work performed by general practitioners has come under the scrutiny of public servants charged with implementing health policies and politicians wishing to be re-elected. Such scrutiny and the ensuing regulation is often viewed as an affront to the medical profession. However, if one accepts the argument that regulation is here to stay, the potential threats – but also opportunities for the profession to influence the nature of that regulation – become clearer.

This article introduces the notion of responsive regulation which asserts that governments should be responsive to the conduct of those they seek to regulate and should adjust the level of intervention according to the extent it is required to achieve regulatory goals.¹ Rather than a heavy handed approach to regulation that treats all cases alike and seeks to maximise consistency, responsive regulation challenges the regulator to accurately determine both when it is appropriate to engage in punitive action and the severity of that action. This approach returns some power, both in terms of the process and the outcome, to those regulated. It also offers the possibility that private individuals and groups might influence the state's own regulatory approach.² Furthermore, some within the profession are beginning to champion responsive regulation,³ although the terminology, at present, is unfamiliar.

Australian general practice – a history

The history of Australian general practice training will be familiar to many readers, but for those new to the profession or those who chose not to engage in the process, a brief

synopsis follows. The Royal Australian College of General Practitioners (RACGP) was established from state based faculties of the British Royal College of General Practitioners (RCGP) in 1958, but it wasn't until 1974 that the Family Medicine Program – subsequently the RACGP Training Program – commenced. In an attempt to formalise the discipline's knowledge base, augment the financial position of GPs, and raise the quality and status of general practice, the RACGP, initially supported by the Australian Medical Association (AMA), approached the then Labor Health Minister, Dr Neal Blewett, with a proposal for vocational registration. The minister was willing to offer vocationally registered GPs higher rebates in return for improved quality, which was to be achieved through better initial training and continuing medical education.⁴ Vocational registration was incorporated into the Health Insurance Act 1973 in September 1989, and a pitched battle was waged by opponents from within the profession.⁴

One consequence of this process was to re-open a three-way dialogue among the state, the RACGP and the AMA. The eventual outcome – for good or ill – was the adoption of the General Practice Strategy by the Australian Government in its 1992/1993 Federal Budget.^{5,6} A raft of changes followed. Millions of dollars in project grants were distributed to individuals and organisations,⁷ divisions of general practice sprang up all over Australia, and practice accreditation was introduced. After 5 years of momentous and taxing change, the General Practice Strategy was reviewed,⁷ as was the approach to training GPs.⁸ Further modifications occurred as a result of these two reviews, most significantly state funding for the computerisation of general practices

across Australia,⁹ and the establishment of General Practice Education and Training Ltd (GPET). Integral to this process was the tension and growing animosity between many rurally based GPs and the RACGP over the extent to which the training program delivered the type and quality of training desired by rural doctors. Despite the creation of the Faculty of Rural Medicine within the RACGP in 1991, these tensions continued to mount and culminated in the formation of the Australian College for Rural and Remote Medicine (ACRRM) in 1997.

The remainder of this article examines the ensuing changes in the way general practice education and training is funded and organised. It draws on over 70 qualitative, in depth interviews conducted during 2000 with senior commonwealth officers and GPs engaged in negotiating the changes. In doing so, I hope to demonstrate the way that interactions between the regulator (in most cases the state) and the regulatee (the profession) influenced the outcome, indicate ways that it might have proceeded differently, and propose an approach to regulatory negotiations in the future.

From the training program to GPET

Whereas the RACGP once received state funds to deliver training, GPET now manages funds largely according to the state's agenda. Consequently, what was once an education program administered and controlled by the profession, but with little state input or direction, has become a tightly directed and highly monitored system grounded in a contract between an independent, legal entity and the state. The autonomy and freedom that the profession once enjoyed in the use of those funds to deliver its educational programs

has been significantly curtailed. This is not to suggest that the training received by registrars is now of a lesser standard. Indeed it may well be higher, but one must await an evaluation of at least the first cohort of registrars, some of whom sat the RACGP Fellowship exam in 2004. I merely make the point that the state is now in a position to exert far greater influence over the profession via GPET than in the past, and in this sense, general practice as a profession is more highly regulated than ever before.

The theory of responsive regulation suggests that the state, having decided in the first half of the 1990s that it was not satisfied with the quality of general practice education and training, should have been able to negotiate improvements with the profession. However, mutual respect and trust between the regulator and regulatee are central to the notion of responsive regulation.

Given the state's incompetence as a regulator, the RACGP responded quite rationally to the loose regulatory environment, ie. it continued to function as before. Consequently, the state was left with no option but to emasculate the profession. The ultimate sanction involved supplanting self regulation by the profession with tight contractual arrangements between the state and the newly formed GPET. However, to fully comprehend the reasons and the process of this shift, one must also consider the context in which this regulatory change took place.

For most of the 1990s and into the 21st century, macro government policy has encouraged competition as a means of improving quality while simultaneously managing budgets. Competition in the provision of general practice training is not yet viable, so 'contestability' is used to describe the current arrangements. Unfortunately the term is poorly specified and consequently, poorly understood.¹⁰ Nevertheless, moves by ACRRM to achieve certification for its fellowship may bring more meaning to both terms. The very existence of ACRRM highlights what I believe to be a more significant factor in the change; the inability of the profession to manage its internal disputes which led to the establishment of

a rival medical college, thereby providing the necessary conditions for contestability.

How might things have proceeded differently?

First, the profession may have responded in a more considered way to the state's concerns about quality and could have acknowledged the state's not unreasonable desire to account for public funds spent. After all, the health bureaucracy, with its many attendant irritations, remains accountable to the Australian Parliament and thereby to the Australian public.

On the other hand, representatives of the state did not always display either an understanding or an appreciation of the profession's position or its long historical precedent. The necessity to juggle the profession's competing agendas makes it difficult to formulate or implement constructive and considered health policy. If the regulation of general practice training seems excessive, the profession might best begin by re-assessing its own approach to regulation.

Possibilities for future negotiations

From the perspective of responsive regulation, trust and mutual respect form the basis of productive negotiations. In terms of respect, it may be helpful for both parties to acknowledge that GPs are best placed to set the standards for general practice, to train the next generation of GPs, and to develop innovative strategies for future training. Similarly, commonwealth officers are able to draw on their extensive knowledge both of the Australian health system and the processes necessary to prepare and deliver the most effective funding and administration within budgetary constraints. Trust is more difficult to summon and foster.

However, as a starting point both parties can sincerely acknowledge the boundaries and difficulties of the other. For instance, commonwealth officers need to account for the expenditure of public funds. Merely hoping that the profession will dispense these funds appropriately is neither reasonable nor sufficient to meet standards of public accountability. Furthermore, the policies that frustrate GPs are not necessarily of the bureaucrats' making, for

political imperatives very often override more rational grounds for policy. For their part, some GPs may have become too wedded to the golden age of general practice – which arguably never existed – and this leaves them less open to future possibilities. Most importantly, perhaps, it may be helpful to remember that both GPs and commonwealth officers perceive their role as serving the public, albeit in different ways. This common basis – and the common goal of an efficient and effective training program for future GPs – provides a solid foundation for trust, if both parties have sufficient courage and commitment.

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