

**REVIEW OF THE
SPECIALIST TRAINING
PROGRAM AND THE
EMERGENCY MEDICINE
PROGRAM**

FINAL REPORT

MARCH 2017

Contents

Executive Summary.....	4
1 Background to the Review.....	14
1.1 Rationale for Commonwealth Investment in Specialist Medical Training.....	14
1.1.1 Context.....	14
1.1.2 Outcomes.....	17
1.2 The Specialist Training Program.....	20
1.2.1 The History of the Specialist Training Program	20
1.2.2 Aims of the Specialist Training Program.....	20
1.2.3 About the Specialist Training Program	21
1.3 The Emergency Medicine Program.....	23
1.3.1 History of the Emergency Medicine Program	23
1.3.2 Aims of the Emergency Medicine Program	24
1.3.3 About the Emergency Medicine Training Program	24
1.4 Health Workforce Australia 2012 Report, Health Workforce 2025 – Medical Specialties – Volume 3.....	26
1.5 The Review Process.....	26
1.5.1 Operational reforms	27
1.5.2 Data analysis	28
1.6 The Integrated Rural Training Pipeline	29
2 Reforms to the Specialist Training Program	30
2.1 Overview	30
2.2 Administration of the Specialist Training Program	30
2.3 Allocation of STP training places	38
2.3.1 Background	38
2.4 Allocation of training posts to colleges and specialties	38
2.5 STP training post targets – rural and private	43
2.6 College Recommendations on the Review and Selection of training posts	45
2.7 Expressions of interest to host STP trainees.....	48
2.8 Rural classification system for the STP.....	51
2.9 Dedicated Indigenous training posts	52
2.10 Specialist International Medical Graduates (SIMGs).....	53
2.11 Reporting by colleges	54
3 Funding of the STP and EMP	57
3.1 Current STP and EMP funding.....	57
3.2 Future funding for the STP and EMP.....	59
3.3 Salary Support funding.....	59
3.4 Rural Loading funding	61
3.5 Support Project funding	63
3.6 Administrative and Governance funding	66
3.7 Private Infrastructure and Clinical Supervision (PICS) Allowance.....	67
4 Proposed reforms to the Emergency Medicine Program.....	70

4.1	The Emergency Medicine Training Program	70
4.1.1	Background	70
4.2	Proposed reform: Integration of STP and ETP	70
4.3	The Number of Emergency Medicine Training Posts Allocated to ACEM	71
4.4	The Emergency Medicine Education and Training (EMET) Program	73
4.4.0	Background	73
4.4.1	Proposed reforms to EMET	74
4.5	The Emergency Department Private Sector Clinical Supervisor Program (EDPSCS).75	
4.5.1	Background	75
4.5.2	Proposed reforms to the EDPSCS	76
ATTACHMENTS.....		78

Executive Summary

On 19 March 2015, the Minister for Health and Aged Care and Minister for Sport, the Hon Sussan Ley MP, announced the review of the Specialist Training Program (STP) and Emergency Medicine Program (EMP) through a process of consultation with specialist medical colleges¹ and other stakeholders. The Minister outlined that the review would:

...focus on in depth workforce planning to better match investments in training with identified specialties of potential shortage and areas that may be oversubscribed into the future.²

The STP and EMP have subsequently been reviewed together by the department over this period, with the process informed by the release of an early discussion paper and a preliminary draft report, each of which has been discussed with stakeholder groups in detail. This final report reflects the outcome of the consultation process and the evidence gathered by the departmental team in relation to program efficiency, effectiveness and appropriateness, with a clear focus on ensuring the investment in these initiatives is aligned with Government policy priorities and the future needs of the Australian community.

The final review report has been developed in the context of significant fiscal challenges for the Commonwealth, which are reflected in decisions to attach broad savings targets to the overarching Health Workforce Program. This review acknowledges those challenges and seeks to identify reforms and efficiencies in the STP and EMP that will ensure future investment is well-targeted and within the Government's fiscal priorities.

Review Background

Since the early 2000s the issue of training specialists in expanded settings has been a matter of interest for the Commonwealth, leading to the establishment of a number of new programs as described later in this report. Most notably, in July 2006 the Council of Australian Governments (COAG) announced that the Commonwealth and the states and territories would establish, by January 2008, a system for trainees to undertake rotations through an expanded range of settings beyond traditional public teaching hospitals. This was designed with the complementary aims of addressing projected future growth in domestic medical graduates, improving workforce distribution and enhancing the quality of the future workforce to meet community needs for specialist medical services.

Under the 2009-10 Budget, the different Commonwealth funded specialist training initiatives were consolidated into the STP, with the EMP commencing the following year.

The STP has been progressively expanded by successive governments based on evidence of strong projected demand for advanced vocational training positions and continuing workforce distribution challenges. At the same time, the commitment to the EMP has been implemented

¹ The STP/EMP has 13 participating colleges. The two general practitioner colleges – the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine – are not participating colleges in the STP or EMP.

² The Hon. Sussan Ley MP. Minister for Health and Sport, *Media Release*, “\$150 million for special medical training”, 19 March 2015,

www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley021.htm?OpenDocument&yr=2015&mth=03 (accessed 9 June 2015).

with the number of training places growing from an initial 22 per year to the current ongoing 110 places, complemented by investment in emergency workforce support.

Current Aims and objectives of the STP

The STP supports the training of medical registrars seeking specialist fellowships in an expanded range of settings. Expanded settings are:

... a range of public settings (including regional, rural and ambulatory settings), the private sector (hospitals and rooms), community settings and non-clinical environments.³

Combined, the STP and EMP fund an estimated five to seven per cent of all specialist training posts nationally. The remaining positions are funded directly by the states and territories through their public hospital systems.⁴

The current aims and objectives of the STP are:

- Increase the capacity of the health care sector to provide high quality, appropriate training opportunities to facilitate the required educational experiences for specialists in training;
- Supplement the available specialist workforce in outer metropolitan, rural and remote locations;
- Develop specialist training arrangements beyond traditional inner metropolitan teaching settings:
 - with rotations to accredited training posts in health care settings that include private hospitals; specialists' rooms; clinics and day surgeries; Aboriginal Community Controlled Health Service (ACCHS); publicly funded health care facilities which can provide training opportunities not previously available, particularly in areas of workforce shortage (such as regional, rural and community health settings); and non-clinical settings (such as simulated learning environments);
 - with training in these settings fully integrated with and complementing training occurring at the major public teaching hospitals; and
 - that provide training for Australian specialist trainees, overseas trained doctors (OTDs) and specialist international medical graduates (SIMGs) in pursuit of Fellowship of the relevant College within the boundaries of Australia.

The STP is effectively a set of three initiatives:

1. Support of 900 training posts through the specialist medical colleges;
2. The Tasmanian Project that supports the employment of supervisors and trainees in the Tasmanian public health system; and

³ STP Operational Framework, p. 3,

[www.health.gov.au/internet/main/publishing.nsf/Content/4AAA78E3A7D8FA47CA257BF0001B73E0/\\$File/STP%202013%20Operational%20Framework.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4AAA78E3A7D8FA47CA257BF0001B73E0/$File/STP%202013%20Operational%20Framework.pdf) (accessed 15 December 2015).

⁴ Note states and territories currently receive substantial Commonwealth funding support for teaching, training and research in the public hospital system through the National Health Reform Agreement 2011.

3. The new Integrated Rural Training Pipeline (IRTP) measure that will support 100 training posts by 2018.

Current Aims and objectives of the EMP

The current aims and objectives of the EMP are:

- Enhance the specialist emergency medicine workforce and contribute to reduced waiting times for patients;
- Extend emergency medicine training into new settings; and
- Improve the quality of rural emergency services.

The EMP is a set of three initiatives:

1. Emergency Medicine Training Program (the ETP), which supports the training of prospective emergency medicine specialists;
2. Emergency Medicine Education and Training program (EMET), which provides clinical education, training and supervision by specialist emergency physicians (Fellows of the Australasian College for Emergency Medicine) to the emergency care workforce and increasing access to emergency medical services for people living outside of urban areas.; and
3. Emergency Department Private Sector Clinical Supervisor program (EDPSCS), which provides support for training emergency medicine specialists in the private sector.

Review Process and Consultations

The review has been conducted in two, concurrent strands; one looking at the operation of the STP and EMP, the other at how training posts are allocated. The department has engaged with stakeholders extensively during the review and in the preparation of this report.

Stakeholder feedback on the STP and EMP was overwhelmingly positive. Most felt the programs were meeting their aims and objectives. Both programs have been effective in building training capacity and demonstrating the value of investing resources in expanded or non-traditional training settings. The STP and EMP are supported by the sector both from an educational and service delivery perspective. Importantly, there is agreement that they generate benefits to patients and communities, particularly outside the major metropolitan areas.

Consultation indicated that the STP and EMP are appropriate and efficient programs that help meet needs in the provision of specialist training in the health system. For example, one rural-based stakeholder commented that the STP is “a very valuable program (and) one of the few supports for rural specialist practice”.

The consultation process has confirmed the conclusion reached by the Australian National Audit Office (ANAO) in its 2015 examination of STP that:

Health has made substantial progress towards achieving the key STP targets and objectives ... Further, college reporting indicates that the STP has been successful in

*utilising non-traditional settings to expand the number of specialist training opportunities.*⁵

At the same time, there has been a wide variety of views about how the STP and EMP could be improved, as outlined in the department's draft review findings report of August 2016.

Key Issues Identified in the Review

The key program management issues identified during the review are that:

- the administration of the STP is overly prescriptive for a mature program and, in some cases, this affects its ability to respond to training needs;
- workforce data informing the program requires updating;
- the process for allocating training posts to colleges is unclear;
- the persistence of a relatively high number of vacant training posts represents a key opportunity cost which risks undermining the effectiveness of the program;
- while the programs have increased the amount of time trainees spend in rural and regional areas, most of their rotations are still in metropolitan settings;
- some changes to funding are needed to provide greater support to trainees in rural and regional settings;
- there is a need to address the incidence of short-term high-throughput rotations, particularly in rural areas, in light of the potential impact on rural recruitment as well as the capacity of other rural training programs;
- stakeholders are seeking an increase to the core salary contribution provided for registrar placements, however most colleges would prefer that the number of training posts be maintained at current levels, rather than reduced to accommodate a significant increase in the salary contribution;
- EMP investment in posts does not align with preliminary workforce projections recently undertaken by the National Medical Training Advisory Committee (NMTAN); and
- although colleges consider funding of support projects beneficial, it is one area in which savings could be made.

Workforce Planning and the Allocation of Training Places

As well as considering the operations of the STP and EMP, the review examined the process used to allocate training places. The department undertook an analysis of some sections of the medical specialty workforce using information from the colleges and the jurisdictions and building on the Health Workforce Australia report *Health Workforce 2025 - Medical Specialties - Volume 3* (HW 2025 Vol 3).

⁵ ANAO Report No.26 2014–15, *Administration of the Medical Specialist Training Program*, Australian National Audit Office, 10 March 2015, p. 14.

KPMG was engaged to provide assistance to the department on the development of a process for the allocation of training posts to the colleges in the future, with a focus on addressing identified workforce shortages. The purpose of this analysis was to identify the extent of any future undersupply or oversupply in medical specialties participating in the STP and EMP, which would then be used to inform decisions about how many training posts would be allocated to each college and their annual targets.

For the STP, KPMG's analysis of the program did not find major problems with the current allocation of training places to the colleges/specialties, at least in terms of the overall national supply of specialists. However, it did suggest some reforms to the way in which training posts are selected to ensure they best meet the aims and objectives of the STP. KPMG's proposed allocation methodology provides a system to help ensure the allocation of places is supported by the available evidence.

This allocation methodology does not lead to significant changes in the number of training posts allocated to most specialties. This indicates that the department's existing allocation method has functioned well and generally addressed workforce needs. It is timely, however, to consider adopting an updated approach that can inform program delivery as the specialist workforce develops in the future.

However, since KPMG completed their modelling, new emergency medicine data and forecasts were considered by the NMTAN. Although preliminary, and subject to finalisation through NMTAN, the forecasts for 2030 indicated a significant oversupply of emergency medicine specialists.

In this situation, the department consulted with the Australasian College for Emergency Medicine (ACEM) to determine an appropriate adjustment to the support provided under the EMP. ACEM provided a well thought out and appropriate proposal that suggested the integration of the EMP into the STP, a 50% decrease in the number of EMP training posts to be supported, continuation of funding to support EMET, and management of the EDPSCS by the College, as described further below.

Review Findings

Based on the evidence and stakeholder feedback captured during the review process, the department has made findings and developed a number of reform proposals for Government consideration. Overall, its recommendations are aimed at making the STP more efficient and effective within the context of a tight fiscal environment with a need to identify potential savings, by:

- increasing the colleges' flexibility to manage the STP to ensure its delivery is responsive to emerging training needs (the EMP already operates under a flexible system);
- having more training take place in rural and expanded settings;
- maintaining the current number of training posts; and
- seeking to avoid supporting training that is already being funded by the jurisdictions.

The department would retain overall policy and oversight responsibilities for the programs.

In brief, the department's primary findings and recommendations are:

- The review has found that the STP/EMP program remains an appropriate investment of Commonwealth funds. The program ensures that identified gaps in the coverage of specialist training measures undertaken by state and territory jurisdictions can be effectively targeted and enables the Commonwealth to work collaboratively with jurisdictions to meet future workforce needs. Investment in STP/EMP presents a continuing opportunity for engagement with medical specialist colleges to meet national training objectives, with benefits for future collaborative reform, including through the NMTAN.
- The scope of the STP should continue to be focussed on the non-GP medical specialties. GP training for fellowship of the Royal Australian College of General Practitioners (RACGP) and/or the Australian College of Rural and Remote Medicine (ACRRM) is well-supported through the Australian General Practice Training (AGPT) program. Further, in the current resource-constrained environment, STP/EMP priorities need to continue to focus on fellowship-level training rather than advanced training or up-skilling for existing college fellows. Issues around advanced post-fellowship training and the implementation of the Government's commitment to a national rural generalist training pathway will be considered through other policy development mechanisms in consultation with the Rural Health Commissioner.

- *Administration of the STP:*

The review has indicated that the STP's current, top-down administration model lacks flexibility and is too prescriptive now that the program has matured. The department recommends that greater responsibility be put in the hands of the colleges as they are the bodies that manage the training of fellows, accredit settings and are in the best position to efficiently fill vacant training posts or fund other training posts. The department would continue to manage agreements outlining the expected outcomes for the program, as well as the number of training posts allocated to each college and any related training distribution targets.

The department also considers that funding agreements of at least three years' duration should be negotiated between the department and colleges in future, to increase certainty in the sector and allow long-term training plans to be created.

A one-off adjustment to administration funding has been proposed to ensure the increased range of responsibilities expected of colleges can be successfully implemented. It is noted that colleges have already absorbed the administration of the Tasmanian Project and potentially some costs of the new Integrated Rural Training Pipeline – STP initiative. Feedback from colleges suggests that while they are supportive of the proposed reforms to the program, their implementation will have an administrative impact. The proposed adjustment to current administration funding is designed to ensure colleges have sufficient resources to successfully implement the revised program.

- *Allocation of training posts and addressing workforce shortages:*

The Government's announcement made it clear that the review would look at matching investment to identified areas of potential specialist shortage. Based on its workforce analysis, and with the assistance of KPMG, the department has developed a recommended

process for allocating training places in the STP and determining which posts best meet the required aims and objectives.

In selecting training posts, it is important that colleges seek to address workforce shortages and maintain their focus on posts in expanded settings and defined workforce priorities. With that in mind, the department recommends training post targets be set for each college at the start of the funding agreement period. The targets would be based on the updated data modelling and the more refined allocation process developed during the review. The review found that training posts tend to effectively become permanent once established. To address this problem, colleges would assess all existing posts against principles set by the department, reflecting Government priorities and informed by clearly defined assessment parameters.

One consequence of making colleges responsible for selecting training posts is that it may place administrative burdens on settings from having to deal with each college separately whenever new training posts are allocated. This has been addressed through the development of an online expression of interest (EOI) process for settings interested in hosting STP, ETP and IRTP training posts (see Section 1.6 below for an explanation of the IRTP). The EOI approach was trialled during November 2016 and included an opportunity for state and territory health departments to comment on the EOIs submitted. Colleges will need to consider this feedback in selecting posts for STP support, in combination with their view on the educational value of the setting.

Any revisions to the allocation of training posts to the colleges would occur at the end of each funding agreement with EOIs occurring approximately every two years.

With a refreshed reserve list following the 2016 EOI, and regular EOIs in future, the Colleges will be well placed to fill any vacant posts that may arise over the next three years. Vacant posts may occur for a number of reasons but often reflect an inability for settings to recruit a registrar, retain a supervisor and maintain accreditation status. However, there will always be some gaps between the colleges identifying vacancies and contracting new posts.

Some colleges were concerned that their new roles of selecting training and reviewing posts may put them at risk of breaching competition law. The department sought advice from the Australian Government Solicitor (AGS) on this matter and has been advised that in general, the enhanced role proposed for medical specialist colleges is unlikely to present major legal risks in terms of competition law.

However, the AGS advised that it is not possible to discount the risk of legal challenge entirely in situations where colleges are making decisions that could impact on areas with particularly small workforce concentrations, such as more rural and remote locations. Competition issues may be more acute in these settings because of the limited geographic scope of the market. To mitigate this risk, some final program funding decisions will need to continue to be made by the department, informed by college recommendations. This should not have a major impact on the proposed reforms to program delivery and can be reflected in the negotiation of future funding agreements with the colleges.

- *Rural and Private Targets:*

In addition to providing each college with an overall allocation of posts or target, the review has suggested that within that allocation each college be given a target for the number of posts in a rural setting and for those in a private setting. These settings are not mutually exclusive.

The review has suggested significant increases in the total number of rural and private posts supported by the STP. Rural posts will increase by over 18% up to 400 of 900 STP posts. Private posts will increase by over 9% to 440 of 900 STP posts. Enhancing these training distribution targets will be a key step in ensuring the allocation of STP resources is aligned with Government workforce development priorities.

The increase in rural posts will be achieved through the review of existing posts, the EOI identifying potential new settings, and transitional arrangements put in place by the colleges over the three year funding agreements.

It is acknowledged that some colleges may achieve their targets in the first year but the colleges with large numbers of posts may take three years. Further, the existing college training arrangements may require a more flexible approach to imposing targets on some colleges but overall the total targets should not be reduced as this is a key reason and aim of the STP.

The support of rural posts will increase further through the IRTP-STP initiative and the integration of ACEM into the STP. These activities will result in an additional 128.5 full-time equivalent (FTE) rural posts being supported by the reformed STP.

- *Reporting requirements:*

The review has found that the key performance indicators against which colleges report at present are unclear and inconsistently applied. The department recommends they be simplified and redesigned to measure the extent to which the STP is meeting its aims and objectives. Financial and enhanced statistical reporting would be required to make the suite of data received more useful from a policy and program management perspective, along with the development of online, or web-based reporting, building on the EOI process.

- *Proposed expenditure:*

In their submissions to the review, many stakeholders argued for an increase in the financial support provided to settings hosting training posts. This appears to be of particular concern to rural settings. Financial support has not increased since the program commenced and it was argued that the gap between the salary contribution and the cost of hosting a trainee is increasing each year. In the current tightened financial situation it is not possible to increase payments significantly. However, the department recommends modest increases to the salary contribution and rural loading elements of STP and ETP funding. Colleges should also be given greater flexibility in the amount of the rural loading paid to settings, within limits set by the department, provided it is used to meet the aims and objectives of the STP.

The department recommends that the amount allocated to colleges for support projects be decreased, while maintaining some ongoing investment in critical projects at each college that clearly address the program objectives and help support the delivery of training in expanded settings. This initiative results in savings of about \$3.4 million per year which contributes to savings generated by the reforms to the STP.

The department has found that the Private Infrastructure and Clinical Supervision (PICS) program is important to private sector settings but that the purposes for which it can be used should be made clearer and easier to administer. Consideration should be given to a streamlined model where the infrastructure and clinical supervision elements of funding would be combined into one, annual payment and the program would be administered by the college responsible for the relevant post, not the Royal Australasian College of Medical Administrators (RACMA). This would be consistent with the principal of devolving more of the management of the STP to the colleges. It would also simplify the administration of the program. Further, there may be some reduction of PICS funding to support other elements of the program, such as salary support.

- *Specific Changes to the EMP:*

As outlined above, the most recent (unpublished) workforce data and modelling of the Emergency Medicine specialty by NMTAN provides support for a proposed reduction in ETP posts to better reflect projected workforce need. Following detailed consultation with ACEM the department proposes the following changes to help ensure the sustainability and effectiveness of the program:

- The investment in EMP training places should be merged with the STP with a 50% decrease in the number of emergency medicine training posts supported by 2019.
- As part of the STP, ACEM would be eligible to receive support project funding to reflect the new allocation of posts, in line with the other specialist colleges. Its administration funding would remain broadly similar to its current funding due to its new responsibilities outlined below.
- The department proposes to retain the investment in the EMET program at current levels for at least three years, as the program has demonstrated benefits for the quality and accessibility of rural emergency services to patients. It is recommended that ACEM seeks to enhance stakeholder engagement in relation to the program through the creation of a more effective representative group that includes the participation of other key stakeholder organisations.
- While in general the EDPSCS has been implemented successfully, there is some evidence participating private hospitals would benefit from a more direct relationship with ACEM. This could assist with staff recruitment and enhance trainee support. The EDPSCS could thus be aligned with other aspects of the EMP and made more responsive to emerging opportunities in the private sector if ACEM takes over its direct administration from 2018. The ETP and EMET are already managed by ACEM, so synthesising the management of the three arms of the EMP would create efficiencies and increase the effectiveness of the programs.

- *Contribution to Health Workforce Savings:*

STP and EMP combined need to contribute to Health Workforce savings targets and as a result, this review has identified efficiencies in the funding model for both programs, as well as a reduction in EMP positions.

The proposed savings can be delivered without compromising the Government's commitment to deliver 1,000 ongoing STP places from 2018, as announced in the December 2015 Mid- Year Economic and Fiscal Outlook and the subsequent 2016-17 Health Portfolio Budget Statement.

1 Background to the Review

On 19 March 2015, the Hon. Sussan Ley MP, the then Minister for Health and Minister for Sport, announced that there would be consultation with specialist medical colleges and other stakeholders about reforms to the STP and EMP. The review would:

...focus on in depth workforce planning to better match investments in training with identified specialties of potential shortage and areas that may be oversubscribed into the future.

Broadly stated, the objectives of the review are to:

- assess the effectiveness and efficiency of the management of the STP and the EMP; and
- recommend future reforms to enable the STP and the EMP to better meet Australia's future specialist medical workforce and emergency medicine needs, having regard to priority areas of shortage.

The reforms were initially expected to take place from 2017. However, to enable appropriate consultations with stakeholders it was determined that the reforms would not take place till 2018. Minister Ley approved an extension of the STP and EMP to cover the 2017 academic year to accommodate this change in timing.

The department has now completed its review of the STP and the EMP. Its findings and recommendations are set out below in Sections 2, 3 and 4 of this Report.

1.1 Rationale for Commonwealth Investment in Specialist Medical Training

1.1.1 Context

Over the last decade, Commonwealth investment in medical specialist training has increased substantially, primarily driven by a consensus view across health jurisdictions and training colleges that the range of settings in which specialist training occurs should be expanded beyond the traditional metropolitan teaching hospitals. In summary, the imperative to expand training to other settings originated from several concurrently occurring factors:

- A case mix gap in which the type of patient presentations or procedures currently seen in major metropolitan teaching hospitals does not allow curricular and experiential objectives to be optimally met;
- A continuity gap in which the entirety of 'the patient journey' was not seen by trainees in major metropolitan teaching hospitals; and
- A perceived need to expand the specialist workforce, particularly in terms of addressing maldistribution and market failure in the provision of specialist services outside the capital cities.

The cross-jurisdictional focus on expanding settings for medical specialist training escalated after the creation in 2001 of a working party on specialist training outside major teaching hospitals by the Australian Health Ministers Advisory Council (AHMAC). The resulting discussion paper (the Phelan Report), which explored the potential use of settings other than

public teaching hospitals, included an assessment of changes to health care delivery that limited traditional approaches to medical specialist training.⁶

The Phelan Report identified that, as the role and capacity of public teaching hospitals was changing, they were becoming less appropriate settings for some aspects of vocational training and some requirements for training were not being met. The medical conditions of patients admitted to public teaching hospitals had increased in number and complexity while the length of stay was becoming shorter. As a result, opportunities to learn about the management of less complex conditions and the provision of continuity of care had been decreasing.

These issues were subsequently taken up by the Medical Specialist Training Taskforce, which reported to AHMAC in October 2004 on a model for implementing training in other settings. This model defined the settings to be involved in training and assessed the barriers to implementation.

The Phelan Report and subsequent processes had observed that training in a diverse range of settings had already been occurring on an ad hoc basis with the support of local, enthusiastic health care settings and supervisors. However, the success and continuation of these arrangements was often subject to funding uncertainties. Funding issues were also cited as the main barrier to expansion by many of the working groups and stakeholders who were involved in the conceptual development of training in other settings.

The Medical Specialist Training Steering Committee (MSTSC) was established by AHMAC in November 2004 to complete an assessment of particular issues before implementation of training in a diverse range of settings. The developments in Australia's health system which necessitated a reassessment of the sites and facilities in which specialist medical training occurs are outlined in the 2006 MSTSC Report, and include the following:

- The clinical management of patients in public teaching hospitals has changed. Lengths of stay have shortened and for many conditions important aspects of patient care are now managed in separate non-hospital settings.
- Many medical conditions are now managed entirely in non-hospital settings such as private rooms and private sector free-standing diagnostic and treatment facilities. Specialist trainees can have limited exposure to such conditions.
- Many 'traditional' outpatient clinics attached to public hospitals have closed with the result much ambulatory and longitudinal care of patients has shifted to private rooms leaving trainees with limited exposure to outpatient care.
- The number of students in Australia's medical schools had doubled over five years and these students would be seeking vocational training places in coming years; and
- Significant shortages in some medical specialties in Australia are unlikely to be overcome with the current training capacity.⁷

⁶ Phelan P. 2002, *Medical Specialist Education and Training: responding to the impact of changes in Australia's health care system*. AHMAC Working Party to research issues relevant to specialist medical training outside teaching hospitals: Canberra.

⁷ Medical Specialist Training Steering Committee (2006), *Expanding settings for medical specialist training*, MSTSC Report 2006, Canberra

The 2006 MSTSC Report suggested that diversifying training across a range of settings would bring four major benefits to trainees, specialist medical practitioners, the training settings, and the community respectively:

for trainees there would be improved training opportunities and experiences available, ensuring that as independent practitioners they would be competent to address the widest spectrum of practice in their specialty.

- both trainees and medical specialists would benefit because training would become more targeted. It would also create opportunities to expand training to match service delivery and community needs, and more closely align the provision of high standard, multi-disciplinary patient care with community expectations.
- patients were expected to benefit because there would be more specialists working in rural public hospitals, private hospitals, community and private ambulatory centres.
- the expanded settings would increase the health system's capacity to take in more trainees without increasing pressure on public teaching hospitals.

The Council of Australian Governments subsequently announced in July 2006, during the course of this project, that the Commonwealth and the states and territories would establish, by January 2008, a system for trainees to undertake rotations through an expanded range of settings beyond traditional public teaching hospitals. This resulted in the introduction of the Commonwealth's Expanded Specialist Training Program (ESTP), which was independently reviewed shortly after its introduction in 2008.⁸

The review of the ESTP concluded that the program was an appropriate expenditure of Commonwealth funds as its purpose is to enhance medical education, and state governments face tensions between meeting long term education needs and maintaining short term service provision. The authors contended that overall program efficiency may decline if program management was devolved to the states, stating:

If the whole program, including the selection process, was in the hands of the states, it is possible that service provision imperatives may achieve higher priority than education imperatives, despite education being the reason for the existence of the program.

The report also argued that a number of the places funded in the public sector through the program would not have had sufficient priority from the states to be funded, despite a demonstrable need for the additional training places and the lack of equivalent training within public teaching hospitals. Examples included community paediatric placements in Melbourne, and rural public health placements in Western Australia.

Following its successful implementation, on 1 January 2010 the ESTP was amalgamated with a number of other Commonwealth grants support programs to form the STP as it is currently formulated, with the intention of expanding the number of specialist training posts to 900 per annum by 2014 from an initial base of 360.

⁸ Coote, B. and McRae, I. 2008, *Expanded Specialist Training Program*. Consultants' report to the Department of Health and Ageing on the appropriateness, effectiveness efficiency of the program – detailed findings: Canberra.

1. Background to the Review

1.1.2 Outcomes

Published by Health Workforce Australia in 2012, HW 2025 Vol 3 identified persistent imbalances within the medical specialist workforce, including geographic mal-distribution of medical specialties across rural, regional and metropolitan areas; mal-distribution across the various medical specialties; and imbalances between generalists, specialists and sub-specialists. The report pointed to the poor coordination of the medical training pathway by the numerous bodies involved in the funding and delivery of training as the reason underlying the imbalances.

The uneven growth in trainee positions across the medical specialties over the decade to 2011 was partly attributed to the way in which vocational training was traditionally funded. Specifically, HW 2025 Vol 3 noted that, as vocational training is primarily funded through registrar positions in the public sector, the service requirements of the public hospital system significantly influence the number of trainees in each specialty, which can lead to service requirements for trainees exceeding the requirement for consultant specialists. It also means that the workforce requirements of the community and private hospital sectors tend to be overlooked, with the report citing dermatology as an example of a specialty for which there are few funded training positions in public hospitals, due to the adoption of a private sector outpatient model for dermatology services in many hospital systems.

Significantly, the report highlighted the role of the STP in addressing some of these workforce imbalances at an early stage in its expansion.

The increased cross-jurisdictional focus in recent years on expanding both the quantity and distribution of specialist training places is reflected in the most recent available data. [Table 1](#), drawn from Medical Training Review Panel reports, indicates that there has been substantial growth in the provision of non-GP vocational training since the introduction of the STP, with an overall increase of almost 28 per cent in the number of vocational trainees between 2010 and 2015. Changes in levels of investment in specialist training have not been evenly distributed across jurisdictions, with Western Australia and Tasmania recording stronger growth than other jurisdictions.

Table 1: Specialist Trainees, 2010-2015 by jurisdiction

	2010			2015			Change 2010 - 2015	Change 2010 - 2015 (%)
	Basic	Advanced	Total	Basic	Advanced	Total		
NSW	1,483	2,173	3,656	1,928	2,762	4,690	1,034	28.3
VIC	1,273	1,827	3,100	1,646	2,260	3,906	806	26.0
QLD	1,120	1,203	2,323	1,311	1,691	3,002	679	29.2
SA	423	532	955	439	645	1,084	129	13.5
WA	433	474	907	604	815	1,419	512	56.4
TAS	104	84	188	135	144	279	91	48.4
NT	49	94	143	60	94	154	11	7.7
ACT (a)	105	252	357	136	171	307	-50	-14.0
Total	4,990	6,636	11,626	6,259	8,582	14,841	3,215	27.7

a) A decrease in the number of reported trainees for ACT during the period is a result of several colleges reporting ACT trainees under NSW figures in later years.

1. Background to the Review

The nationwide increase in medical specialist training activity since 2010 is broadly consistent with the significant expansion in undergraduate medical school places which has occurred over the past decade and aligns with the increasing community need for specialist medical services. The Commonwealth's investment in specialist training through the introduction and subsequent expansion of STP/EMP is reflected in this growth.

The data suggests that the funding by the Commonwealth of up to 900 specialist training places nationally per annum in expanded settings during 2011-15 was outstripped by additional state and territory investments in the public hospital training system over the same period. While not insignificant, the Commonwealth's investment in specialist training has been appropriately targeted to the extent that it does not appear to have led to cost shifting in terms of displacing state-funded training positions with those funded by the Commonwealth.

Table 2 confirms that the national increase in the number of vocational trainees has been accompanied by a commensurate rise in the number of specialist college fellows across all states and territories, although the growth rate is moderated by the time lag between the recruitment of new trainees into the system and their subsequent admission into fellowship.

Table 2: Specialist Fellows, 2009-2014 by jurisdiction

	2009	2014	Change 2009 - 2014	Change 2009 - 2014 (%)
NSW	8,890	10,731	1,841	20.7
VIC	6,977	8,813	1,836	26.3
QLD	4,761	6,207	1,446	30.4
SA	2,266	2,649	383	16.9
WA	2,436	3,175	739	30.3
TAS	585	696	111	19.0
NT	193	245	52	26.9
ACT	543	667	124	22.8
Total	26,651	33,183	6,532	24.5

Statistics derived from the National Health Workforce Dataset (NHWDS)⁹ demonstrate that the level of non-GP specialist rural training is still quite low, with some 13 per cent of all specialist trainees identifying as being based outside the major metropolitan areas in the 2015 NHWDS workforce survey. Given a regional and rural population share of approximately 33 per cent, the data indicates that medical specialist training continues to be disproportionately located in major cities, even after accounting for potential errors in the estimate.¹⁰ Specialist training is particularly unlikely to occur in Remote and Very Remote (ASGC RA 4-5) areas, with only 75 trainees identified by the survey in 2015.

⁹ The data from the annual national registration process for 14 health professions, together with data from a workforce survey that is voluntarily completed at the time of registration, forms the NHWDS. Data in the NHWDS includes demographic and employment information for registered health professionals.

¹⁰ Comparisons between the 'training' classification data in the NHWDS and specialist college data on trainees show that the NHWDS consistently undercounts trainees by 10-30 per cent. Furthermore, as trainees tend to regularly rotate through training positions, their location according to the NHWDS data is more likely to be reflective of their residential address.

Of those specialist trainees identified through the NHWDS workforce survey, almost 1,600 are located in regional, rural and remote areas. The STP is making a substantial contribution to enabling this training to occur, given that the program supports over 320 annual FTE training positions in Australian Standard Geographical Classification – Remoteness Area (ASGC RA) 2-5 areas. The Commonwealth's contribution is more marked in remote locations (ASGC RA 4-5) where STP is supporting around 40 annual FTE positions.

The total number of NHWDS workforce survey respondents identified as specialist trainees increased between 2013 and 2015 and the number of these trainees in rural and regional employment also increased. The proportion of rural training compared to metropolitan training increased slightly over the period. While the STP and EMP are contributing to this growth, the bulk of the increase can be attributed to the actions of state and territory jurisdictions.

Anecdotally, it has been suggested that the STP has provided important impetus for the expansion of rural specialist training by stimulating the development of new models of training and demonstrating the educational value for registrars working in these areas. The most recent funding application rounds for the program generated substantially more applications for rural training positions than the program was able to support, particularly the 2013 and 2014 STP/EMP application rounds, which were each oversubscribed by a factor of more than two to one and featured a strong increase in rural applications over this period.¹¹ Assessment of these proposals by colleges and jurisdictions has provided each of those stakeholders with useful measures of both demand and capacity for rural specialist training.

Numbers of specialist trainees in rural and regional settings are expected to increase further over 2017 and 2018 with the introduction of 100 new STP positions as part of the Integrated Rural Training Pipeline (IRTP) initiative. The department will monitor how this increased investment influences the distribution of urban and rural training into the future.

The NHWDS workforce survey collects data on clinical hours worked by specialist trainees in private and public sector settings.¹² For the years between 2013 and 2015, this data shows that the proportion of total training hours completed in the private sector has been consistently low, with approximately seven per cent of reported clinical training hours annually involving at least some private sector exposure.

The survey results confirm the trend towards private sector service delivery for particular specialties, such as Pathology and Sports and Exercise Medicine, for which training places funded under the STP are likely to be especially important.

Given its emphasis on supporting training in expanded settings, the STP is likely to be providing the bulk of the training that is being delivered in the private sector, at least for registrars on a fellowship pathway. The lack of overall growth in private sector training over the last three years substantiates the ongoing need for the STP, but also suggests that a renewed cross-

¹¹ In 2014, 512 applications were received against a total allocation of 172 new training posts in the STP/EMP application round, compared with 422 applications for 150 available posts in 2013. For the 2013 round up to 37% of applications were from rural settings, increasing to 42% of applications in 2014.

¹² Data reflects total clinical hours worked, including training hours and other hours.

jurisdictional focus on exploring specialist training opportunities in private settings may be needed.

1.2 The Specialist Training Program

1.2.1 The History of the Specialist Training Program

Since 1997, successive Commonwealth Governments have implemented initiatives to support the training of specialist medical officers outside metropolitan areas.

The first such program was the Advanced Specialist Training Posts in Rural Areas measure. In 2006, the COAG determined to fund training outside traditional public teaching hospital settings (the ESTP). Simultaneously, COAG initiated the National Action Plan on Mental Health (2006-2011), which provided funding for the Psychiatry Training Outside Teaching Hospitals program.

In 2008, COAG committed to additional investment via the Hospital and Health Workforce Reform - Health Workforce package. Upon its commencement on 1 January 2010, a range of programs were amalgamated into the STP.¹³

The STP was designed to expand from an initial 360 specialist training posts to 900 FTEs by 2014, with particular emphasis on the geographic distribution of trainees and placing trainees in expanded settings. Expanded settings are:

...a range of public settings (including regional, rural and ambulatory settings), the private sector (hospitals and rooms), community settings and non-clinical environments.¹⁴

This brought private sector and rural and regional settings into the training equation in a way they had not been before.

On 12 June 2012, the Government announced the Tasmanian Project to support the training and retention of specialist doctors in the Tasmanian public health system. The Tasmanian Project is administered under the STP but falls outside the scope of this review.

1.2.2 Aims of the Specialist Training Program

The current aims and objectives of the STP are:

- Increase the capacity of the health care sector to provide high quality, appropriate training opportunities to facilitate the required educational experiences for specialists in training;
- Supplement the available specialist workforce in outer metropolitan, rural and remote locations;
- Develop specialist training arrangements beyond traditional inner metropolitan teaching settings:

¹³ As well as the above programs, the Outer Metropolitan Specialist Trainee Program, the Overseas Trained Specialist Upskilling Program and the Pathology Memorandum of Understanding were incorporated into the STP.

¹⁴ *Specialist Training Programme (STP) Operational Framework* (the *STP Operational Framework*), January 2013, p.3, [www.health.gov.au/internet/main/publishing.nsf/Content/4AAA78E3A7D8FA47CA257BF0001B73E0/\\$File/STP%202013%20Operational%20Framework.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4AAA78E3A7D8FA47CA257BF0001B73E0/$File/STP%202013%20Operational%20Framework.pdf) (accessed 15 December 2015).

- with rotations to accredited training posts in health care settings that include private hospitals; specialists' rooms; clinics and day surgeries; ACCHS; publicly funded health care facilities which can provide training opportunities not previously available, particularly in areas of workforce shortage (such as regional, rural and community health settings); and non-clinical settings (such as simulated learning environments);
- with training in these settings fully integrated with and complementing training occurring at the major public teaching hospitals; and
- that provide training for Australian specialist trainees, OTD sand specialist SIMGs in pursuit of Fellowship of the relevant college within the boundaries of Australia.

The STP Operational Framework also requires its aims to be achieved without an associated loss to the capacity of the public health care system to deliver services.

Attachment B outlines the current program logic for the STP.

1.2.3 About the Specialist Training Program

The main stakeholders in the STP are:

- the Commonwealth government;
- state and territory governments, and through them public health services;
- specialist medical colleges;
- the private health services sector;
- community-controlled health services; and
- doctors training to be specialists.

The Minister, with advice from the department, has oversight of the STP, including deciding which training posts to fund and responsibility for its ongoing direction.

In its present form, the STP uses a prescriptive, “top-down” administration model that is controlled by the department:

1. In each selection round eligible entities apply to the department to host an STP-funded training post.
2. Applications are rated by the relevant specialist medical college and state and territory health departments against an operational framework. Colleges also consider whether settings meet “the standards set by the relevant college and ... deliver educational value.”¹⁵ The jurisdictions also look at “the availability of registrars to fill the posts identified and areas of workforce need”.¹⁶
3. The department consolidates and reviews the colleges' and states and territories' ratings.
4. The highest ranked applications are approved by a senior departmental officer, under a delegation from the Minister.

¹⁵ STP Operational Framework, January 2013, p. 4.

¹⁶ STP Operational Framework, January 2013, p. 5.

1. Background to the Review

5. A Reserve List of posts that are not initially selected for funding is created.
6. The department enters into a funding agreement with the college for it to fill the allocated training posts. Posts are identified by individual numbers.
7. If a post is not filled, where possible the college promotes an applicant from the Reserve List.

Each year since the program commenced, the department has extended its funding agreements with the colleges in 12 month increments to provide for the additional posts that were selected in each funding round up to 2014 as well as annual extensions to cover 2015, 2016 and 2017.

The STP was designed to grow from an initial 360 training posts in 2010 to 900 by 2014, through annual selection rounds. It has met this target, in that there are 900 posts available, though it should be noted that not all have been filled. There are a number of possible reasons for this:

- insufficient numbers of trainees have accepted posts in smaller hospitals in rural areas when there are posts available in large metropolitan training hospitals;
- trainees have been unwilling to relocate their families to rural and regional areas;
- the prescriptive nature of the program in stating which posts can be supported, both on the selected and reserve lists;
- the long lead time needed to appoint trainees to fill any vacancies; and
- many colleges have few, if any, rural/private posts on the reserve list as the last funding round was conducted in 2013, for commencement in 2014.

It should also be noted that there are significant educational benefits for trainees from working in regional and rural areas, including:

- trainees gain skills in balancing the needs and treatment of patients with multiple conditions;
- rural, regional and remote health care presents different challenges compared to urban areas;
- trainees may need to handle conflicts of interest and maintain 'boundaries' with people in a small community; and
- educational benefits in terms of continuity of care for patients and in continuity of supervision.

The department's funding agreements with colleges for 2016 were for a total of 870.4 FTE, though through the use of "period" posts (temporary posts supported for limited periods using surplus funds) colleges have agreements with settings for 951.8 FTE. [Attachments C1](#) shows the STP posts contracted by the colleges by ASGC-RA system classification. [Attachment C2](#) also sets out the number of contracted training posts each college has, their location by state or territory and whether they are in the private or public sector in 2015. The key summary statistics of the posts contracted by the colleges are:

- 64.3 per cent of FTEs were in RA1 settings and 35.7 per cent in RA2-5 settings;
- 44.7 per cent of training posts have some component in an RA2-5 setting;
- 57.7 per cent were in public settings and 42.3 per cent were in private settings; and

- 90.4 per cent of contracted FTEs were filled.¹⁷

In 2014, the ANAO review of the STP found that colleges were holding collective surpluses of \$56.31 million, or 16.4 per cent of total STP funding. The inability of colleges to fill all posts is considered to be the main contributing factor in the accumulation of these surpluses. The department responded by withholding a total of \$23.89 million in funding in the next financial year.¹⁸ The department is keen to ensure that these surpluses are not repeated and has considered how the design of the program can be changed to minimise any structural impediments to the ability of colleges to fill STP posts.

There are five funding elements to the STP:

- a salary contribution of \$100,000 per annum (GST exclusive) per post, pro-rated if a post is not a full FTE;
- a rural loading of up to \$20,000 per training post/FTE per year, to compensate settings for any additional expenses incurred in having a trainee in a rural STP Post.
- administrative support payments, generally up to \$10,000 per post to assist colleges in managing the program;
- the PICS, which funds activities associated with clinical supervision and training infrastructure in private sector settings; and
- support project funding, to enhance training opportunities for those trainees in STP posts.

Thirteen colleges participate in the STP, though the department has funding arrangements with only twelve specialist medical colleges.¹⁹ The STP only funds new training positions and does not support positions that have been funded by another source for more than twelve months in the previous three years. The STP does not fund post-fellowship training by a specialist. The department estimates that it funds around 5-7 per cent of specialist training posts nationally; the balance being funded by the state and territory jurisdictions.

1.3 The Emergency Medicine Program

1.3.1 History of the Emergency Medicine Program

In 2010, the then Government announced the *More doctors and nurses for Emergency Departments* initiative, which is aimed at increasing the health system's capacity to train emergency department specialists, nurses and support staff, as well as training general practitioners in outer suburban and rural areas where emergency medicine specialists are not always available.²⁰ The EMP commenced in 2011 as the *Improving Australia's Emergency Department Medical Workforce Project*.

¹⁷ It should be noted that one FTE can be distributed across a number of RA categories and in both public and private facilities.

¹⁸ ANAO Report, March 2015, p. 82.

¹⁹ The Australian and New Zealand College of Anaesthetists administers the College of Intensive Care Medicine's STP-funded posts.

²⁰ ALP Policy Statement, "More doctors and nurses for Emergency Departments", parlinfo.aph.gov.au/parlInfo/download/library/partypol/NRGX6/upload_binary/nrgx60.pdf;fileType=application%2Fpdf#search=%22library/partypol/NRGX6%22 (accessed 19 January 2016).

1.3.2 Aims of the Emergency Medicine Program

The current aims and objectives of the EMP are:

- Enhance the specialist emergency medicine workforce and contribute to reduced waiting times for patients
- Extend emergency medicine training into new settings
- Improve the quality of rural emergency services

The EMP is a set of three initiatives:

- The ETP, which financially supports training posts for doctors wishing to become fellows of ACEM. The ETP is established by a funding agreement between the department and ACEM, which commenced in 2011.
- The EMET, which enables ACEM Fellows to deliver training in emergency departments to specialist trainees and other emergency department staff, particularly in regional and rural areas. The aim of EMET is to boost the quality of care and increase access to emergency services for people living outside urban areas. EMET forms part of the funding agreement between the department and ACEM.
- The EDPSCS, which supports specialist training by making a contribution to the employment of clinical training supervisors or staff specialist training coordinators in private hospitals. The EDPSCS was established in 2011. It is administered through agreements between the department and the private hospitals.

Attachment D outlines the current program logic for the EMP.

1.3.3 About the Emergency Medicine Training Program

Under the ETP, ACEM is funded to deliver 22 emergency medicine specialist training posts each year from 2011, reaching a total of 110 annually in 2015.

The number of ETP training posts reached its capacity in 2015. With the addition of period posts this has risen to 129 FTEs.

In its February 2016 progress report to the department, ACEM advised that for 2015 it had filled 105.8 FTEs out of 129 FTE contracted posts. As with the STP, the ETP is oversubscribed; 44 applications were received for the 22 training positions in the 2014 round. Those numbers are consistent with the ratio of applications to training positions in previous years.

1. Background to the Review

Table 3 shows the spread of ETP contracted training posts by ASGC-RA category and jurisdiction for 2015.

Table 3: ETP training posts (FTE) by RA category and jurisdiction, 2015 Academic Year

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	TOTAL	%
RA1	3	20.85	0	11	2	0	10	16	62.85	48.72
RA2	0	13.15	0	8	0	0	15	8.5	44.65	34.61
RA3	0	0	0	4	0	2	5	3.5	14.5	11.24
RA4	0	0	3	1.5	0	0	0	0.5	5	3.88
RA5	0	0	1	0.5	0	0	0	0.5	2	1.55
TOTAL	3	34	4	25	2	2	30	29	129	
Filled FTE	2.5	28.5	3.5	19.75	1.5	0	23.33	26.5	105.58	

Of ETP posts, 33.7 FTE, or 25.7 per cent, are in private settings.

The ETP has largely the same funding elements and procedures as the STP:

- a contribution to the trainee's salary of \$100,000 per annum per post, pro-rated;
- a rural loading to support posts in RA2 – RA5 categories of up to \$20,000 per post, also pro-rated; and
- a payment to the college for the cost of administering a post, currently about \$5,600 per post.

Funding for support projects was not included in the original funding agreement, though some have been funded using a surplus in ETP expenditure.

Prior to the 2015 funding round, ETP posts were allocated by the department in the same way it allocated STP training posts. For the 2015 round, ACEM assumed the primary role in the administration of the program. While the department retained its overall policy and oversight responsibilities, ACEM has responsibility for:

- developing a priority framework in consultation with the department;
- promotion of the funding round;
- receiving and assessing applications before choosing the posts to be funded;
- managing the relationship with health care settings directly;
- increasing the use of private settings for training; and
- developing processes to allow trainees to complete their specialist training in rural areas.

Unlike the STP, the ETP does not operate under an Operational Framework or a Priority Framework, primarily because only one specialist medical college is involved in its operation,

meaning they are not necessary. Consequently, the aims and objectives of the program, its governance rules and other important operational matters are set out in the funding agreement between the department and ACEM and the Deeds of Variation entered into each year.

1.4 Health Workforce Australia 2012 Report, Health Workforce 2025 – Medical Specialties – Volume 3

In November 2010, the Australian Health Ministers commissioned Health Workforce Australia (HWA) to examine and report on national planning for a sustainable health workforce. The first two volumes of HWA's report were published in April 2012. Health Workforce Australia 2012 Report, HW 2025 - Vol 3 was published in November 2012. It contained:

... Australia's first major, long-term national projections for doctors at the medical specialty level, presenting the best available planning information on our future medical workforce.²¹

HW 2025 Vol 3 was prepared following extensive consultation by HWA:

... to obtain feedback on the data and assumptions underpinning the workforce projections, as well as to obtain information on considerations for future workforce requirements that may influence the interpretation of the projections.²²

HWA also obtained expert opinions from state and territory governments, private employers and the medical profession, as well as analysing current vacancies and waiting times, where that information was available.

The report confirmed that while the supply of medical specialists was increasing, "significant inequity in service access – to specialties and in geographical regions – is likely to persist".²³ HWA highlighted three areas of imbalance that it felt needed to be addressed:

- geographic maldistribution of the total medical workforce, in general practice and a number of other medical specialties, in both rural and regional and metropolitan areas;
- maldistribution across medical specialties, in particular obstetrics and gynaecology, ophthalmology, anatomical pathology, psychiatry, diagnostic radiology, and radiation oncology; and
- imbalances between generalists, specialists and sub-specialists, particularly in general practice, general medicine and general surgery.

1.5 The Review Process

The review was conducted in two, concurrent strands:

1. Operational reforms: The department sought feedback on the operation of the STP and EMP through written submissions in response to discussion papers sent to key stakeholders in September 2015, face-to-face meetings and input from nominated members of the NMTAN and contact officers from the jurisdictions provided by the

²¹ *Health Workforce 2025 – Volume 3 – Medical Specialties*, (November 2012), p. 1, www.hwa.gov.au/sites/uploads/HW2025_V3_FinalReport20121109.pdf (accessed 17 December 2015).

²² *Health Workforce 2025 – Volume 3 – Medical Specialties*, (November 2012), p. 19.

²³ *Health Workforce 2025 – Volume 3 – Medical Specialties*, (November 2012), p. 1.

Health Workforce Principal Committee (HWPC). A draft Findings Report was distributed to stakeholders for further comment in August 2016.

2. Data analysis: The department, with the assistance of a consultant, KPMG, conducted a data analysis of medical specialist workforce requirements and developed a process that could be considered for the allocation of training posts to colleges/specialties, and selection and review of training posts from 2018 onwards.

1.5.1 Operational reforms

On 4 September 2015, the department released three discussion papers relating to, respectively, the STP and the ETP, EMET and the EDPSCS.²⁴ The department received 35 written submissions in response to the discussion papers, including from:

- all colleges involved in the STP, other than the College of Intensive Care Medicine of Australia and New Zealand;
- RACGP and ACRRM;
- all state health departments, though not the territories;
- medical practitioner representative groups, including the Australian Indigenous Doctors' Association and the Australian Medical Association (AMA); and
- private hospitals and their main representative groups, Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA).

A full list of stakeholders consulted is at Attachment E.

Almost all stakeholders indicated in response to those discussion papers that they felt the STP is meeting its aims and objectives and argued that Commonwealth expenditure on the program should not be reduced. There was a diversity of views on potential improvements to the program. The main issues raised by stakeholders in submissions were:

- the process for selecting training posts;
- tying funding to the trainee;
- mandating the length of STP rotations;
- generalist training;
- the contribution to salary, including whether it should be increased;
- the rural loading;
- funding for education support projects;
- using the STP to promote Aboriginal and Torres Strait Islander (ATSI) health;
- the need to create rural training pathways; and
- what could be done to encourage a doctor to move to and stay in a rural area after attaining fellowship.

²⁴ The STP Discussion Paper is available on the Department of Health website at www.health.gov.au/internet/main/publishing.nsf/Content/review_specialist_training_program_stp (accessed 10 December 2015)

A round of face-to-face consultation with stakeholders on operational reform options took place in November and December 2015. The department met with all colleges participating in the STP, as well as the APHA, CHA and the AMA. Stakeholders were generally in agreement with the department on the direction of the proposed reforms, though some colleges indicated that the particular nature of their specialties made it hard for them to have more training take place in rural areas and expanded settings.

February 2016, a second short Discussion Paper setting out the department's proposed reforms to the operational aspects of the STP and EMP was sent to all jurisdictions, the Chair of NMTAN, Professor John Horvath, and ten members of the NMTAN Executive Committee. Feedback was generally constructive and favourable. The majority of jurisdictions expressed the view that they should be consulted in decision-making on the allocation of training posts.

On 19 August 2016, the department released its draft Findings Report for comment. Written submissions received from stakeholders have informed the recommendations contained in the Final Report.

A summary of the responses and comments to the major issues raised during the consultation process, including Discussion Papers, the Draft Findings Report and meetings, can be found at [Attachment F](#).

The department also worked with colleges to develop an online EOI form for settings interested in hosting specialist training posts. Feedback on this reform was positive. As well as being used for EOIs, information obtained through the form can be used by the department in future planning for the STP.

1.5.2 Data analysis

Data analysis for the second stream of the review has been undertaken by the department's Workforce Data Analysis Section, in conjunction with KPMG, building on HW 2025 - Vol 3.

KPMG was appointed to provide assistance to the department with the development of a process for the allocation of training posts to the colleges in 2018 and beyond, with a focus on addressing identified workforce shortages.

The data analysis process and its results are discussed in more detail in Section 2.4. The outcome of the analysis was included in the draft findings report distributed in August 2016 for comment.

It is acknowledged that the data available for use in the analysis had some limitations but over time this situation will improve. In particular, the NMTAN is undertaking detailed forecast modelling for each of the major specialties and as they become available will be taken on board by the STP. To date NMTAN has published reports on Anaesthesia and Psychiatry. Emergency medicine is currently being reviewed with a report expected to be published later in 2017. The department consulted with the Australasian College for Emergency Medicine on this work and its implications for the ETP in 2018 and beyond.

1.6 The Integrated Rural Training Pipeline

In December 2015, the Minister announced the introduction of the IRTP, which involves activities across the different levels of medical training, including a targeted expansion of the STP.

The STP component will provide up to 100 new training posts in rural areas over two years, in addition to the current 900 training posts. The new STP posts will be restricted to RA 2-5 areas and be designed to enable a specialist trainee to complete two thirds of their training within a rural region, with only limited metropolitan rotations where this is necessary to meet fellowship standards. The 50 posts available in 2017 have been allocated to the colleges following an assessment of proposals from colleges. Eligible settings with an interest in hosting IRTP-STP posts in future have been provided an opportunity to lodge EOIs through the online process described in Section 2.7.

Funding for each IRTP-STP post will be made in the form of one total payment to the relevant college of up to \$150,000 per FTE per annum. This includes all the elements of funding; the salary contribution, rural loading, a private sector loading and administration, with the actual funds provided reflecting the characteristics of the post.

Up to 30 new regional training hubs will be set up under the IRTP to work with local health services to help stream students through the medical training pipeline. A regional training hub will be a team of people dedicated to integrating medical training opportunities for students within their catchment area. The regional training hubs will be located at existing sites managed by universities under the Rural Health Multidisciplinary Training program. Funding will support new academic and administrative positions at these sites and this additional capacity will support the coordination of rural training opportunities for doctors at all stages of their medical training (undergraduate, junior doctor and specialist vocational training), building regional training capacity through providing support for local medical practitioners to become supervisors, and assisting health services to accredit new training posts. The hubs will also provide an enhanced level of support for rural students/trainees in their region.

Supported by the hubs, rural healthcare settings will engage with their respective specialist colleges to identify local needs to inform the allocation of funding and development of new models of training.

2 Reforms to the Specialist Training Program

2.1 Overview

Based on the evidence and stakeholder feedback captured during the review process, the department has made findings and developed recommendations to reform the program.

Overall, the department's proposed reforms are aimed at making the STP more efficient and effective in the context of a tight fiscal environment by:

- Ensuring the allocation of training positions aligns with the Australian community's need using data and evidence derived from the best available workforce planning tools;
- increasing the colleges' flexibility to manage the program;
- facilitating more training in rural and expanded settings; and
- maintaining the current number of training posts.

The department would retain overall policy and oversight responsibilities for the STP.

The proposed reforms affect most aspects of the STP, but especially the way training posts are reviewed and selected and the level of funding support. Colleges responded favourably to the proposals during consultations, but some raised concerns about the potential for colleges to breach competition law in the selection process. Although this potential risk for the colleges is considered low it can be mitigated by the department continuing to make the final decision on the selection of posts to be funded, but informed by college recommendations. It is proposed that the department would follow college recommendations except in exceptional circumstances.

Jurisdictional and other stakeholders were generally supportive of the proposed reforms, though the states and territories were keen to maintain their key role in selecting training posts, as they felt they had the expertise and the greatest interest in posts being allocated to areas of workforce need. These concerns have been addressed in the development and implementation of a trial online EOI process and subsequent assessment processes (see below). Further, as the department will be making the final decision on post selection, jurisdiction concerns should now be minimal.

Flow chart 1 shows the proposed format for the STP and how it will integrate with the IRTP.

2.2 Administration of the Specialist Training Program

The optimal selection of training posts so that they address the needs of the health care system is crucial to the successful operation of the STP.

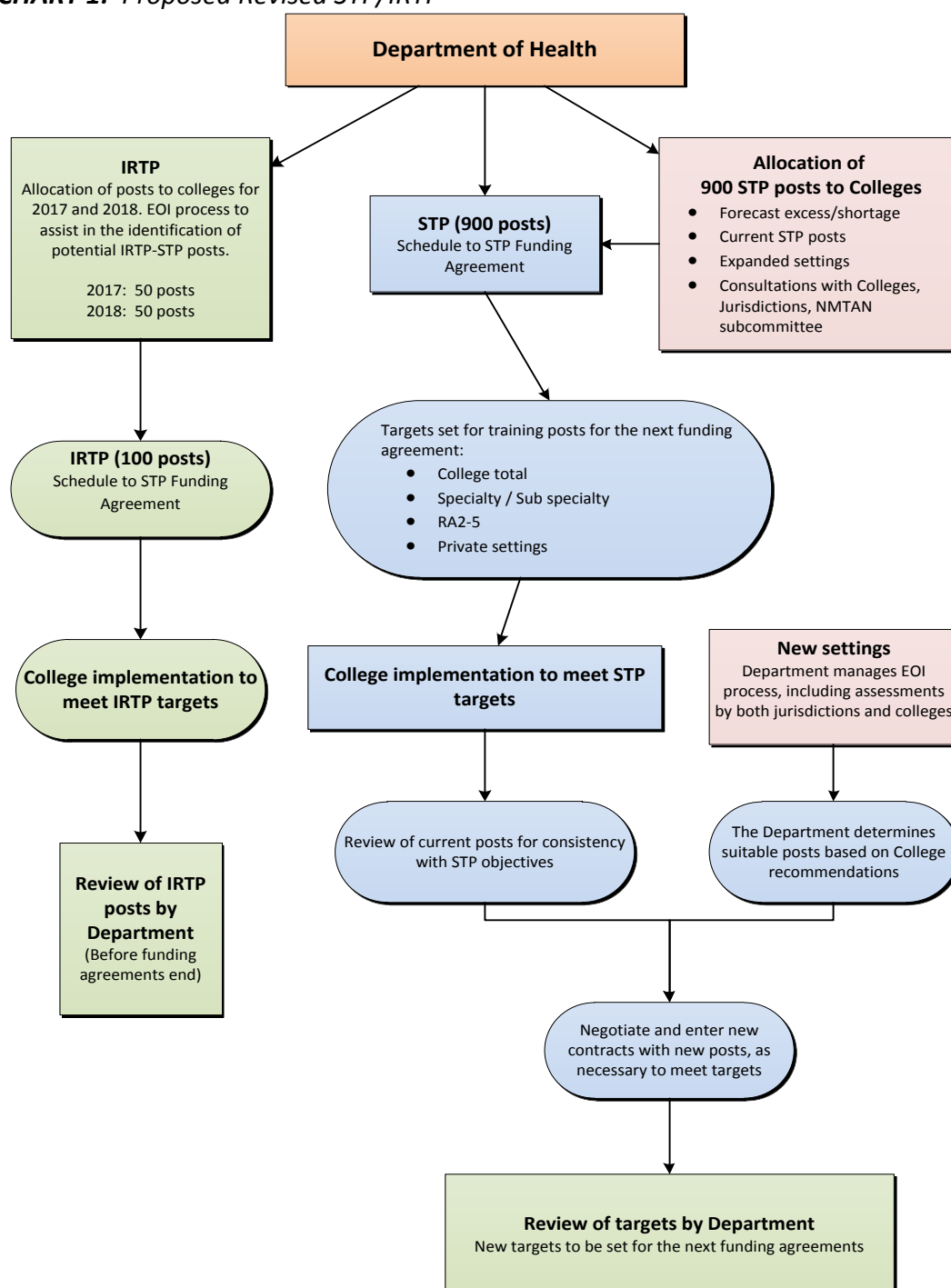
Decisions in relation to STP-funded training posts have been conducted in "funding rounds" from the program's inception to 2014. Until the maximum of 900 posts was met in 2014, this approach gave the program flexibility, as the annual allocation of new STP posts allowed the program to be responsive to the training needs of the community and the health system. However, with the program meeting its limit, this flexibility no longer exists.

2. Reforms to the Specialist Training Program

The department has found that the present model for administering the STP is considered top-down and prescriptive by stakeholders. It is the department that determines what training posts will be funded; instructs colleges how to manage those posts and approves each alteration to the program, such as the placement of a training post or a change to its FTE. As a result, even though they are responsible for developing training regimes for aspiring fellows, colleges have little control over STP training posts.

This management system was necessary to establish the STP. However, feedback from the colleges during consultation argued that it could now be considered inflexible and a contributing factor to there being unfilled STP posts, though not the only factor.

FLOW CHART 1: Proposed Revised STP/IRTP



2. Reforms to the Specialist Training Program

A significant number of colleges also commented that the existing selection process lacks transparency, in that the final selection of training posts sometimes “does not reflect what the profession have agreed and ranked in order of priority of what is required”, to quote one college. On the other hand, the jurisdictions feel that the present selection system works. As one state put it, “broad consultation with jurisdictional health departments and medical specialist colleges [on the allocation of training posts] is essential.”

During the consultation phase on the draft Findings Report in late 2016 three colleges raised concerns about the proposal that they select the posts to receive STP funding. The colleges were concerned about the risk of them breaching competition law. The department thought that this risk was low but in light of these concerns advice was sought from the Australian Government Solicitor (AGS). In summary, the AGS advice noted that while the overall level of risk remains very low, the proposed changes could in certain limited circumstances expose some of the Colleges to competition law risks. It was considered that those circumstances would only arise in relation to training settings in regional areas in specialities where patients are unlikely to travel long distances for treatment. However, Colleges only face a competition law risk if they make a STP funding decision. The competition law risk for the Colleges could therefore be removed by re-instituting the department as the decision maker for STP funding. Even if the department acted solely upon the recommendation of the College, the College would not face a competition law risk as the College is not making the final decision.

Based on college concerns and AGS advice it is proposed that the department would be the decision maker but those decisions would be based on recommendations from the college. In determining their recommendations the college(s) would need to take into account the assessment of the relevant jurisdictions.

The department proposes the following, more flexible, less prescriptive system of management for the STP that gives participating specialist medical colleges greater responsibility:

1. A determination would be made on the number of training posts to be allocated to each college (and specialty) and the targets the college should meet in filling its posts. Targets would be based on the department’s data analysis and the allocation process outlined in Section 2.4 of this Report.
 - Allocations and targets set for colleges will be reviewed by the department before the end of the funding agreement. Any revisions to the allocation of training posts to the colleges would be included in the next funding agreement.
2. The department would develop broad guidelines for use by the colleges in recommending EOIs for possible future support and inclusion on the Reserve List.
 - These guidelines would also address the review of existing STP posts by the colleges.
3. To provide an opportunity for new training settings, and to help fill all STP posts throughout the funding agreement period, there would be a call for EOIs from settings that wish to host an STP-funded post.

2. Reforms to the Specialist Training Program

- The department would manage the EOI process. EOIs are expected to be held regularly, say every two years, but this timing could be adjusted if necessary.
- State and territory health departments would be provided an opportunity to comment on EOIs. Colleges would need to consider this feedback in selecting those posts to be recommended to the department for possible, future STP support, in combination with their view on the educational value of the setting and its contribution to meeting their STP targets.
- 4. Each college should review its training posts over the life of the funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts and those identified by the department as potentially not meeting the STP's aims and objectives. Based on the outcome of those post reviews, colleges would recommend to the department whether a post should continue to receive STP support. Those recommendations would be provided on an agreed timeframe which would be included in the funding agreement.
 - A minimum of 12 months' notice should be given to training posts that are to be discontinued following the outcome of a review.
- 5. In light of AGS advice on competition law, the department would be the decision maker in selecting those posts to be supported for possible future STP funding and those that will not be supported in future.
 - The department's decision would be based on the recommendations of the colleges;
 - Only in exceptional circumstances would the department not follow college post recommendations. For example:
 - i. jurisdiction advice had clearly not been taken into account; or
 - ii. not consistent with operational and priority frameworks; or
 - iii. inconsistent with the college attaining its targets outlined in their funding agreement.
- 6. Funding agreements of three years' duration would be entered into with each participating college for it to deliver the program starting in the next academic year. Agreements would specify the colleges' allocation of posts, its targets, the funding the college would receive, post review requirements, reporting requirements and ancillary matters.

A similar template for these reforms to the STP is provided by the model introduced for the ETP in 2015, under which ACEM has the role of selecting training posts. ACEM's selections have generally been guided by the national priority settings for the STP and this has demonstrated that good distribution outcomes can still be achieved while maintaining the focus of a college on educational merit. The proposed process would put greater responsibility for the selection of posts in the hands of the colleges as the bodies that manage the training of fellows, accredit settings and are in the best position to efficiently facilitate the filling of vacant training posts.

A similar management model was put forward as an option in the Discussion Papers and was generally favourably received by the colleges. One college welcomed the proposed system, noting that, at present:

... certain sites not ranked particularly highly by the College (in terms of educational/training imperatives) [are] being ranked much more highly by the Department and getting preference for

2. Reforms to the Specialist Training Program

funding. The College appreciates that this has been due to other factors...such as health jurisdictional needs.

It recognised that:

Advice from state and territory governments in relation to areas of need would, of course, also be factored into the colleges' priorities, as indicated in the proposed model.

Another stated:

Stronger input from Colleges in relation to selection of posts would be beneficial and perhaps more likely to achieve positive outcomes for the STP [as] Colleges are better informed in relation to the probability of successful programme outcomes for each post selected for funding...Colleges could provide a greater level of support and contribute more towards the aims and objectives of the STP programme.

The jurisdictions, on the other hand, had some reservations about this approach. A typical view expressed by one state Health Department was:

[The colleges'] key roles are in education and training and not workforce planning or service provision and therefore delegating the medical colleges to select posts is not supported. Ongoing close collaboration between jurisdictions, health services and colleges is strongly supported in ensuring the best distribution of posts to meet workforce priorities.

A more critical view was that there is "a potential conflict between the education and training focus of specialist medical colleges and the medical workforce focus of jurisdictions". The state argued that the jurisdictions engage in "significant workforce planning [to] identify and forecast potential issues of workforce supply and distribution", therefore, they should have a greater role in selection of training posts, so that they fit with workforce needs, especially in rural and regional areas.

The department has noted the concerns expressed by the jurisdictions about maintaining their role in selecting posts. They are being addressed by two aspects of the proposed new management system:

1. states and territories being given the opportunity to assess and comment on EOIs lodged by settings to host STP training posts; and
2. the criteria for colleges to review existing posts and select future posts would include the requirement to consider the jurisdictional assessment of the local workforce need for the training post.

The devolution of more responsibility to the colleges should streamline the operation of the STP and make it more efficient and responsive to the needs of the health system. It should also help to maintain the distinctive nature of the STP, with its focus on supporting training in expanded settings, including in the private sector. States and territories will continue to support up to 95 per cent of all specialist training positions and will be free to allocate their own funding to their identified priorities.

The department's proposals would be complemented by the IRTP, which will establish 100 additional training posts over two years that will be counted as part of the STP, though funding arrangements will be separate and specifically targeted towards rural workforce development.

2. Reforms to the Specialist Training Program

While any new allocation model will affect the number of training posts each college has, an examination of the effects of the model developed with KPMG indicates that the model does not propose any significant change to the current allocation of STP training posts to colleges.

The Operational and Priority Frameworks developed for the 2014 STP funding round was drafted by the department in consultation with the jurisdictions and colleges. It was revised for the EOI conducted in 2016 and a copy is at [Attachment G](#).

The department also proposes that funding agreements be for three years, reflecting the Budget forward estimate for the program. This will provide colleges and settings with greater certainty than the present system, noting that only twelve month funding extensions have been provided for the program in recent years. It will also lead to administrative efficiencies for the department and should help to reduce the number of unfilled posts in the future by giving settings more certainty in the recruitment of trainees.

While future changes to funding agreements cannot be ruled out, annual extensions of all funding agreements are no longer considered essential, as targets would only be set once for the duration of the agreement.

Generalist training

ACCRM and other medical specialist organisations define 'Rural Generalism' according to the Cairns Consensus Statement on Rural Generalist Medicine, which refers to the provision of medical care with a broad scope by doctors in the rural context, including advanced skills ordinarily associated with consultant specialist practice services as appropriate to meeting the needs of their rural communities.

Most stakeholders that addressed the STP being used to increase generalist specialist training support the idea. Comments include:

- if more generalists can be trained for rural/regional areas, networks of generalists and sub-specialists could be developed;
- there should be a special focus on posts in community health settings, sub-regional and rural locations; and
- most broad training of general practitioners with advanced skills training should take place in rural/regional settings, with rotations into metro settings.

Some stakeholders oppose the suggestion, arguing that:

- generalist training is contrary to the STP objective of providing training for specialists;
- specialties and subspecialties are needed to deal with complex patients;
- generalist training in surgery is best achieved over the life of the training program;
- generalist training is well supported already; and
- a greater number of ATSI doctors work as GPs or as generalists, whereas there is a need for further specialty training.

The department notes that the STP is not currently targeted towards supporting general practice training and does not focus on advanced skills acquisition for fellows of any medical specialist college.

2. Reforms to the Specialist Training Program

Given the current tight fiscal environment, the department believes it would be challenging to expand the scope of the STP to support advanced skills training for GPs or future rural generalists. The department considers that the Australian General Practice Training program is better placed to contribute to the development of a National Rural Generalist Training Pathway. The STP, with its focus on medical specialists other than general practitioners, will complement the rural generalist pathway by helping to generate a good mix of future rural doctors to meet community needs.

Recommendation 1: Administration of the Specialist Training Program

The review found that the STP's current top-down administration model lacks flexibility and is overly prescriptive.

The department recommends greater responsibility being put in the hands of the colleges, as they are the bodies that manage the training of fellows, accredit settings and are in the best position to efficiently fill vacant training posts. The department would still determine the number of training posts allocated to each college over the course of the funding agreement as well as setting the overall priorities for the STP. The following process for administering the STP is recommended:

- A determination would be made on the number of training posts to be allocated to each college (and specialty) and the regional/rural and private targets the college should meet in filling its posts.
 - The allocation and targets for each college will be reviewed by the department before the end of the funding agreement.
- To provide an opportunity for new training settings, and to help fill all STP posts throughout the funding agreement period, there would be a call for EOIs from settings that wish to host an STP-funded post.
 - The department would manage the EOI process. EOIs are expected to be held regularly, say every two years, but this timing could be adjusted if necessary.
 - State and territory health departments would be provided an opportunity to comment on EOIs. Colleges would need to consider this feedback in selecting those posts to be recommended to the department for possible, future STP support, in combination with their view on the educational value of the setting and its contribution to meeting their STP targets.
- Each college should review its training posts over the life of the funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts and those identified by the department as potentially not meeting the STP's aims and objectives. Based on the outcome of those post reviews, colleges would recommend to the department whether a post should continue to receive STP support. Those recommendations would be provided on an agreed timeframe which would be included in the funding agreement.
 - A minimum of 12 months' notice should be given to training posts that are to be discontinued following the outcome of a review.
- The department would develop broad guidelines for use by the colleges in assessing EOIs and reviewing existing STP posts. Broad guidelines will also be developed for jurisdictions to assess EOIs. These guidelines would include the overall priorities determined for the STP.
- In light of AGS advice on competition law, the department would be the decision maker in selecting those posts to be supported for possible future STP funding and those that will not be supported in future.
 - The department's decision would be based on the recommendations of the colleges;
 - Only in exceptional circumstances would the department not follow college post recommendations. For example:
 - jurisdiction advice had clearly not been taken into account; or
 - not consistent with operational and priority frameworks; or
 - inconsistent with the college attaining its targets outlined in their funding agreement.
- Funding agreements of three years duration would be entered into with each participating college for it to deliver the program starting in the next academic year. Agreements would specify the colleges' allocation of posts, its targets, the funding the college would receive, post review requirements, reporting requirements and ancillary matters.
- The STP will maintain its focus on medical specialists other than general practitioners, including rural generalists.

2.3 Allocation of STP training places

2.3.1 Background

As noted earlier, in announcing the review the then Minister for Health made it clear that it would:

... focus on in depth workforce planning to better match investments in training with identified specialties of potential shortage and areas that may be oversubscribed into the future.²⁵

Consequently, the department's proposed process for determining the number of training posts that will be allocated to each college and college targets stands on three pillars:

- HW 2025 Vol 3 showed that as at November 2012 there was an imbalance between and within medical specialty workforces. It also stated that there was a geographic mal-distribution, with shortages in regional and rural areas but a potential oversupply in metropolitan areas. This position was confirmed in the department's report on *Australia's Future Health Workforce* in December 2014. HWA's projections indicated that the projected imbalance could be expected to continue into the future;
- The department has undertaken an analysis of the medical specialty workforce using information from the colleges and the jurisdictions. This work has built on the findings of HW 2025 Vol 3; and
- KPMG has developed a methodology for the allocation of training posts to the colleges in 2018 and beyond, with a focus on addressing identified workforce shortages.

The purpose of the data analysis undertaken by the department was to identify the extent of any future undersupply or oversupply in medical specialties participating in the STP, which was then used to inform decisions about how many STP-funded training posts would be allocated for each specialty or subspecialty and their respective targets. In some cases, where detailed data was available, the department made calculations for sub-specialties rather than specialties. Accordingly, a reference to specialties in this report includes sub-specialties.

It should be remembered that the STP funds only around 5 to 7 per cent of all training posts, the rest being funded by the state and territory governments. The program will not, therefore, remedy all undersupplies of trainees and was not designed to perform this role. The NMTAN is responsible for building collaboration between jurisdictions and training providers to address the broader national workforce planning issues around the supply and demand of medical specialists.

This process excludes the allocation of Emergency Medicine training posts. This allocation is discussed at Section 4.3.

2.4 Allocation of training posts to colleges and specialties

In announcing the review, the then Minister made it clear that the review would seek to match government investment to identified areas of potential specialist shortage. The

²⁵ The Hon. Sussan Ley MP. Minister for Health and Sport, *Media Release*, "\$150 million for special medical training", 19 March 2015, www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley021.htm?OpenDocument&yr=2015&mth=03 (accessed 9 June 2015).

2. Reforms to the Specialist Training Program

department proposes the process outlined below for determining the number of training posts that will be allocated to each specialty to address that aim.

The starting point for the proposed allocation of STP training posts is the number of posts (FTEs) allocated to the specialty in the current funding agreement.

For those colleges that have a number of specialties/sub specialties where at least one was reviewed by HWA, the starting point is the number of ongoing STP posts reported to the department for Semester 1, 2015. This number may be adjusted to ensure the total number of ongoing posts is equal to the number of posts allocated to the college in the current funding agreement.

Based on information held by the department on the number of Fellows and estimated changes to supply - such as domestic and international graduates - over the period to 2030, a forecast of the total number of Fellows in 2030 was determined. The demand for the number of Fellows was also estimated by the department taking into account such information as population trends and Medicare billing.

A supply and demand analysis using this information needs to assume that the 2014 supply was equal to demand, that is it was nominally in balance. However, this is not true for all specialties; to address this issue, the department used the HWA analysis that highlighted those specialties considered to be in undersupply. The degree of undersupply was assigned a colour by HWA: red, orange and green. For the purposes of the allocation methodology the department assigned a percentage of undersupply to each colour code: red was assigned 10%; yellow 5% and green 0%.

Following this adjustment the department compared the estimated supply and demand situations in 2030 to determine whether the specialty was forecast to be in an under or over supply situation at that time. To reflect the significance of this variance the forecast under/over supply was calculated as a percentage of the forecast 2030 supply.

As forecasting is not a precise science and there may be some limitations in the data, a specialty is considered to be in balance if it falls within a margin of 10% above or below that point where supply was equal to demand.

Table 4 shows the specialties, the colours assigned to them by HWA and each specialty's assigned 2014 workforce undersupply percentage. Table 4 also shows the Department's 2016 forecast of oversupply / undersupply at 2030 for each specialty. The Department's forecasts with a margin greater than -10% (or undersupply) are coloured red, greater than 10% (or oversupply) are coloured white, those with a margin between 0% and +10% (in balance) are coloured green, and those between -10% and 0% (in balance) are coloured yellow.

2. Reforms to the Specialist Training Program

Table 4: 2014 workforce undersupply colour and assigned percentage
2016 Department workforce oversupply undersupply forecast for 2030

Speciality	Table 4: 2014 workforce undersupply colour and assigned percentage	2016 Department workforce oversupply undersupply forecast for 2030
Anaesthesia	5%	-3.19%
Anatomical pathology n.a.	5%	-3.62%
Cardiology n.a.	0%	4.40%
Dermatology	5%	-5.82%
Endocrinology n.a.	5%	4.77%
Gastroenterology and hepatology n.a.	0%	15.04%
General medicine n.a.	10%	3.74%
General surgery	5%	-5.53%
Geriatric medicine	5%	1.45%
Intensive Care	0%	1.97%
Medical oncology n.a.	10%	8.96%
Nephrology n.a.	5%	-8.79%
Neurology n.a.	0%	3.70%
Obstetrics and gynaecology	5%	-10.47%
Ophthalmology	5%	-14.81%
Orthopaedic surgery n.a. (incl in general surgery)	0%	-13.52%
Other (clinical) pathology(a) n.a.	5%	-13.68
Other surgery(b)	0%	2.08%
Otolaryngology n.a. (incl in general surgery)	0%	25.25%
Paediatrics and child health	5%	-2.67%
Plastic surgery	0%	20.74%
Psychiatry	10%	-8.41%
Radiation oncology	10%	-63.70%
Radiology	5%	-23.53%

To determine the proposed allocation of future STP posts the following approach was adopted:

- for those specialties determined to be in balance, that is, the margin is between -10% and +10%, the number of STP posts allocated would not change;
- for those specialties with an oversupply, that is, the margin is greater than 10 per cent, the allocation to the specialty would be decreased. The size of the decrease would be based on the percentage above 10 per cent. The most likely effect of this is that no STP posts would be allocated to the college; and

2. Reforms to the Specialist Training Program

- for those specialities with an undersupply, that is, greater than minus 10 per cent, the speciality would be allocated additional STP posts. The number of additional posts would be based on the percentage above -10%. However, the actual number of additional posts needs to reflect reductions in other specialties as no more than 900 STP posts can be funded.

Specialties that were not analysed by HWA are assumed to be in balance. The proposed supply-demand assessment is based on the projected entrants and exits from the workforce. Following that step, the same approach as described above is applied for those specialties, depending on whether they are determined to be in undersupply, oversupply or in balance.

The draft Findings Report distributed to stakeholders in August 2016 included attachments that provided detailed examples of the allocation process for in balance, oversupply and undersupply scenarios as well as a table showing the key information, including forecasts and proposed future allocation of posts for each specialty.

Modelling of workforce projections is an ongoing process. The quality and accuracy of data is likely to improve as additional specialties are modelled. The department anticipates that enhanced datasets will be available to inform future modelling and allocation of STP posts. In particular, the NMTAN work plan will improve the datasets available for a number of specialties.

Based on the above processes, [Table 5](#) sets out the proposed allocation of training posts to each college and specialty. Future allocations (post 2020) are expected to benefit from more refined data analysis available through NMTAN.

2. Reforms to the Specialist Training Program

Table 5: Allocation of training posts by college and specialty

College	Current STP Allocation of Posts (FTEs)	College: Proposed STP Allocation of Posts (FTEs)	Specialty	Specialty: Proposed STP Allocation of Posts (FTEs)
Australasian College of Dermatologists (ACD)	27	27		
Australasian College for Emergency Medicine (ACEM)*	2	2		
Australasian College for Sport and Exercise Physicians (ACSP)	4	4		
Australian and New Zealand College of Anaesthetists (ANZCA)	42	42		
College of Intensive Care Medicine of Australia and New Zealand (CICM)	16	16		
Royal Australasian College of Medical Administrators (RACMA)	17.5	17		
Royal Australasian College of Physicians (RACP)	351.4	343		
			Addiction Medicine	3
			Cardiology	8
			Clinical Genetics	2
			Clinical Pharmacology	2
			Endocrinology	12
			Gastroenterology & Hepatology	0
			General Medicine	58
			Geriatric Medicine	35
			Haematology	2
			Immunology & Allergy	2
			Infectious Diseases	2
			Medical oncology	18
			Nephrology	6
			Neurology	7
			Paediatrics & Child Health	66
			Rehabilitation Medicine	27
			Respiratory & Sleep Medicine	6
			Rheumatology	6
			Public Health Medicine	33
			Palliative Medicine	24
			Other Physicians	24
Royal Australasian College of Surgeons (RACS)	73	70		
			General Surgery	45
			Plastic Surgery	0
			Orthopaedic Surgery	13
			Otolaryngology	0
			Other Surgery	12
Royal Australian & New Zealand College of Ophthalmologists (RANZCO)	12	15		
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	32	32		
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	160	160		
Royal Australian and New Zealand College of Radiologists (RANZCR)	47	82		
			Radiology	54
			Radiation Oncology	28
Royal College of Pathologists of Australasia (RCPA)	87	90		
			Anatomical Pathology	47
			Forensic Pathology	2
			Other (Clinical) Pathology	41
Total	870.9	900		

*ACEM's allocation of training posts is discussed in Section 4.3

2. Reforms to the Specialist Training Program

The Royal Australasian College of Surgeons raised some concerns about the reduction of STP posts in the specialties of Plastic & Reconstructive Surgery and Otolaryngology Head and Neck Surgery. The College noted that of the five Plastic & Reconstructive Surgery STP posts two are in private hospitals that provide training opportunities not available in public hospitals such as skin cancer management and one at the Royal Darwin Hospital. Royal Darwin Hospital is located in an ASGC RA 3 location and provides opportunities for outreach work to regional hospitals such as Gove, Katherine, Alice Springs and Tenant Creek. Further the trainee is an integral support to the two specialists operating in this region.

These comments may be as a result of the proposed allocation model adopting a national approach. It is acknowledged that detailed forecasting at a regional level is not possible with the available data. Accordingly, it would be appropriate to provide some flexibility to the college(s) to manage any proposed reduction in STP posts in specialties under their governance. As shown in [Table 5](#) only four colleges (RACP, RACS, RANZCR and RCPA) have allocations at the specialty level.

It is proposed that the number of posts allocated to each college not be changed. However, for a college with a reduction in a specialty (ies) it would be open to the college to seek approval to retain some of the posts in that specialty for the next funding period. To retain a post the college would need to show that it provides significant benefits to regional and rural communities or provides significant private sector training experience. The retention of a post(s) must be offset by a reduction in the college's other STP posts.

Recommendation 2: Allocation of training posts to colleges and specialties

One of the aims of the review is to match Government expenditure on the STP to identified areas of potential specialist shortage.

To address this, the department recommends that on the basis of the supply/demand analysis and the replacement methodology discussed in Section 2.4 the number of training posts that will be allocated to each college and specialty for the period of the next funding agreement is as set out in [Table 5](#).

For those specialties with reductions in allocated STP posts the college may seek approval to retain some of the posts in that specialty for the next funding period. To retain a post the college would need to show that it provides significant benefits to regional and rural communities or provides significant private sector training experience. The retention of a post(s) must be offset by a reduction in the college's other STP posts.

2.5 STP training post targets – rural and private

To address the aim of the STP of having training posts in expanded settings, it is proposed to increase the number of STP posts in:

- regional, rural and remote areas (RA 2-5); and
- private settings.

2. Reforms to the Specialist Training Program

Under the current funding agreements the number of RA 2-5 posts is specified along with the total amount for the rural loading. In total there are 338.52 FTEs nominated as being in RA 2-5 areas. It is proposed to increase this to a target of 400 FTEs. This represents an increase of over 18% and about 44% of the total number of STP posts (900).

Colleges have reported that over 400 FTEs are located in private settings. It is proposed to increase this to a target of 440 FTEs. This represents an increase of nearly 10% and about 48% of the total number of STP posts (900).

To determine the RA 2-5 targets for each college it is proposed to apply the same percentage increase to each college so as to achieve the overall target of 400 FTEs. The same approach will be applied to determine the private setting target for each college.

It is proposed that the same targets would apply in each year of the funding agreement. However, in some cases a college may need to make a significant adjustment to meet its targets, as well as the need to provide advance notice to any post that may be terminated. In such cases, it is proposed that the target would not need to be reached until the last year of the funding agreement, giving the college sufficient time to make the necessary transition.

Based on the above approach, Table 6 shows the proposed targets for each college with their current allocation of training posts.

Table 6: Proposed rural and private setting targets for each college

College	Proposed STP Funded FTEs	Rural FTE Target	Current Rural FTEs (Funding Agreement)	Private FTE Target	Current Private FTEs (2015)
ACD	27	8	6.16	22	19.82
ACEM*	2	0	0.00	2	2.00
ACSP	4	2	1.30	4	4.00
ANZCA	42	20	17.00	16	14.61
CICM	16	6	5.00	11	10.00
RACMA	17	11	9.70	7	6.50
RACP	343	179	151.64	158	143.96
RACS	70	37	31.00	38	34.90
RANZCO	15	7	6.00	9	8.35
RANZCOG	32	11	9.12	16	14.55
RANZCP	160	50	42.80	71	64.90
RANZCR	82	29	24.80	17	15.90
RCPA	90	40	34.00	69	62.90
Total	900	400	338.52	440	402.39

*ACEM's allocation of training posts is discussed in Section 4.3

Recommendation 3: Training Post Targets - Rural and Private

To address the aim of the STP of supporting training posts in expanded settings, it is recommended that the total number of training posts increase in:

- RA 2-5 from 338 FTE to 400 FTE per year; and
- Private settings from 402 FTE to 440 FTE per year.

To meet the overall STP targets it is recommended that the colleges be set annual targets for both RA 2-5 and private settings. The targets for each college are set out in [Table 6](#).

It is acknowledged that the proposed targets may not be reached until the last year of the funding agreement, thereby giving the college sufficient time to make any necessary transition.

2.6 College Recommendations on the Review and Selection of training posts

The review identified that there has been a tendency for STP training posts to effectively become permanent once they are established, making the program less responsive to workforce needs and weakening the focus on supporting expanded settings. This is accentuated by the STP not reaching its capacity of 900 posts. Included in the present 900 posts are 360 legacy posts that are holdovers from the training programs incorporated into the STP when it commenced. Stakeholders told the department that some posts have changed considerably since the STP commenced and so may not be the best available training options.

During consultation the department and stakeholders discussed ways of ensuring training posts are the best options on offer and addressing areas of need within the health system. It was proposed that colleges review each of their existing training posts over the life of the funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts. Colleges with large numbers of posts would be able to conduct their reviews progressively over the funding period, while colleges with fewer posts would be expected to review all of their posts in the first year of each funding agreement. This is separate to the colleges' internal process for accrediting a setting. This proposal was supported by stakeholders.

One result of colleges reviewing their existing posts and any subsequent reallocation is the need to select new (replacement) posts.

As discussed above, due to concerns raised by some colleges about competition law and AGS advice on the matter, the department will make the final decision on selecting posts, but those decisions would be based on recommendations from the college(s).

The department proposes that colleges apply the following principles when determining their recommendations to the department on the review of existing training posts and selecting new posts for possible future STP funding support:

- There should be a spread of training posts in RA 2-5 areas: The importance given to this principle will depend on how difficult it will be for the college to meet its

overall RA 2-5 target. The more difficult the target would be to reach, the greater the priority the college should give to posts in an RA2-5 area. This principle should be given greater priority than whether the post is in a private setting in the case of specialties that are considered to be in balance, as there is likely to be some mal-distribution of posts.

- There should be a spread of training posts across public and private settings: The importance of this principle also results from the college's need to meet its overall private post target.
- Posts should meet the area's local workforce needs: The colleges would apply this principle based on comments provided by jurisdictions through the EOI process. For an existing post, colleges may take into account its importance for the state or territory. One measure of the importance of a post could be the percentage impact of the post on the total number of training posts in that specialty in that jurisdiction.
- Trainees should be able to spend a significant time in an STP post: A trainee should not spend less than three months in an STP post (or 0.25 FTE) without the specific approval of the department. This would not preclude the establishment and maintenance of regional training networks, with training provided across a group of settings within a larger region, but would be designed to avoid a high level of churn by trainees being placed in those areas. Changes are proposed because
 - Evidence shows that longer training placements generate better workforce distribution outcomes. On this basis, trainees should spend a significant period in each training post if they are to experience the post properly and provide a genuine benefit to the delivery of services to communities. This is especially important for posts in RA2-5 settings if the STP is to promote training in rural centres and trainees working in a rural centre once they have achieved Fellowship.
 - In written feedback to the review, the majority of colleges supported a minimum period for placements (including in rural and remote areas), although some preferred that the duration of rural STP rotations be determined by individual colleges. On balance, the department considers that a mandated minimum period for rural training is important for meeting the objectives of the STP.
- Innovative approaches to training should be encouraged: The department feels that colleges and jurisdictions would be keen to use the STP to fund "outside the box", innovative training models. This could be through the creation of rural-based training pathways or by establishing training initiatives that use STP-funded posts outside the standard teaching model. Developing new approaches is considered important in ensuring the STP improves patient care and provides trainees with a rounded training experience.
- The post should have significant educational value: When applying this principle, colleges should consider the accreditation and track record of the setting. However, the department does not believe this should be the key factor in

deciding whether or not to select a training post. Instead, the contribution of each post towards meeting the outcomes of the STP need to be the guiding principle.

- Applying these principles would prevent colleges making decisions based purely on the educational merits of the post, which has been the subject of criticism from some states and territories. These principles would also ensure training posts fit in with the aims of the STP and that the review is implemented consistently across all colleges.

In its development of a methodology for allocating training posts, KPMG also examined a number of ways of identifying posts that do not meet the aims and objectives of the STP:

- Binary method: Criteria based on the aims and objectives of the program would be applied sequentially. In this way posts that meet any of the criteria will be shortlisted for continuation and those that do not meet any would be excluded.
- Weighted variables: The same criteria as applied in the binary method are applied concurrently to give each setting a weighted score. That score is based on the relative importance of each of the criteria.
- A combined approach: This uses the binary method to shortlist applications and then the weighted variables approach to prioritise posts that best meet the criterion. It is considered especially useful when the number of settings significantly exceeds the number of posts on offer, which is generally the case with the STP.

The department's preferred option is the combined approach. Colleges may use this approach to facilitate the selection of posts from the Reserve List and assessing EOIs.

Using the combined approach the department proposes to identify posts that may not meet the aims and objectives of the STP and ask the relevant college to review them at the same time as the legacy posts.

The department considers that training posts that are to be discontinued following the outcome of a review be given sufficient notice so as to not adversely impact a trainee currently in that post or has been recruited to fill that post. It is expected that any notice period would not exceed 12 months.

Recommendation 4: Selection and Review of training posts

The review has shown there has been a tendency for STP training posts to effectively become permanent once they are established, making the program less responsive to workforce needs and weakening the focus on supporting expanded settings.

As discussed above the department will make the final decision on selecting posts, but those decisions would be based on recommendations from the college(s).

The department recommends that colleges be required to review all existing training posts over the life of each funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts and posts that the department considers may not meet the aims and objectives of the STP.

The following principles should be applied by the colleges when determining their recommendations on the selection or review of training posts:

- there should be a spread of training posts across RA2-5 areas and in private settings (reflecting the targets set for the college);
- the post should meet the local workforce needs of the area in which it is placed based on jurisdictional comment;
- trainees should not spend less than three months in a post, without the specific approval of the department; and
- the post should have significant educational value.

If a training post is to be discontinued following the outcome of a review the post should be given sufficient notice about the termination of its STP funding so as to not adversely impact a trainee currently in that post or has been recruited to fill that post. It is expected that any notice period would not exceed 12 months.

2.7 Expressions of interest to host STP trainees

The draft Findings Report suggested that colleges would be responsible for selecting training posts. One consequence of that approach is that each college would potentially have to hold its own application round, with settings applying to each college separately.

To avoid a consequent administrative and financial burden on training settings and, to a lesser extent, colleges, the department decided to trial a national EOI process in the latter half of 2016 to provide an opportunity for settings to submit an EOI to participate in the STP. This opportunity was also open to existing training sites that were interested in expanding their current placements. The STP Operational Framework was updated in July 2016 to facilitate the revised arrangements.

The call for EOIs was not a formal departmental application process or request for proposal. It aimed to provide the colleges with a selection of eligible posts to add to their reserve lists, from which post vacancies occurring in 2017 could be filled. Generally a training post

2. Reforms to the Specialist Training Program

vacancy would be replaced by a post in the same specialty. Previously, entities wishing to host an STP-funded training post were required to provide the department with:

- a letter of support indicating the setting has accreditation from the college to host a training post;
- written evidence of support for the post from the local hospital network and that the hospital will allow the trainee to take rotations in an expanded setting; and
- other documents, such as insurance policies and evidence of medical indemnity arrangements for trainee cover.

The department has sought to streamline this process through the development and launch of an online EOI template in consultation with the jurisdictions and the colleges that requires settings to provide in electronic form the minimum information necessary for the college to determine whether the EOI should be considered for support. The department's trial web-based EOI round was open for a period of four weeks during November 2016 to allow hospitals and other training settings to register their interest in participating in either the STP, EMP or IRTP program.

The EOI process includes a jurisdictional assessment of each EOI. State and territory health departments have been granted access to the online EOI portal to review information provided by each setting, record comments and provide a suitability rating against each EOI. The jurisdiction's primary consideration is workforce needs at a local level. The colleges have been encouraged to discuss with the relevant jurisdiction their assessments if they wish to better understand the suitability rating given for an EOI. Colleges are expected to take jurisdictional comments into account when considering an EOI. The department has not specified how much weight should be given to the advice of jurisdictions; however it is unlikely a college would be able to establish a post that received no jurisdictional support.

The department has developed assessment guidelines to assist colleges to rate the suitability of applications to host STP trainees submitted via the EOI process. A copy of these guidelines is provided at [Attachment H](#). Further examination by colleges may be necessary to enable the supported EOIs to be ranked or shortlisted for the next stage of selection. It is not intended that EOIs to host an STP post would be the same as formal applications, so they may not include all the information a college would need to satisfy itself that a setting should be given a training post. The department expects that where a college thinks it is necessary it will seek further information from the settings before entering an agreement with a training post.

Preliminary results of the trial EOI process demonstrate continued strong demand from settings wishing to be included in the department's programs. More than 450 individual facilities and health training settings registered an account on the online portal with a total of 623 EOIs being successfully submitted, including 112 for the IRTP-STP initiative. These results compare favourably with the last STP/EMP application round held in 2014, in which 512 applications were received in total.

2. Reforms to the Specialist Training Program

A substantial proportion of EOIs received related to training positions located in priority settings:

- 347 were identified as being in either a regional, rural or remote (AGSC RA 2-5) area;
- 244 were identified as being in either a Private Hospital or Private Practice; and
- 66 were identified as being in either a Community Health Care or Indigenous Health Care setting.

The department will undertake an evaluation of the efficiency and effectiveness of the trial EOI process after the assessment period concludes in February 2017. Modifications will then be made to the EOI templates and process based on that evaluation for the next EOI.

To ensure that Reserve Lists are refreshed regularly and thereby enable the colleges to fill all of their allocated posts future EOIs will be held regularly but at least every 2 years.

Recommendation 5: Expressions of interest to host training posts

The department has developed and trialled a streamlined online process for taking expressions of interest from settings that wish to host new STP-funded posts. A web-based template for expressions of interest has been designed and launched in late 2016 by the department in consultation with the colleges.

Colleges and states and territories have been given access to the website to record comments and provide a suitability rating against each EOI, with the jurisdictions looking at workforce needs at a local level.

An evaluation of the EOI will be undertaken after the assessment period concludes with any necessary modifications made before the next EOI. Some modifications will be made to accommodate the proposal that the department will make the final decision on selecting posts based on recommendations from the colleges.

It is recommended that the department host future EOIs regularly, at least every 2 years.

2.8 Rural classification system for the STP

There are differences of opinion amongst stakeholders on whether the ASGC system for classifying settings should be replaced with the Modified Monash Model (MMM). Feedback, by and large, supported the retention of the ASGC system over a move to the MMM. One college, for example, argued that while the MMM provides for “greater specificity” than the ASGC system, the current model is reasonable. A different college argued that the ASGC model accurately identifies rural and remote settings and that many regional, rural and remote settings, which undertake important outreach work, would be reclassified under the MMM. Another submission argued that neither system is “sufficiently robust to manage the complexities” of a training program.

Given stakeholder comments that the MMM system is not relevant to the STP, as it was designed around primary care services, and that the major cities classification under the MMM (MMM-1) matches that under the Australian Bureau of Statistics (ABS) remoteness area system, the department proposes that the STP not adopt the MMM.

The ASGC is based on 2006 census data and uses ‘districts’ as the building blocks for defining remoteness areas. However, a more recently developed system for classifying the remoteness of settings is the Australian Statistical Geography Standard (ASGS). The ABS revised its geographies to better reflect local demographic profiles based on the 2011 Census and released the ASGS as an updated remoteness area classification. The ASGS will be updated after each census, thereby ensuring it reflects the current population distribution.

The department therefore proposes that the ASGS be used as the classification system for determining whether a training post in the STP and EMP is in an RA1 or RA2-5 area, as it is based on the most recent census data. As the ASGS is based on more recent data, the RA 1 boundary has moved, compared with the ASGC, to reflect the urban sprawl occurring in major metropolitan areas. An analysis of currently funded STP posts shows that six posts located in Richmond, NSW, and Nambour, Queensland would move from being in an RA-2 area in ASGC to being in an RA 1 area if the ASGS is adopted.

This is unlikely to inconvenience stakeholders, as the department proposes setting targets according to the broad band of RA 2-5 areas, which match MMM 2-7 areas. The DoctorConnect website will continue to provide a tool to determine a location’s ASGC classification, as many health programs still use that geography for eligibility purposes, however, an additional tool to determine a location’s ASGS classification has been added to the website.

Recommendation 6: Rural classification system

The classification system presently being used for determining whether a training post in the STP and EMP is in an RA1 or RA2-5 area has been superseded by the Australian Statistical Geography Standard model.

The department recommends that the Australian Statistical Geography Standard system be used as the rural classification system for training posts under the STP and EMP as it is regularly updated to reflect population trends.

2.9 Dedicated Indigenous training posts

The department raised the creation of dedicated Indigenous training posts in the STP discussion paper and during face-to-face consultations.

A number of colleges advised that they do not collect information on the number of trainees from an Indigenous background and that the information they do have is not reliable as some Indigenous trainees prefer not to be identified as such.

While they were generally supportive of the concept, a number of stakeholders felt a more fundamental concern is that more Indigenous students should be graduating as doctors. The experience of some stakeholders is that Indigenous students have a greater need for mentoring and dedicated support services at that point, to ensure they complete their medical studies. A number of colleges also noted in their responses to the STP/ETP discussion paper that statistics on Indigenous trainees are not reliable and suggested that this be added to their reports to the department.

On the other hand, in its response to the second Discussion Paper, the peak representative body for Indigenous doctors, the Australian Indigenous Doctors' Association, argued that "STP training posts for ATSI trainee doctors is essential for supporting and growing this workforce." It felt that this would align "appropriate specialist medical care and expertise with the actual health needs of Indigenous communities." It pointed to the success of identified STP posts for Indigenous trainees with the Australasian College of Dermatologists.

The department agrees the number of Indigenous students completing their medical studies is a serious issue, however, it feels this is not something that can be addressed within the scope of the STP. The purpose of the STP is to support trainees to become specialists. It can take steps to support Indigenous graduates that wish to obtain specialist skills.

A range of other initiatives are in place to address the issues around producing more Indigenous doctors. This includes continued support for the Leaders in Indigenous Medical Education network and the implementation of enrolment and graduation targets for medical schools participating in the Rural Health Multidisciplinary Training Program.

One of the aims of the STP is to develop specialist training requirements beyond traditional inner metropolitan teaching settings with rotations to a range of settings including Aboriginal Medical Services (AMS). The STP currently supports some posts in AMS, but these posts are not necessarily filled by Indigenous doctors. The STP should continue to prioritise Indigenous training settings and encourage further growth in the number of posts in these settings.

The department believes that increasing the number of Indigenous trainees and posts in Indigenous settings should be objectives of colleges and the STP and EMP can be used to support those outcomes. For example:

- the increased autonomy being proposed for colleges should encourage them to identify potential training posts in Indigenous settings within their overall STP allocation;
- colleges could negotiate with the department for dedicated Indigenous training posts to be included in its STP or IRTP targets ; and
- support projects could be developed that assist Indigenous trainees directly.

While the department does not suggest dedicated Indigenous training posts be included in STP targets, this does not prevent colleges assigning posts on their own initiative. The department will support them in doing so where it can. Further, colleges could be asked to report on how many STP funded training posts have been filled by Indigenous trainees and on their efforts to increase the number of Indigenous Fellows. This reporting requirement would be included in the next Funding Agreement. The performance of the colleges could be measured over the next agreement period and future targets could be considered once better data has been collected.

Recommendation 7: Dedicated Indigenous training posts

The department found during the review that there is little reliable statistical evidence on the number of Indigenous specialist trainees, but that it is believed to be a low number. Further, most colleges do not appear to have programs to promote specialist training amongst Indigenous doctors.

The STP should continue to prioritise the delivery of training in Indigenous health settings.

While the department does not recommend that dedicated Indigenous training posts be introduced as part of the STP, it proposes that colleges be required to report on the number of STP-funded training posts that have been filled by trainees that have identified as being Indigenous and on what efforts they are undertaking to increase the number of Indigenous Fellows. This reporting requirement would be included in the next Funding Agreement.

The department notes that STP support project funding may be used to support Indigenous specialist trainees to complete their training.

2.10 Specialist International Medical Graduates (SIMGs)

One of the aims of the STP is to:

... provide training for Australian specialist trainees, overseas trained doctors (OTDs) and specialist international medical graduates (SIMGs) in pursuit of Fellowship of the relevant College within the boundaries of Australia.²⁶

The review found that while some STP posts have been designated as SIMG dedicated training places, more recently colleges have found it difficult to fill them and have sought approval for another trainee to be placed in that post. There are no SIMGs in dedicated STP training posts at present. ACEM, on the other hand, receives funding for SIMG specific posts under the ETP.

²⁶ STP Operational Framework, January 2013, p. 3.

The importance of SIMGs in the delivery of specialist health care in Australia, especially in areas of identified workforce shortages and in rural areas was made clear during consultation.

However, since the STP commenced in 2010 the number of Australian medical graduates has grown and there is a view in some quarters that they may soon be in oversupply.²⁷ Accordingly, the department believes there is no need for STP posts to be designated for SIMGs and this will not be one of the targets set for colleges. Of course, this does not mean SIMGs cannot seek and fill STP-funded posts, provided they meet the relevant selection criteria; which would be a matter for the colleges and settings in their recruitment of trainees. This approach does not prevent colleges from prioritising some posts for SIMGs nor proposing support projects aimed at assisting SIMGs.

Recommendation 8: Specialist International Medical Graduates

The review found that colleges have had difficulty in filling SIMG dedicated STP training places.

The department recommends that no STP posts be designated for only SIMGs.

2.11 Reporting by colleges

Since 2012, STP agreements have required specialist medical colleges to report to the department against Key Performance Indicators (KPIs). The KPIs were developed in consultation with colleges.

The ANAO report on the STP commented that the KPIs are clearly linked to STP outcomes and the majority are quantifiable, though in most cases they are “proxy measures”, meaning they are only indirect measures of the effectiveness of the program. Inconsistent interpretation of the KPIs between colleges makes it difficult for the department to evaluate and compare their responses. Consultation indicated that colleges were generally supportive of the KPIs but felt they could be streamlined and made clearer without compromising the integrity of the STP, particularly by creating standardised definitions.

If the proposed devolution of STP administration is implemented, the department will not require the same detailed reports it currently obtains from colleges. This presents an opportunity to ensure the program KPIs can provide consistent and meaningful information to inform future evaluations and national policy development.

The department therefore recommends a streamlining of the current reporting requirements. The department could leverage off its online EOI process to develop a web-based reporting system for assessing whether colleges are meeting the aims and objectives of the programs. A better, redesigned reporting system could be used in any future evaluation of the STP and EMP.

²⁷ Based on the ‘combined scenario’. See *Health Workforce Australia 2014: Australia’s Future Health Workforce – Doctors*, August 2014, www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-doctors (accessed 5 February 2016)

2. Reforms to the Specialist Training Program

In its report to the department, KPMG stated that it felt the STP and EMP would benefit from colleges being required to provide the department with unit record data. Unit record data is specific, disaggregated information about individuals. It noted the number of unfilled training posts and argued that more detailed, timely and accurate data would enable the department and colleges to make better decisions about allocation of training posts in the future. This would give the department a clearer picture of whether the STP is succeeding in assisting trainees to attain Fellowship, and colleges would be able to better account for their use of government funds.

The department does not feel colleges should be required to provide unit record data at this stage, given the likely system development that some colleges would need in order to comply with this requirement. Some of this information may be built into the EOI form and into future online reporting of key data.

The department proposes that colleges be required to provide reports covering:

- KPIs linked to the national program outcomes;
- statistical data;
- financial information; and
- risks and emerging issues in program implementation.

The department may need to continue to consult with colleges on developing standard definitions for KPIs to make them clearer and on providing enhanced and timelier statistical reports.

Recommendation 9: Reporting to the department

The department has found that the present key performance indicators against which colleges report are unclear and inconsistently applied. As a result we propose to streamline reporting requirements for colleges so that reports provide clear and relevant information for assessing whether each college is meeting the aims and objectives of the STP and EMP.

It is also recommended that future funding agreements require colleges to provide the department with the following reports:

- KPIs linked to the national program outcomes;
- statistical data;
- financial information; and
- risks and emerging issues in program implementation.

The department also proposes to consult with colleges during the development of these reports to ensure consistent interpretation and timely reporting.

3 Funding of the STP and EMP

3.1 *Current STP and EMP funding*

The current funding elements of the STP are:

- a salary contribution of \$100,000 per annum (GST exclusive) per post, pro-rated if a post is not a full FTE;
- a rural loading of up to \$20,000 per post per FTE to support trainees and settings for any additional expenses incurred in having a trainee in a rural STP Post (RA 2-5);
- administrative support payments of up to \$10,000 per post to assist colleges in managing the program, though currently averaging about \$5,800 per post;
- the PICS program, which provides private settings with \$30,000 per post per year for clinical supervisor support and \$10,000 per post every three years for infrastructure support; and
- support projects to enhance training opportunities for STP-funded trainees.

Funding for the EMP is made up of largely the same elements as the STP. The salary support contribution and rural loading are in the same amounts, while administrative support payments to ACEM totalled \$616,760 in 2016. There is no PICS funding element to the EMP. Funding for the EMET program and the EDPSCS is about \$9.4 million per year and about \$2.5 million per year respectively.

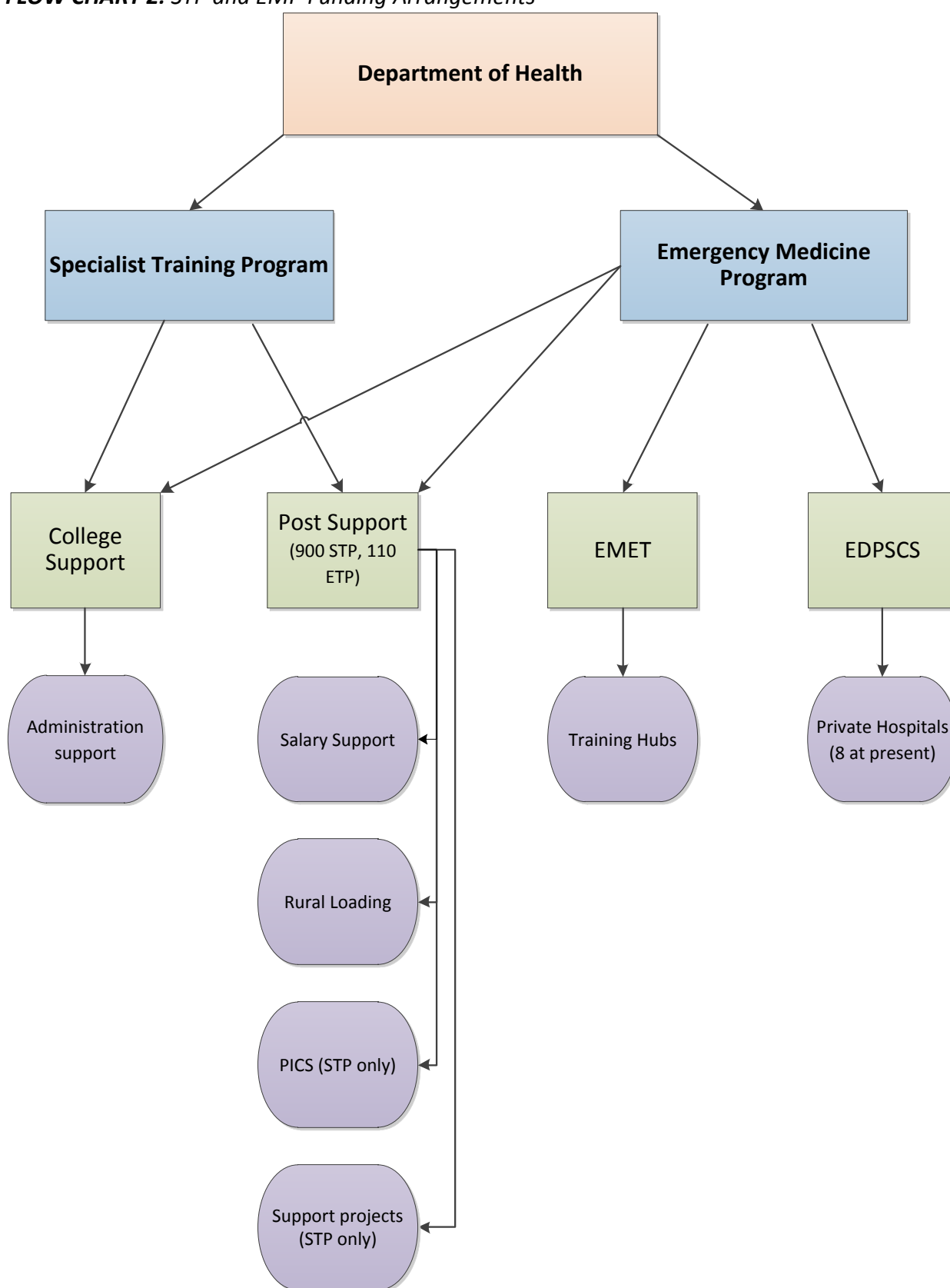
Proposed STP expenditure also includes funding for the Tasmanian Project.

The department makes funding payments directly to colleges, except in relation to the PICS program, for which payments are made to RACMA to administer the program and make payments to the relevant settings. The colleges disburse the salary contribution and the rural loading to the settings as required. The administrative support and educational support project funding is for use by colleges; however support projects have to be approved by the department before they are funded.

Flow chart 2 below shows how STP and EMP funding currently operates.

3. Funding of the STP and EMP

FLOW CHART 2: STP and EMP Funding Arrangements



*Excludes funding for Tasmanian Project and IRTP

3.2 Future funding for the STP and EMP

Funds for the STP and EMP come from the overarching Health Workforce Program. There is a range of demands on the investment in workforce programs required to meet government priorities. STP and EMP combined need to contribute to Health Workforce savings targets and as a result, this review has identified efficiencies in the funding model for both programs.

In their feedback to the review, many stakeholders argued for an increase in the funding levels for various elements, in particular the salary support contribution and the rural loading. However, when faced with a choice between increased funding to those elements and fewer training posts there was a strong preference that there should not be any reduction in the number of STP posts.

The review has proceeded on the basis that savings must be identified against both programs in future years. However, for the reasons set out below, there is strong support for increases to some components of funding, which the department feels should be accommodated, where possible, with offsetting reductions in other components.

In the current challenging fiscal climate, the department has been able to propose modest increases to the salary support contribution and rural loading, offset by reduced funding for support projects, as well as a substantial reduction in EMP positions which is supported by the latest workforce modelling data.

The department's proposed savings can be delivered without compromising the Government's commitment to deliver 1,000 ongoing STP places from 2018, as announced in the December 2015 Mid- Year Economic and Fiscal Outlook and the subsequent 2016-17 Health Portfolio Budget Statement.

The department's proposals for funding individual elements of the STP are discussed and set out below.

3.3 Salary Support funding

The salary contribution is the main and essential element of STP funding of trainees. It was set at \$100,000 per annum (GST exclusive) per FTE regardless of location when the program commenced and has not changed since then. The fixed contribution model leaves it up to each setting to determine whether it can afford to host an STP training post, as it will be required to fund the difference between the STP contribution and the trainee's full salary.

During consultation a number of stakeholders commented that each year, as salaries rise, it is more difficult to make up the salary contribution shortfall. A wide range of stakeholders, including colleges, settings, representative bodies and jurisdictions, argued for the indexation of the salary contribution at various rates from 1 per cent to 3.5 per cent or at the CPI rate. However, when faced with the alternatives of fewer training posts or an increase in the salary contribution, most colleges preferred to maintain the number of available posts.

3. Funding of the STP and EMP

Some stakeholders, rural-based stakeholders in particular, argued the salary contribution should be scaled according to either the location of the post or, recognising that some posts in the same ASGS RA area have higher costs than others, its particular needs. One stakeholder described the fixed-contribution model as “a blunt instrument that does not recognise the different costs of training in public, private hospitals, rural and remote areas.” It was felt that funding should take into account the increased costs and incentives needed to train specialists in rural or remote areas.

Any increase would have to be off-set by savings in another component of the program. There is little evidence that a decision not to increase the salary contribution would lead to many, if any, settings withdrawing from the program. It may be that the change is in the make-up of settings that could afford to meet the difference between the salary contribution and the cost of a trainee; that is, that larger, well-funded hospitals would be in a better position to host an STP training post than small, rural or private settings. Consideration was given to allowing colleges the flexibility to pay a higher salary contribution for some posts than others, with particular emphasis on posts in regional and remote areas, to make it more attractive for those posts to host trainees. However, the department does not feel this approach is practical and the cost of hosting a trainee in those places will be offset to some degree by recommended changes to the rural loading.

The STP was meant to support 900 posts from 2014. The proposed expenditure assumes the STP will fund a full schedule of 900 posts. The ETP, as discussed below, will fund only 50% of the current allocation of 110 posts by 2019.

The department recognises that \$100,000 salary support is less sufficient each year. Further, the aim of the STP is to encourage training in expanded settings and the department feels it would better able to meet that aim by increasing the salary contribution.

Therefore, the department proposes a modest increase in the salary contribution, bearing in mind the expenditure constraints ([Table 7](#)).

3. Funding of the STP and EMP

Table 7: Proposed Increase in Salary Support Funding

Salary support funding (per FTE, per annum)	2017 Current Funding	2018	2019	2020
	\$100,000	\$102,500	\$105,000	\$105,000

There is no evidence warranting changes to how the salary contribution is administered.

Recommendation 10: Salary Support funding

The department has found that, because of the increasing gap between the salary support contribution component of STP funding and the cost of hosting a trainee, there is strong support from stakeholders for an increase in the salary contribution. However, stakeholders also prefer that the program should continue to fund its full complement of 900 posts.

The department recommends increasing the salary support contribution to \$102,500 in 2018 and \$105,000 in 2019 and each remaining year of the funding agreement. This increase would be funded by savings in another component/s of the program.

3.4 Rural Loading funding

The majority of submissions to the department, from a range of stakeholders, favoured the scaling of the rural loading to provide greater support for trainees in more remote placements. One college argued that the present system did not recognise the costs associated with employing a trainee in a rural or remote location. Another stakeholder felt that the loading should be scaled to reflect the “substantial difference in the weight of professional responsibility upon trainees in regional centres and remote towns”.

Some of the extra costs highlighted by stakeholders include personal and family relocation and travel to attend professional development courses. In some cases, it was argued, a doctor’s partner may not be able to find employment in a rural area, potentially placing stress on the trainee’s family or even dissuading them from taking up a rural position.

The STP has always had a strong regional and rural focus; that is, having posts in an RA 2-5 area. At present, STP funding agreements specify a total of 338.52 FTEs be in an RA2-5 area. The colleges reported that for 2015, 339.42 FTEs, or 35.62 per cent of total FTEs, have an element of training in a regional/rural area. It is proposed that this be increased to 400 FTEs, or 44.44 per cent. That amount is the basis for the draft expenditure calculations in this Report.

The current funding agreement with ACEM for training posts includes a clause limiting the rural loading to half the 110 training posts supported. Under the revised proposal the number of posts supported decreases significantly, but the proportion of posts in a rural area remains at 50%.

3. Funding of the STP and EMP

Evidence to the review indicates that there are higher costs to training in rural and remote locations. As with the salary contribution, any increase in the rural loading would have to be off-set by savings in other components of the STP. Under the department's proposed expenditure:

- the total rural loading pool paid to each college would be increased to \$22,500 in 2018 and \$25,000 in 2019 and each remaining year of the funding agreement;
- the rural loading that could be paid to settings for the support of a trainee would be determined by each college within its overall allocation but should be no less than \$15,000 and not greater than \$30,000 per FTE per year; and
- colleges would be given the option of varying payments according to need, including allowing funds to be used to support a rurally based trainee during a rotation to a metropolitan setting, rather than only being available when the trainee is in a rural area, as is currently the case.

Rural loading funding over the course of the agreement is set out below at [Table 8](#).

Table 8: Proposed Rural Loading Funding

Rural loading funding (per FTE, per annum)	2017 Current Funding	2018	2019	2020
	\$20,000	\$22,500	\$25,000	\$25,000

The purpose of the rural loading is to compensate settings for any additional expenses incurred by them in having a trainee in a rural STP Post. There is anecdotal evidence from the review that in some cases the loading has contributed to the settings' general budgets, rather than assisting trainees with expenses incurred by their rural placement or making specific investments in training services. Generally, the department and the colleges have left it to the individual setting to determine how the rural loading is used, although most do provide guidelines.

The department does not believe it is appropriate for the rural loading to be used purely for the settings' purposes. Trainee support is a priority, and is likely to contribute to the ability of colleges to fill available rural places. The department intends to develop guidelines for the administration of the rural loading in consultation with specialist colleges. In addition, the department proposes:

- having colleges include clauses in their agreements with settings that require the setting to use the rural loading to meet the aims and objectives of the STP and the needs of trainees; and
- requiring colleges to identify how the rural loading funding is used in their reports to the department.

Recommendation 11: Rural Loading funding

Evidence to the review shows that there are higher costs to training in a rural or remote location, prompting strong support for an increase in the rural loading component of STP funding. The department believes that even a modest increase in the rural loading would assist rural settings in attracting and keeping trainees. This is consistent with the aims and objectives of the STP.

The department recommends:

- that the rural loading paid to each college be increased to \$22,500 in 2018 and \$25,000 in 2019 and each remaining year of the funding agreement;
- allowing the rural loading payment to a training setting to be determined by the relevant college with reference to a lower limit of \$15,000 per FTE per year and an upper limit of \$30,000 per FTE per year;
- allowing colleges to vary rural loading payments according to need, including allowing funds to be used to support a rurally based trainee during a rotation to a metropolitan setting;
- requiring colleges to include clauses in their agreements with settings that require the setting to use the rural loading to meet the aims and objectives of the STP and the needs of trainees; and
- requiring colleges to identify how the rural loading funding is used in their reports to the department.

3.5 Support Project funding

At present, colleges are allocated funds for:

... a range of support activities, including ... developing system wide education and infrastructure support projects [and] support projects aimed at SIMGs to assist these doctors gain Fellowship in a timely and efficient manner.²⁸

Colleges advise the department of their planned projects for the coming academic year and if the projects meet its guidelines, the department approves their commencement.

In keeping with the overall principle of devolving greater responsibility for the program to the colleges, the department does not propose to introduce new guidelines on what support projects should be funded. Instead, college proposals for support project funding should be considered according to the principles already outlined in the *Operational Framework*:

Proposals for specialist college support funding will be evaluated ... taking into consideration each proposal's capacity to meet the overall aims, objectives and outcomes of the STP and the availability of program funds. Proposals will be assessed on the range of potential projects to be undertaken, the rationale for potential projects to contribute to training in the expanded settings and the governance arrangements within the organisation to determine the allocation of support funds to particular projects.²⁹

²⁸ STP Operational Framework, January 2013, p. 5.

²⁹ STP Operational Framework, January 2013, p. 9.

3. Funding of the STP and EMP

If the department's recommendations relating to salary support and the rural loading are adopted, savings will have to be made in other areas. Payments for support projects for STP-funded trainees have been identified as one area in which savings could be made. During face-to-face consultation and in their submissions to the review, the colleges, not surprisingly, supported the retention of this funding. They argued that educational projects are important in the training of doctors in rural and remote locations and that it was not practical for projects to be directed to STP-funded trainees only. However, the colleges did acknowledge that, assuming there is no increase in overall program funding, this was one area in which savings could be made.

Consideration was given to a model for funding support projects involving two funding pools – a “direct funding pool” and a “discretionary funding pool”. The department tested this proposal during consultations with stakeholders.

Direct funding pool: Colleges would be allocated an annual amount from the direct funding pool in a similar fashion to how funds are allocated to them for support projects now. The allocated amount would be included in the funding agreement. This would enable those projects that are considered to have the greatest ongoing priority for the successful delivery of the STP to be maintained by the colleges. Key learning systems could be maintained but funding would be reduced for more discretionary or exploratory projects. A set, reduced funding amount would be established under the new agreements for a guaranteed support project allocation. Colleges would broadly report against these funds and identify which projects have been conducted over each period.

The department could suggest to colleges that they could work together to improve their projects and increase their efficiency and effectiveness, if the department finds that proposed projects are similar.

Under the department's proposed expenditure for support project funding ([Table 9](#)) the direct funding pool would be made up of base funding for each college of \$100,000 and an allowance of \$1,208 per post. The department considers the proposed amounts would be sufficient to allow each college to run suitable support projects for its STP trainees under the direct funding pool.

Discretionary funding pool: The discretionary funding pool refers to a proposed common pool of funds that would have been allocated to support priority projects that best met the program's objectives and aligned with the development of the profession. This pool would have allowed for more forward thinking projects to be established, for example, those helping to test new models of training or developing new distance learning systems.

Under the proposal, colleges would have applied for funding for a support project from this pool. Peer assessment of projects in this pool would have been undertaken by a sub-group of the CPMC, in the same way that college project proposals were assessed under the former Rural Health Continuing Education Program. This work could have been linked with the CPMC's role in delivering the new Rural Specialist Support initiative, generating some efficiency in program administration.

3. Funding of the STP and EMP

Approval would have been a more rigorous task than endorsement of a direct funding pool project. The guidelines would have sought to promote the most efficient use of funds and encourage cooperative projects and those with a cross-college application.

In written feedback on the proposal to establish a discretionary funding pool for support projects, stakeholders raised some concerns about the administrative impact and potential challenges in achieving an equitable distribution of funding across colleges. In light of these comments and the need to contribute to the government's savings target, this approach is no longer proposed and only the more limited and reduced direct support project funding is suggested over the next funding period. The proposal for a discretionary funding pool for support projects may be revisited in the future if sufficient funds are available.

The expected savings of \$3.3 million from not proceeding with the proposed discretionary funding pool and limiting the direct funding pool would enable these funds to be partially used to offset other STP component increases and contribute to the required level of savings.

Table 9: Proposed Support Project Expenditure

College	Posts per college	Proposed funding (\$100,000 + \$1,208 per post)
ACD	27	\$132,616
ACEM*	77 in 2018	\$193,016
	57 in 2019	\$168,856
ACSP	4	\$104,832
ANZCA	42	\$150,736
CICM	16	\$119,328
RACMA	17	\$120,536
RACP	345	\$516,760
RACS	70	\$184,560
RANZCO	15	\$118,120
RANZCOG	32	\$138,656
RANZCP	160	\$293,280
RANZCR	82	\$199,056
RCPA	88	\$206,304
Total	2018 977	2018 \$2,477,800
	2019 955	2019 \$2,453,640

*See Section 4.3 for discussion & allocation of ACEM training posts as this impacts on support project funding

Recommendation 12: Support Projects funding

Colleges participating in the STP have indicated a willingness to accept a reduction in the support project component of STP funding if it means an increase in other components. The increases in the salary contribution and rural loading components of STP funding rely on savings being made elsewhere in the program.

The department recommends:

- reducing the total funding provided for STP support projects by \$3.3 million per year;
- providing funding for support projects to each college using the following formula:
 - Base funding of \$100,000 per year plus \$1,208 per post/FTE per year.

College support project funding proposals will continue to be assessed and approved by the department using the current guidelines.

3.6 Administrative and Governance funding

Colleges receive administration and governance funds for initial set up costs, contract administration, governance arrangements covering delivery of the program and to provide reports to the department.

To date, funding has been negotiated following each funding round. It is based on the number of posts allocated to the college; for smaller colleges, the minimum funds they require; and, for larger colleges, potential economies of scale.³⁰ The department's EMP funding agreement with ACEM specifies that administrative funding is for staffing (annual salary and FTE for each position identified), infrastructure and consumables, and consultants and outsourced staff (covering technical support, database specialists, e-learning consultants, instructional designers and web designers).

As part of its consultation with colleges, the department requested details of their administrative costs for 2015. The information provided covered a range of categories such as salary and on-costs for those staff directly managing the program, legal costs, audit expenses, and overheads (for example, office furniture, IT, finance, stationery & printing, and senior management oversight).

The evidence suggests there is likely to be little room to reduce administrative and governance funding, as the department's proposed STP reforms would require the colleges to undertake additional tasks, including the management of PICS, completing reviews of existing posts and assessments of EOIs and making recommendations to the department on the outcome of those reviews and assessments. Further, colleges will not be provided with dedicated administrative funding for the implementation of the IRTP.

In written feedback to the department, the colleges generally expressed the view that they should be compensated for these additional administrative tasks. The department is conscious of the additional administration workload that colleges have absorbed in the past

³⁰ ANZCA administers STP posts for CICM. ACEM's funding is provided under its EMP agreement.

3. Funding of the STP and EMP

and the impost the proposed reforms will place on colleges in the future. The department therefore proposes to provide a one-off increase in funding to colleges in 2018 in recognition of their expanded role. The planned increase would be funded from savings proposed elsewhere in the program, including the reduction in support project funding. It would be retained in subsequent years but not indexed.

On this basis, it is recommended that college administration funding be increased by 10% in the 2018 academic year and then maintained at that level ([Table 10](#)).

Table 9: Proposed Increase to College Administration Funding

STP Administrative & Governance	2017 current funding	2018	2019	2020
	\$6,707,899	\$7,387,355	\$7,387,355	\$7,387,355

Note: this does not include payments to RACMA to administer the PICS program nor to ACEM to administer the ETP and EMET components of the EMP.

Recommendation 13: Administrative and Governance funding

The evidence to the review does not support the department reducing administrative and governance support funding, as the colleges would have extra roles to perform if the department's proposed reforms on the operation of the STP are accepted.

The department recommends a marginal one-off increase in college administration funding support in 2018 by 10% in recognition of the expanded role of colleges

3.7 Private Infrastructure and Clinical Supervision (PICS) Allowance

The PICS allowance:

...provides funding support for activities associated with clinical supervision and training infrastructure. [It] recognises the cost of delivering training in the private sector with funding designed to contribute to meeting these costs.³¹

It was introduced to encourage private sector involvement in training, as private settings do not benefit from the larger Commonwealth investment in teaching, training and research through the healthcare agreements with jurisdictions and generally do not have the same economies of scale to support teaching.

The PICS allowance is made up of two elements, which are paid to the settings on a pro rata basis:

- a \$30,000 contribution per FTE per year for clinical supervision; and
- a \$10,000 contribution per FTE for infrastructure costs, paid once only in any 3 year period.

³¹ STP Operational Framework, January 2013, p. 8.

3. Funding of the STP and EMP

The program is administered by RACMA, rather than the college relevant to the post. At the time of its introduction, this arrangement was considered appropriate as this targeted funding element did not fit neatly into the existing funding agreements, and the arrangement was administratively convenient. For all private STP posts it is necessary for the setting to enter into an agreement with RACMA for the PICS allowance and also with a college in relation to the training post.

Stakeholder feedback suggested that PICS allowance is important and useful, with one private hospital commenting that it would be hard for it to run quality training without the extra funding. However, consultation also revealed that stakeholders feel the purposes for which PICS funds can be used should be more clearly defined.

In their submissions to the review, colleges generally agreed that the administration of the present system is unduly complex and redundant and that it adds excessive costs to the program. Colleges feel that it would not present a problem for them to administer the PICS contribution along with the other funding elements of the STP.

The department therefore proposes that management of the PICS allowance be placed in the hands of the college that administers the post. This would create a more direct decision-making process and remove the need for settings to enter into two agreements in relation to the one post. The department would work closely with the current administrator, RACMA, to develop a transition plan for the administration of the PICS allowance.

Further, the administration of the PICS allowance could be streamlined by combining its infrastructure and clinical supervision elements into one payment. It is also proposed to allow settings to use the PICS payments flexibly for clinical supervision and/or infrastructure. This payment would be \$30,000 per FTE per year for eligible posts, a small reduction on the current 'average' annual payment of \$33,333 ([Table 10](#)).

Table 10: Proposed Reduction in PICS Payment

	2017	2018	2019	2020
	Current Funding			
PICS funding	<ul style="list-style-type: none">• \$30,000 for Clinical Supervision• \$10,000 for Infrastructure Support paid once every 3 years	\$30,000	\$30,000	\$30,000

At present, PICS allowance applies to 403 FTE, however this would increase with the proposed STP target of 440 FTE in private settings from 2018.

While the department's review did not find evidence of misuse of the PICS allowance, it is apparent that the uses to which it can be put should be made clearer. In light of RACMA's experience in managing PICS the Department will consult with RACMA in developing

3. Funding of the STP and EMP

guidelines for use by the colleges in managing PICS funds to ensure the program's future administration is efficient and effective.

The department proposes that colleges be asked to include clauses in their agreements with settings that require the setting to use the PICS allowance to meet the STP's aims and objectives. Further, colleges should identify how PICS funding is used in their reports to the department.

Recommendation 14: Private Infrastructure and Clinical Supervision allowance

The department has found that the PICS allowance is important to private sector settings.

The department recommends the adoption of a streamlined administration model that:

- combines the infrastructure and clinical supervision elements of funding into a single payment of \$30,000 per year per FTE; and
- responsibility for administration of the PICS allowance be transferred from RACMA to the college responsible for the relevant post.

The department will consult with RACMA to develop guidelines for use by the colleges in managing PICS to ensure the program's future administration is efficient and effective. .

It is also recommended that colleges be required to:

- include clauses in their agreements with settings that require the setting to use the PICS allowance to meet the STP's aims and objectives; and
- identify how the PICS allowance is used in their reports to the department.

4 Proposed reforms to the Emergency Medicine Program

4.1 The Emergency Medicine Training Program

4.1.1 Background

The background of the Emergency Medicine Training Program (ETP) is set out in Section 1.3 above.

Table 12 and 13 show the placement of ETP training posts by ASGC RA category, public/private status and state/territory and filled FTEs, for the 2015 academic year.

Table 12: ETP Training Posts by ASGC RA Category

	RA1	RA2	RA3	RA4	RA5	Public	Private	Total
FTEs per agreement between college and settings	62.85	44.65	14.5	5	2	95.3	33.7	129

Table 13: ETP Training Posts by Stated and Filled FTEs

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
FTEs per agreement between college and settings	3	34	4	25	2	2	30	29	129
Filled FTEs	2.5	28.5	3.5	19.75	1.5	0	23.33	26.5	105.58

4.2 Proposed reform: Integration of STP and ETP

The STP/ETP discussion paper released in September 2015 raised the option of the two programs being integrated. It noted the following similarities between the programs:

- both are responsible for training specialists;
- the contribution towards a trainee's salary, the rural loading and funding for administration are the same for both programs;
- they are administered by specialist medical colleges under an agreement with the department;
- policy and overall management control of them lies with the department; and
- prior to 2014, the training program was, by and large, administered in conjunction with the STP.

and some differences:

- ACEM has a greater role in the administration of the program;
- ACEM does not receive an annual Support Project funding allocation, administration and governance funding is limited to specific uses (thereby

4. Proposed Reforms to the Emergency Medicine Program

inhibiting the college from prioritising its use and seeking efficiencies and economies of scale over time); and ETP posts are not eligible for PICS; and

- the ETP is not as focussed on expanding training to rural and regional and private sector settings as the STP. It was designed to contribute to the wider measure of seeking to improve the timely delivery of care to patients in emergency departments across Australia. Part of this strategy was increasing the qualified emergency medicine workforce.

Those stakeholders that were not supportive of the integration of STP and ETP suggested that integration could have a negative impact on emergency care delivery in rural and regional areas and that it is not clear what benefits would be gained from integrating the programs.

The department considers that the integration of the STP and ETP will provide the following benefits:

- streamline administration of both programs;
- all STP & ETP posts able to seek the same funding support elements, for example PICS;
- avoid confusion in public and private hospitals about the differences between the two programs;
- administrative support for ACEM would be consistent with that provided to specialist colleges under the STP;
 - would be simplified by providing a total amount rather than funding for each staff position and other administrative functions
- ACEM would be eligible for funding for support projects;
- ACEM would be set appropriate targets for regional/rural posts as well as private posts.

ACEM has indicated its support for the proposal in discussions with the department.

Recommendation 15: Integration of STP and ETP

The department considers that on balance the ETP and the STP should be integrated into one program.

The department recommends that:

- the ETP be integrated into the STP commencing in the 2018 academic year;
- ACEM and the emergency medicine training posts would then be open to receive funding under the various STP components such as salary support, rural loading, PICS, Support Projects and Administration.

4.3 The Number of Emergency Medicine Training Posts Allocated to ACEM

Under the ETP, ACEM is currently funded to deliver 110 emergency medicine specialist training posts each year. ACEM has also been allocated 2 STP posts. In total ACEM manages 112 FTE emergency medicine training posts each year.

4. Proposed Reforms to the Emergency Medicine Program

The process for allocating STP posts to each college/specialty was discussed at Section 2.4 above. In completing that process the data available to the department and KPMG indicated that emergency medicine was in balance and that the allocation of 2 STP posts to ACEM should continue. In this situation it was considered appropriate that ACEM would continue to be funded to deliver the 110 posts under the ETP.

However, during 2016 the department completed a supply and demand analysis of Emergency Medicine for consideration by NMTAN. The preliminary forecasting suggested a high likelihood of oversupply in the Emergency Medicine workforce in the future. NMTAN are expected to publish its report on this matter later in 2017.

ACEM is continuing to work with the department to further refine the forecast modelling and is undertaking discussions with jurisdictions about workforce planning issues, including maldistribution and undersupply in rural/regional settings, assumptions associated with sustainable FACEM workforce models and standards for trainee intake into the FACEM training program.

In this situation of a forecast oversupply the department consulted with ACEM about a reduction in the number of training posts that should be supported in future.

ACEM suggested that if it was able to retain a workable number of STP/ETP posts, where the College was able to exercise a degree of influence over the nature and location of these training posts, it would provide a practical means for ACEM to respond to future training and workforce distributional issues.

In this context ACEM suggested a 50% reduction of the 112 STP/ETP posts over a 2 year period. The College proposed a reduction of 35 posts to 77 posts in the first year (2018) and a further reduction of 20 posts to 57 posts in the second year (2019). The reduction in salary support funding required over the three year period 2018 to 2020 would be \$14.5 million.

The College suggested a regional/rural target of 50% of training posts and a target of 30% for private sector posts.

The department considers that the reduction in STP/EMP posts and the targets for regional / rural and private sector proposed by ACEM is appropriate in light of the revised supply and demand forecasts.

4. Proposed Reforms to the Emergency Medicine Program

Recommendation 16: Allocation of Emergency Medicine Training Posts

The department considers that in light of the current supply and demand forecasts for the emergency medicine workforce the number of training posts supported by the STP/ETP should be reduced.

It is recommended that the number of emergency medicine training posts to be supported are:

- 77 posts in 2018 (a reduction of 35 from the 112 posts supported in 2017)
- 57 posts in 2019 (a reduction of 57 from the 112 posts supported in 2017)
 - the savings in salary support for the reduction of posts would be \$14.5 million over the three year period 2018 to 2020
- The targets for these posts are:
 - 50% of posts are to be in regional/rural areas; and
 - 30% will be private sector posts.

4.4 The Emergency Medicine Education and Training (EMET) Program

4.4.0 Background

The EMET program was introduced by the previous Government in 2011 as part of its *Improving Australia's Emergency Department Medical Workforce* Project to improve the supply of suitably qualified staff in the Australian emergency medical workforce. It provides additional training to staff in regional and rural hospitals that do not have a specialist emergency physician. Training sessions are open to doctors, GPs, nurses and paramedics. The intention is to boost the quality of care and increase access to emergency services for people living outside urban areas.

ACEM has advised that, as at the end of 2015, 644 hospitals in Australia had emergency departments, accident and emergency departments or urgent care services, 24 per cent of which are staffed by Fellows of the college. ACEM advises that of these hospitals over 500 have no specialist emergency physician on duty or on call at any time. It indicates that current funding allows EMET to provide training and support for only 40 per cent of hospitals that do not have Fellows on staff.

ACEM states that in 2015, EMET training was conducted in 352 sites, 334 of which (95 per cent) were in regional and remote settings. Since 2012, more than 45,000 people have attended training. EMET sessions are used by ACEM to promote uptake of its Certificate of Emergency Medicine and Diploma of Emergency Medicine courses. Four hundred participants have graduated from the Certificate course, with 347 candidates currently in progress. Nineteen participants have graduated from the diploma course, with 46 candidates currently in progress.

4. Proposed Reforms to the Emergency Medicine Program

4.4.1 *Proposed reforms to EMET*

One stakeholder expressed its support for the program but argued that fundamental changes to the structure of EMET are needed for it to meet its objective of building the skill base in rural hospitals that do not have emergency medicine specialists. In particular, it was claimed that EMET:

- has been designed and delivered “in complete isolation from the general practice colleges whose membership are the intended practitioners”;
- competes with and duplicates emergency training programs for rural general practitioners run by other colleges;
- does not line up with career pathways for rural general practitioners that incorporate emergency medicine training; and
- could be better managed by a different college.

The department has carefully considered those points. In its view the EMET program should continue to be provided by ACEM as the college approved by the Australian Medical Council to set professional standards in this specialty. The department acknowledges that while other colleges may be capable of providing some emergency medicine training or have particular expertise in rural and remote medicine, ACEM is the specialist medical college for emergency medicine and is therefore best equipped to conduct this training. This is particularly important as the program is not intended to be delivered solely to general practitioners.

However, it is suggested that ACEM consult formally with key stakeholders (including service providers, colleges and other professional groups) on the future implementation and oversight of the program, including through the establishment of a stakeholder reference group. This group should include at a minimum ACCRM, the RACGP Rural Faculty and two jurisdictional nominees from the Health Workforce Principal Committee.

Greater engagement with stakeholder groups should assist in ensuring future EMET investment is well targeted and better aligned to emerging regional health service needs. Further discussions with ACEM on the parameters for the proposed stakeholder reference group will be undertaken following this review process.

The Commonwealth invested in the EMET program as part of a broader contribution towards COAG-agreed efforts to reduce emergency department waiting times. Reporting by ACEM indicates the program has been successful in training persons in rural and regional areas and anecdotal evidence suggests it has saved lives by improving the skills of a broad range of emergency staff. However, there is little evidence that EMET has reduced emergency department waiting times. Refocussing the agreed outcomes for the program may be necessary to ensure the focus on delivering safe and appropriate patient services is highlighted, rather than the direct contribution towards waiting times.

Base-level funding for EMET is currently \$9.4 million per annum. In recent years ACEM has invested significant surplus funds from the other components of the EMP into the EMET stream.

4. Proposed Reforms to the Emergency Medicine Program

ACEM has suggested that the base level of funding for EMET be supplemented by \$1.5 million per year (from salary support savings of \$14.5 million over the three years 2018-2020) to enable the program to be maintained at 2015-16 levels in terms of number of hubs, numbers of training sites, and level of support offered to training sites. Base-level funding for EMET would then be \$10.9 million per year.

It is noted that ACEM would review the performance of existing hubs to determine whether support should continue or new hubs offered support. The department suggests that it should discuss with ACEM the guidelines for selecting hubs and KPIs for the program from 2018.

The College has advised that through a focus on regional/rural outreach and support and availability of additional funding, expansion could be targeted to geographical areas in Australia that have yet to benefit from the EMET Program and to those sites that are under resourced for their coverage area. This would further enhance equity of access to specialist emergency medicine support and training available to more GPs and medical officers working in Australia's regional and rural EDs and emergency care facilities; ultimately ensuring more Australian patients are able to receive appropriate, high-quality emergency medical care, regardless of their geographical location.

There is strong support from within ACEM for the continuation of EMET. The department considers EMET a valuable program.

Recommendation 17: The Emergency Medicine Education and Training Program

The review indicates that EMET is a valuable program.

The department recommends that:

- ACEM establish a stakeholder reference group to formally consult on the future implementation and oversight of the program;
 - The department to hold discussions with ACEM on the parameters and membership of the proposed stakeholder reference group.
- Base-level funding for EMET increase by \$1.5 million to \$10.9 million per year to enable 2015-16 levels in terms of number of hubs, numbers of training sites, and level of support offered to training sites be maintained; and
- ACEM consult with the department on the development of guidelines for selecting EMET hubs and KPIs for the program from 2018.

4.5 The Emergency Department Private Sector Clinical Supervisor Program (EDPSCS)

4.5.1 Background

The EDPSCS program was established in 2011 to support the expansion of specialist training places outside of traditional public teaching hospitals into private hospitals that operate emergency departments.

4. Proposed Reforms to the Emergency Medicine Program

It is a legacy of the then Government's *Building emergency department workforce capacity* initiative, which aimed to lead to:

... improved quality of emergency services, increased efficiencies in emergency departments, including reduced waiting times; and ultimately reduce critical incidents and patient deaths.³²

It supports the employment of clinical training supervisors or staff specialist training coordinators at each private hospital. It should be noted that three of the original eleven hospitals that were participants in the EDPSCS at its commencement have since dropped out of the program and have not been replaced. It is likely that an inability to fill key positions for ACEM Fellows as Directors of Clinical Training has been the main reason for some hospitals ceasing their participation.

Estimated total funding for the EDPSCS from 2011 to 2016 is about \$18.7 million. The EDPSCS is administered by the department through funding agreements entered into with the participating private hospitals. The criteria for selecting an EDPSCS proposal are that the hospital must:

- be able to establish new staff specialist emergency department clinical training coordinator positions; and
- be capable of building projects to support the creation of new staff specialist emergency department clinical training coordinator positions, such as:
 - emergency department training accreditation costs;
 - infrastructure associated with establishing the new coordinator positions; and/or
 - development of effective training networks that support the expansion of private sector training.

EDPSCS funding covers the salary and on-costs for a clinical training supervisor, administrative support and a one-off infrastructure support payment in year one. Funding for supervisors was based on around \$400,000 per FTE per year, pro-rated.

4.5.2 Proposed reforms to the EDPSCS

It was originally intended that the EDPSCS would be administered by key stakeholders. ACEM was initially approached to deliver the program, however it declined at the time. Similarly, a proposal for peak private hospital representative organisations—the CHA, the APHA and Healthscope Australia Ltd to manage the EDPSCS did not proceed.

Consequently, the EDPSCS is administered by the department through a direct funding arrangement with each participating private hospital.

³² Department of Health and Ageing, *Budget Statements - 2011-12*, pp 328-9; [www.health.gov.au/internet/budget/publishing.nsf/Content/2011-12_Health_PBS_sup2/\\$File/2011-12_Health_PBS_18_Outcome12.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2011-12_Health_PBS_sup2/$File/2011-12_Health_PBS_18_Outcome12.pdf) (accessed 17 March 2016).

4. Proposed Reforms to the Emergency Medicine Program

In discussions with ACEM the department raised the possibility of the college assuming administration of the EDPSCS. ACEM was supportive of assuming responsibility for administration of the EDPSCS program, provided there is a planned transition of this role from the department and additional resources for the administration of this program by the College. As part of the transition to ACEM the Program would be reviewed by the College during 2017 to inform the development of Guidelines that enable a standardised funding agreement, an agreed funding model for a specified range of supported activities and a reporting framework for all private hospitals receiving EDPSCS funding.

ACEM noted that since the EDPSCS Program was introduced in 2011, several newly opened private emergency departments, including some in rural/regional areas, have been accredited as ACEM Fellowship training sites. The College anticipates that these additional hospitals will need to be taken into account from 2018, and this would be addressed as part of the proposed review of the Program during 2017. The department would work closely with ACEM during the proposed review.

The department supports ACEM's proposal to manage the program. This would streamline the management of all programs in the EMP and under ACEM's management the EDPSCS would become more responsive to the needs of private hospitals and the emergency medicine sector.

Recommendation 18: The Emergency Department Private Sector Clinical Supervisor Program

The department recommends that:

- ACEM assume management of the EDPSCS. This would bring it into line with the other programs in the EMP and make it more responsive to the needs of the private sector.
- The College review the EDPSCS during 2017. The department would work closely with ACEM during the review.

ATTACHMENTS

Attachment	Title
A	Review Recommendations
B	STP Program Logic
C1	STP FTEs by College, ASGC-RA Category and Public-Private (2015)
C2	STP Posts by College and State and Territory (2015)
D	EMP Program Logic
E	List of Stakeholders Consulted as part of the Review
F	Summary of Responses to STP Discussion Papers
G	STP Operational Framework 2016
H	EOI Assessment Guidelines

A: Review Recommendations

Recommendation 1: Administration of the Specialist Training Program

The review found that the STP's current top-down administration model lacks flexibility and is overly prescriptive.

The department recommends greater responsibility being put in the hands of the colleges, as they are the bodies that manage the training of fellows, accredit settings and are in the best position to efficiently fill vacant training posts. The department would still determine the number of training posts allocated to each college over the course of the funding agreement as well as setting the overall priorities for the STP. The following process for administering the STP is recommended:

- A determination would be made on the number of training posts to be allocated to each college (and specialty) and the regional/rural and private targets the college should meet in filling its posts.
 - The allocation and targets for each college will be reviewed by the department before the end of the funding agreement.
- To provide an opportunity for new training settings, and to help fill all STP posts throughout the funding agreement period, there would be a call for EOIs from settings that wish to host an STP-funded post.
 - The department would manage the EOI process. EOIs are expected to be held regularly, say every two years, but this timing could be adjusted if necessary.
 - State and territory health departments would be provided an opportunity to comment on EOIs. Colleges would need to consider this feedback in selecting those posts to be recommended to the department for possible, future STP support, in combination with their view on the educational value of the setting and its contribution to meeting their STP targets.
- Each college should review its training posts over the life of the funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts and those identified by the department as potentially not meeting the STP's aims and objectives. Based on the outcome of those post reviews, colleges would recommend to the department whether a post should continue to receive STP support. Those recommendations would be provided on an agreed timeframe which would be included in the funding agreement.
 - A minimum of 12 months' notice should be given to training posts that are to be discontinued following the outcome of a review.
- The department would develop broad guidelines for use by the colleges in assessing EOIs and reviewing existing STP posts. Broad guidelines will also be developed for jurisdictions to assess EOIs. These guidelines would include the overall priorities determined for the STP.
- In light of AGS advice on competition law, the department would be the decision maker in selecting those posts to be supported for possible future STP funding and those that will not be supported in future.
 - The department's decision would be based on the recommendations of the colleges;
 - Only in exceptional circumstances would the department not follow college post recommendations. For example:

- jurisdiction advice had clearly not been taken into account; or
 - not consistent with operational and priority frameworks; or
 - inconsistent with the college attaining its targets outlined in their funding agreement.
- Funding agreements of three years duration would be entered into with each participating college for it to deliver the program starting in the next academic year. Agreements would specify the colleges' allocation of posts, its targets, the funding the college would receive, post review requirements, reporting requirements and ancillary matters.

The STP will maintain its focus on medical specialists other than general practitioners, including rural generalists.

Recommendation 2: Allocation of training posts to colleges and specialties

One of the aims of the review is to match Government expenditure on the STP to identified areas of potential specialist shortage.

To address this, the department recommends that on the basis of the supply/demand analysis and the replacement methodology discussed in Section 2.4 the number of training posts that will be allocated to each college and specialty for the period of the next funding agreement is as set out in Table 5.

For those specialties with reductions in allocated STP posts the college may seek approval to retain some of the posts in that specialty for the next funding period. To retain a post the college would need to show that it provides significant benefits to regional and rural communities or provides significant private sector training experience. The retention of a post(s) must be offset by a reduction in the college's other STP posts.

Table 5: Allocation of training posts by college and specialty

College	Current STP Allocation of Posts (FTEs)	College: Proposed STP Allocation of Posts (FTEs)	Specialty	Specialty: Proposed STP Allocation of Posts (FTEs)
Australasian College of Dermatologists (ACD)	27	27		
Australasian College for Emergency Medicine (ACEM)*	2	2		
Australasian College for Sport and Exercise Physicians (ACSP)	4	4		
Australian and New Zealand College of Anaesthetists (ANZCA)	42	42		
College of Intensive Care Medicine of Australia and New Zealand (CICM)	16	16		
Royal Australasian College of Medical Administrators (RACMA)	17.5	17		
Royal Australasian College of Physicians (RACP)	351.4	343		
			Addiction Medicine	3
			Cardiology	8
			Clinical Genetics	2
			Clinical Pharmacology	2
			Endocrinology	12
			Gastroenterology & Hepatology	0
			General Medicine	58
			Geriatric Medicine	35
			Haematology	2
			Immunology & Allergy	2
			Infectious Diseases	2
			Medical oncology	18
			Nephrology	6
			Neurology	7
			Paediatrics & Child Health	66
			Rehabilitation Medicine	27
			Respiratory & Sleep Medicine	6
			Rheumatology	6
			Public Health Medicine	33
			Palliative Medicine	24
			Other Physicians	24
Royal Australasian College of Surgeons (RACS)	73	70		
			General Surgery	45
			Plastic Surgery	0
			Orthopaedic Surgery	13
			Otolaryngology	0
			Other Surgery	12
Royal Australian & New Zealand College of Ophthalmologists (RANZCO)	12	15		
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	32	32		
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	160	160		
Royal Australian and New Zealand College of Radiologists (RANZCR)	47	82		
			Radiology	54
			Radiation Oncology	28
Royal College of Pathologists of Australasia (RCPA)	87	90		
			Anatomical Pathology	47
			Forensic Pathology	2
			Other (Clinical) Pathology	41
Total	870.9	900		

Recommendation 3: Training Post Targets - Rural and Private

To address the aim of the STP of supporting training posts in expanded settings, it is recommended that the total number of training posts increase in:

- RA 2-5 from 338 FTE to 400 FTE per year; and
- Private settings from 402 FTE to 440 FTE per year.

To meet the overall STP targets it is recommended that the colleges be set annual targets for both RA 2-5 and private settings. The targets for each college are set out in [Table 6](#).

It is acknowledged that the proposed targets may not be reached until the last year of the funding agreement, thereby giving the college sufficient time to make any necessary transition.

Table 6: Proposed rural and private setting targets for each college

College	Proposed STP Funded FTEs	Rural FTE Target	Current Rural FTEs (Funding Agreement)	Private FTE Target	Current Private FTEs (2015)
ACD	27	8	6.16	22	19.82
ACEM*	2	0	0.00	2	2.00
ACSP	4	2	1.30	4	4.00
ANZCA	42	20	17.00	16	14.61
CICM	16	6	5.00	11	10.00
RACMA	17	11	9.70	7	6.50
RACP	343	179	151.64	158	143.96
RACS	70	37	31.00	38	34.90
RANZCO	15	7	6.00	9	8.35
RANZCOG	32	11	9.12	16	14.55
RANZCP	160	50	42.80	71	64.90
RANZCR	82	29	24.80	17	15.90
RCPA	90	40	34.00	69	62.90
Total	900	400	338.52	440	402.39

Recommendation 4: Selection and Review of training posts

The review has shown there has been a tendency for STP training posts to effectively become permanent once they are established, making the program less responsive to workforce needs and weakening the focus on supporting expanded settings.

As discussed above the department will make the final decision on selecting posts, but those decisions would be based on recommendations from the college(s).

The department recommends that colleges be required to review all existing training posts over the life of each funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts and posts that the department considers may not meet the aims and objectives of the STP.

The following principles should be applied by the colleges when determining their recommendations on the selection or review of training posts:

- there should be a spread of training posts across RA2-5 areas and in private settings (reflecting the targets set for the college);

- the post should meet the local workforce needs of the area in which it is placed based on jurisdictional comment;
- trainees should not spend less than three months in a post, without the specific approval of the department; and
- the post should have significant educational value.

If a training post is to be discontinued following the outcome of a review the post should be given sufficient notice about the termination of its STP funding so as to not adversely impact a trainee currently in that post or has been recruited to fill that post. It is expected that any notice period would not exceed 12 months.

Recommendation 5: Expressions of interest to host training posts

The department has developed and trialled a streamlined online process for taking expressions of interest from settings that wish to host new STP-funded posts. A web-based template for expressions of interest has been designed and launched in late 2016 by the department in consultation with the colleges.

Colleges and states and territories have been given access to the website to record comments and provide a suitability rating against each EOI, with the jurisdictions looking at workforce needs at a local level.

An evaluation of the EOI will be undertaken after the assessment period concludes with any necessary modifications made before the next EOI. Some modifications will be made to accommodate the proposal that the department will make the final decision on selecting posts based on recommendations from the colleges.

It is recommended that that the department host future EOIs regularly, at least every 2 years.

Recommendation 6: Rural classification system

The classification system presently being used for determining whether a training post in the STP and EMP is in an RA1 or RA2-5 area has been superseded by the Australian Statistical Geography Standard model.

The department recommends that the Australian Statistical Geography Standard system be used as the rural classification system for training posts under the STP and EMP as it is regularly updated to reflect population trends.

Recommendation 7: Dedicated Indigenous training posts

The department found during the review that there is little reliable statistical evidence on the number of Indigenous specialist trainees, but that it is believed to be a low number. Further, most colleges do not appear to have programs to promote specialist training amongst Indigenous doctors.

The STP should continue to prioritise the delivery of training in Indigenous health settings.

While the department does not recommend that dedicated Indigenous training posts be introduced as part of the STP, it proposes that colleges be required to report on the number of STP-funded training posts that have been filled by trainees that have identified as being Indigenous and on what efforts they are undertaking to increase the number of Indigenous Fellows. This reporting requirement would be included in the next Funding Agreement.

The department notes that STP support project funding may be used to support Indigenous specialist trainees to complete their training.

Recommendation 8: Specialist International Medical Graduates

The review found that colleges have had difficulty in filling SIMG dedicated STP training places.

The department recommends that no STP posts be designated for only SIMGs.

Recommendation 9: Reporting to the department

The department has found that the present key performance indicators against which colleges report are unclear and inconsistently applied. As a result we propose to streamline reporting requirements for colleges so that reports provide clear and relevant information for assessing whether each college is meeting the aims and objectives of the STP and EMP.

It is also recommended that future funding agreements require colleges to provide the department with the following reports:

- KPIs linked to the national program outcomes;
- statistical data;
- financial information; and
- risks and emerging issues in program implementation.

The department also proposes to consult with colleges during the development of these reports to ensure consistent interpretation and timely reporting.

Recommendation 10: Salary Support funding

The department has found that, because of the increasing gap between the salary support contribution component of STP funding and the cost of hosting a trainee, there is strong support from stakeholders for an increase in the salary contribution. However, stakeholders also prefer that the program should continue to fund its full complement of 900 posts.

The department recommends increasing the salary support contribution to \$102,500 in 2018 and \$105,000 in 2019 and each remaining year of the funding agreement. This increase would be funded by savings in another component/s of the program.

Recommendation 11: Rural Loading funding

Evidence to the review shows that there are higher costs to training in a rural or remote location, prompting strong support for an increase in the rural loading component of STP funding. The department believes that even a modest increase in the rural loading would assist rural settings in attracting and keeping trainees. This is consistent with the aims and objectives of the STP.

The department recommends:

- that the rural loading paid to each college be increased to \$22,500 in 2018 and \$25,000 in 2019 and each remaining year of the funding agreement;
- allowing the rural loading payment to a training setting to be determined by the relevant college with reference to a lower limit of \$15,000 per FTE per year and an upper limit of \$30,000 per FTE per year;
- allowing colleges to vary rural loading payments according to need, including allowing funds to be used to support a rurally based trainee during a rotation to a metropolitan setting;
- requiring colleges to include clauses in their agreements with settings that require the setting to use the rural loading to meet the aims and objectives of the STP and the needs of trainees; and

- requiring colleges to identify how the rural loading funding is used in their reports to the department.

Recommendation 12: Support Projects funding

Colleges participating in the STP have indicated a willingness to accept a reduction in the support project component of STP funding if it means an increase in other components. The increases in the salary contribution and rural loading components of STP funding rely on savings being made elsewhere in the program.

The department recommends:

- reducing the total funding provided for STP support projects by \$3.3 million per year;
- providing funding for support projects to each college using the following formula:
 - Base funding of \$100,000 per year plus \$1,208 per post/FTE per year.

College support project funding proposals will continue to be assessed and approved by the department using the current guidelines.

Recommendation 13: Administrative and Governance funding

The evidence to the review does not support the department reducing administrative and governance support funding, as the colleges would have extra roles to perform if the department's proposed reforms on the operation of the STP are accepted.

The department recommends a marginal one-off increase in college administration funding support in 2018 by 10% in recognition of the expanded role of colleges.

Recommendation 14: Private Infrastructure and Clinical Supervision allowance

The department has found that the PICS allowance is important to private sector settings.

The department recommends the adoption of a streamlined administration model that:

- combines the infrastructure and clinical supervision elements of funding into a single payment of \$30,000 per year per FTE; and
- responsibility for administration of the PICS allowance be transferred from RACMA to the college responsible for the relevant post.

The department will consult with RACMA to develop guidelines for use by the colleges in managing PICS to ensure the program's future administration is efficient and effective. .

It is also recommended that colleges be required to:

- include clauses in their agreements with settings that require the setting to use the PICS allowance to meet the STP's aims and objectives; and
- identify how the PICS allowance is used in their reports to the department.

Recommendation 15: Integration of STP and ETP

The department considers that on balance the ETP and the STP should be integrated into one program.

The department recommends that:

- the ETP be integrated into the STP commencing in the 2018 academic year; and

- ACEM and the emergency medicine training posts would then be open to receive funding under the various STP components such as salary support, rural loading, PICS, Support Projects and Administration.

Recommendation 16: Allocation of Emergency Medicine Training Posts

The department considers that in light of the current supply and demand forecasts for the emergency medicine workforce the number of training posts supported by the STP/ETP should be reduced.

It is recommended that the number of emergency medicine training posts to be supported are:

- 77 posts in 2018 (a reduction of 35 from the 112 posts supported in 2017)
- 57 posts in 2019 (a reduction of 57 from the 112 posts supported in 2017)
 - the savings in salary support for the reduction of posts would be \$14.5 million over the three year period 2018 to 2020.
- The targets for these posts are:
 - 50% of posts are to be in regional/rural areas; and
 - 30% will be private sector posts.

Recommendation 17: The Emergency Medicine Education and Training Program

The review indicates that EMET is a valuable program.

The department recommends that:

- ACEM establish a stakeholder reference group to formally consult on the future implementation and oversight of the program;
 - The department to hold discussions with ACEM on the parameters and membership of the proposed stakeholder reference group.
- Base-level funding for EMET increase by \$1.5 million to \$10.9 million per year to enable 2015-16 levels in terms of number of hubs, numbers of training sites, and level of support offered to training sites be maintained; and
- ACEM consult with the department on the development of guidelines for selecting EMET hubs and KPIs for the program from 2018.

Recommendation 18: The Emergency Department Private Sector Clinical Supervisor Program

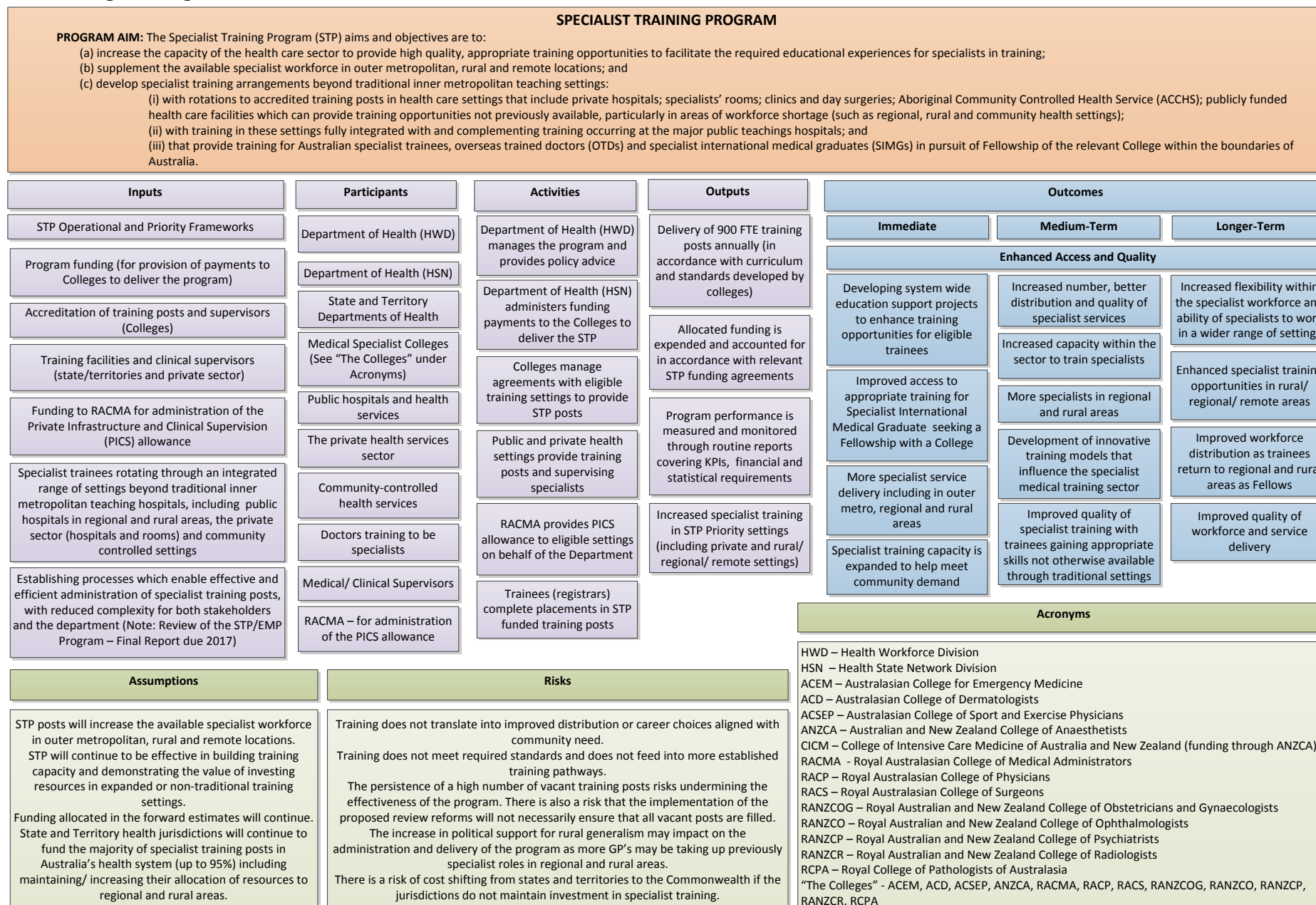
The department recommends that:

- ACEM assume management of the EDPSCS. This would bring it into line with the other programs in the EMP and make it more responsive to the needs of the private sector.

The College review the EDPSCS during 2017. The department would work closely with ACEM during the review.

B: STP Program Logic

ATTACHMENT B



C1: STP FTEs by College, ASGC-RA Category and Public-Private (2015)

ATTACHMENT C1

College	Funding Agreement with Department	College Agreements with Settings*								
		Total Posts	ASGC - RA category					Ownership of Setting		Filled
			RA 1	RA 2	RA 3	RA 4	RA 5	Public	Private	
Australasian College of Dermatologists	27	27	20.1	5.4	0.9	0.6	0.0	7.2	19.8	26.0
Australasian College for Emergency Medicine	2	2	1.0	1.0	0.0	0.0	0.0	0.0	2.0	1.6
Australasian College for Sport and Exercise Physicians	4	4	2.7	1.3	0.0	0.0	0.0	0.0	4.0	4.0
Australian and New Zealand College of Anaesthetists	42	41.5	26.5	10.2	4.1	0.3	0.4	26.9	14.6	39.0
College of Intensive Care Medicine of Australia and New Zealand	16	17	11.0	5.0	0.0	1.0	0.0	7.0	10.0	16.0
Royal Australasian College of Medical Administrators	17.5	18.5	11.8	3.1	2.1	1.1	0.4	12.0	6.5	17.2
Royal Australasian College of Physicians	351.4	419.8	254.1	91.2	49.4	14.5	10.6	275.8	144.0	375.7
Royal Australasian College of Surgeons	73	70	40.0	19.0	10.0	1.0	0.0	35.1	34.9	63.0
Royal Australian & New Zealand College of Ophthalmologists	12	12	6.5	4.0	0.1	1.2	0.2	3.7	8.4	12.0
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	32	31.5	13.3	12.3	5.0	1.0	0.0	17.0	14.6	26.5
Royal Australian and New Zealand College of Psychiatrists	160	177.5	127.9	27.2	14.9	3.3	4.2	112.6	64.9	153.0
Royal Australian and New Zealand College of Radiologists	47	41	24.0	12.5	4.5	0.0	0.0	25.1	15.9	41.0
Royal College of Pathologists of Australasia	87	90	73.5	15.5	1.0	0.0	0.0	27.1	62.9	85.7
TOTAL	870.9	951.8	612.4	207.7	92.0	24.0	15.8	549.4	402.4	860.6
% of Setting agreements (951.8)			64.3%	21.8%	9.7%	2.5%	1.7%	57.7%	42.3%	90.4%
			35.7%							

*Figures rounded to one decimal place

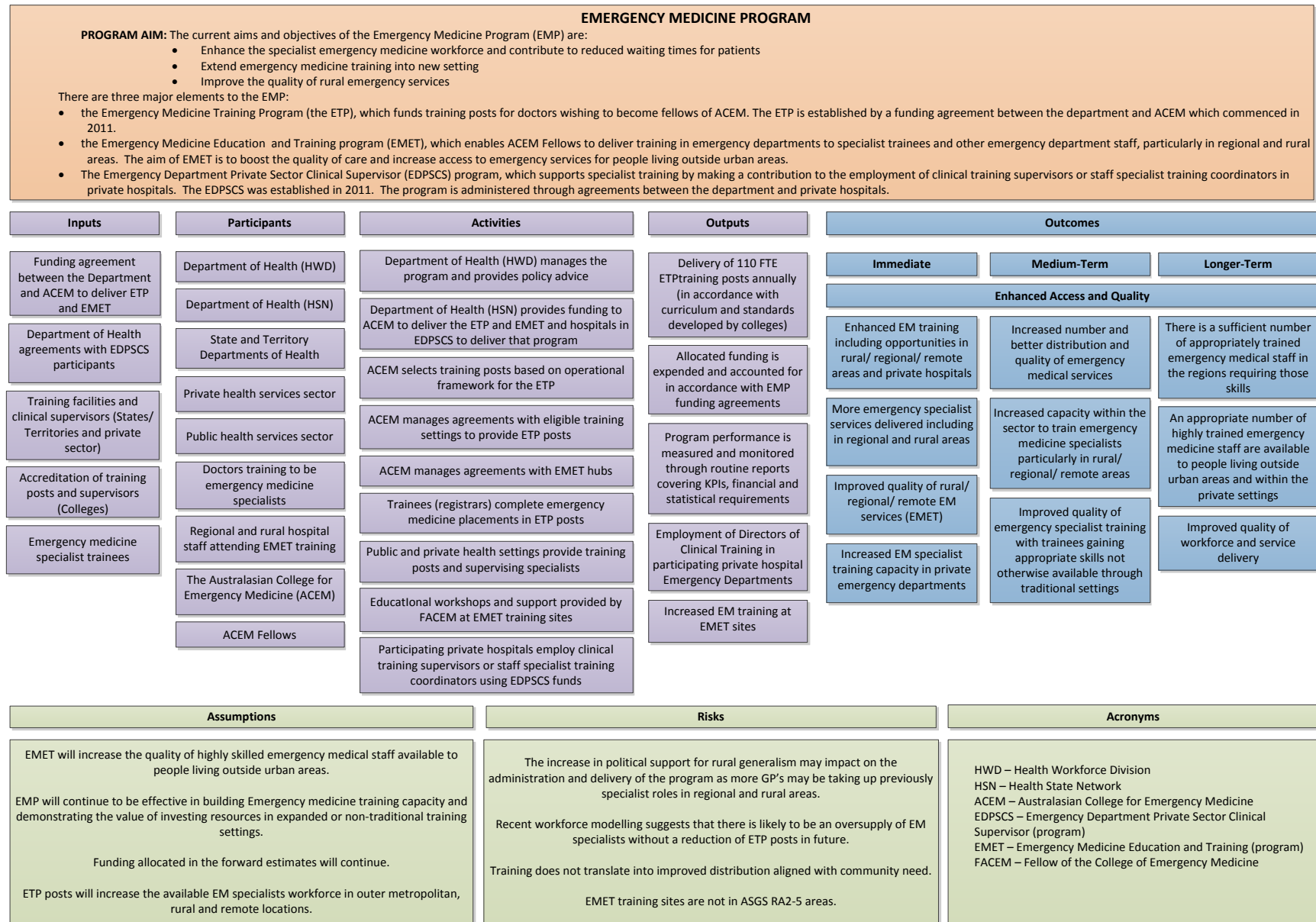
C2: STP Posts by College and State and Territory (2015)
ATTACHMENT C2

College	Funding Agreement with Dept.	College Agreements with Settings*									
		Total Posts	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Filled
Australasian College of Dermatologists	27	27	1	9	0	5	1	0	11	0	26.0
Australasian College for Emergency Medicine	2	2	0	1	0	0	0	0	1	0	1.6
Australasian College for Sport and Exercise Physicians	4	4	0	3	0	0	0	0	1	0	4.0
Australian and New Zealand College of Anaesthetists	42	41.5	0	8	0	11	2	1	4.5	15	39.0
College of Intensive Care Medicine of Australia and New Zealand	16	17	0	4	1	4	0	0	5	3	16.0
Royal Australasian College of Medical Administrators	17.5	18.5	0	7	1.5	2	1	0	6	1	17.2
Royal Australasian College of Physicians	351.4	419.8	6	121.7	27	74	34	11	97.1	49	375.7
Royal Australasian College of Surgeons	73	70	1	18	3	16	6	0	17	9	63.0
Royal Australian & New Zealand College of Ophthalmologists	12	12	0	6	1	1	0	2	0	2	12.0
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	32	31.5	0	11	1	7	2.5	1	6	3	26.5
Royal Australian and New Zealand College of Psychiatrists	160	177.5	3	39	4	43	8	4	63.5	13	153.0
Royal Australian and New Zealand College of Radiologists	47	41	1	5	2	14	1	1	11	6	41.0
Royal College of Pathologists of Australasia	87	90	1	35	1	16	0	1	32	4	85.75
TOTAL	870.9	951.8	13	267.7	41.5	193	55.5	21	255.1	105	860.6
% of Setting agreements (951.8)			1.4%	28.1%	4.4%	20.3%	5.8%	2.2%	26.8%	11.0%	90.4%

* Figures rounded to one decimal place

D: EMP Program Logic

ATTACHMENT D



E: List of Stakeholders Consulted as part of the Review Process

Specialist Medical Colleges
Australasian College for Emergency Medicine
Australasian College of Dermatologists
Australasian College of Sports Physicians
Australian & New Zealand College of Anaesthetists
Australian College of Rural and Remote Medicine
College of Intensive Care Medicine of Australia and New Zealand
Royal Australasian College of Medical Administrators
Royal Australasian College of Physicians
Royal Australasian College of Surgeons
Royal Australian & New Zealand College of Obstetricians & Gynaecologists
Royal Australian & New Zealand College of Ophthalmologists
Royal Australian & New Zealand College of Psychiatrists
Royal Australian and New Zealand College of Radiologists
Royal Australian College of General Practitioners
Royal College of Pathologists of Australasia
State and Territory Health Departments
ACT Health Directorate
NSW Health
NT Department of Health and Families
Queensland Health
SA Department of Health
Tasmania Department of Health and Human Services
Victoria Department of Health and Human Services
WA Department of Health
Stakeholder Representative Bodies
Australian Indigenous Doctors Association
Australian Medical Association – Council of Doctors in Training
Australian Private Hospitals Association
Catholic Health Australia
Council of Presidents of Medical Colleges
Federation of Rural Australian Medical Educators
Medical Deans of Australia & New Zealand
Rural Doctors Association of Australia

Private Hospitals
Cabrini Health Ltd
Calvary Health Care Tasmania
Calvary Wakefield Adelaide
Epworth HealthCare
Greenslopes Private Hospital (Ramsay Health Care)
Knox Private Hospital
Pindara Private Hospital
St Andrew's War Memorial Hospital (UnitingCare Health)
St John of God Murdoch Hospital
Sydney Adventist HealthCare
Others
Dr Jennifer May
Greater Northern Australia Regional Training Network
National Medical Training Advisory Network
Northern Clinical Training Network
Western Australian General Practice Education and Training
Western Australian Radiology Training Program

F: Summary of Responses to STP Discussion Papers

General comments

The department received 35 submissions in response to the discussion papers on the review of the Specialised Training Program (STP) and the Emergency Medicine Program (EMP) sent to stakeholders on 4 September 2015.³³ A list of the submissions received is attached.

The discussion papers were designed to engender comments from stakeholders. They highlighted issues relating to the management and operation of the programs and presented some possible options for change.

Almost all stakeholders stated that they feel the STP:

- is meeting its aims and objectives;
- is promoting training in rural and regional areas and expanded settings (such as private sector settings and community centres); and
- should not be diminished.

However, there was a diversity of views from stakeholders on how the main issues raised in the discussion paper should be addressed. Looking at the submissions broadly:

- almost all stakeholders believe the number of training posts in rural and regional areas and in private sector settings should be increased;
- conversely, there should not be any cuts to the funding elements of the STP, such as the contribution to a trainee's salary, funding for educational support projects for trainees or the rural loading for trainees living outside metropolitan areas – in fact, some submissions argued for increases to some funding elements;
- the specialist medical colleges would like to have a greater role in the selection of training posts, while the jurisdictions tend to believe the criteria for selection of training posts should place greater emphasis on workforce need, which is the issue of greatest importance to them; and
- representatives of doctors practising in rural and regional settings and operators of rural and regional settings and training programs ("rural-orientated stakeholders") argued for changes that will improve health services in rural and regional areas, such as
 - the establishment of training networks;
 - increased payments to trainees in rural and regional areas; and
 - the selection of trainees for STP-funded positions that would be more likely to remain in rural and regional areas after their training is completed.

It should be noted that stakeholders appreciated that these are complicated issues that have to be addressed through a combination of approaches.

³³ The department prepared discussion papers on the STP and EMP and two EMP-related programs which are also being reviewed – the Emergency Medicine Education and Training (EMET) and the Emergency Department Private Sector Clinical Supervisor (EDPSCS) programs. Few comments were received on the EMET and EDPSCS discussion papers. Accordingly, this summary considers comments relating to the review of the STP and the EMP only.

Distribution of training posts under the STP

As indicated, almost all stakeholders feel the STP is meeting its aims and objectives, but there is also a consensus that more posts in rural areas and expanded settings are needed. Suggestions on how this could be achieved include:

- the development of regional training networks, hub centres or similar training models;
- having the STP delivered by organisations that are independent from the colleges and the jurisdictions;
- selecting trainees that are more likely to work in a rural/remote setting;
- increasing the number of trainees in specific remote sites, by creating economies of scale and strengthening the education infrastructure around trainees;
- addressing the “historic bias” towards public metropolitan health services by increasing the number of posts in private hospitals;
- increasing funding for the rural and remote posts; and
- increasing the involvement of the jurisdictions in the selection of training posts, as they have the best understanding of workforce needs.

One submitter advised that research indicates that the factors encouraging doctors to stay in rural areas include:

- positive undergraduate and post-graduate experience in a rural area;
- a positive rural or location connection; and
- early exposure to an under-served specialty.

These views were echoed by organisations working with doctors in rural areas. The submission argued that the STP should develop regionalised training programs and make the move from undergraduate rural clinical school work to post graduate work in a regional centre “seamless”.

Selection of training posts

The selection of training posts and their placement are perhaps the most fundamental, important aspects of the STP. All submissions made suggestions on how these processes could be improved, including:

- greater local and jurisdictional involvement in the selection process;
- greater involvement from colleges in the process, including the adoption of the model outlined in the Discussion Paper, which is based on the EMP system;³⁴
- the development of training networks or hub models;
- allocating training places based on an audit of rural and regional areas to determine where posts are most needed; and
- encouraging stability and continuity so that settings will support STP posts.

Some colleges stated that the application process needs to be better aligned to the recruitment time frames, as settings need time to recruit trainees.

Submissions explained the medical academic year commences in February. At present, colleges start to fill training places in April of the previous year and try to complete the process by July. To meet this deadline, it was argued, the Government should advertise for applications for training posts in early-January, with applications closing in late-February. While this timeline may seem generous,

³⁴ In summary, under this model the department, in consultation with the jurisdictions and the colleges would determine the number of posts to be allocated to each college and the criteria for funding of a post. The settings would apply to the colleges for posts, and the colleges would determine which posts should receive funding, in accordance with those criteria.

submissions indicated that in practise it is not, as the number of posts and their locations must be known, trainees have to be recruited by settings and then contracts entered into between the department and each college and between the college and the setting.

Some stakeholders also argued for increased transparency in the process for selecting STP training posts.

Tied funding

Generally speaking, the jurisdictions and rural-orientated stakeholders were disposed towards the suggestion that STP funds be tied to a trainee rather than a post, while the colleges were opposed or saw potential problems with the suggestion.

Suggestions on how tied funding might be implemented include:

- doing so on a program-by-program basis;
- attaching funding to a trainee if the trainee intends to practise in a rural setting;
- having trainees undergo several rural postings (though funding should not be tied to all posts)
- tying funding to trainees and scaling it according to the location of the training setting; and
- introducing a scholarship model.

Reasons given for not supporting the idea included that it:

- would prioritise training in rural/regional areas over expanded settings;
- may adversely impact recruitment to rural/regional posts and threaten their sustainability;
- would not create any new training posts;
- could be a problem for a small college, as some rural areas may not have enough posts to allow all trainees to have access; and
- would not be feasible for all trainees.

It should be noted that some of these comments indicate a misunderstanding of the suggestion put forward in the discussion paper.

Mandating the length of rotations in rural/regional posts

Most submissions that discussed mandating the length of rotations in rural/regional posts supported the concept, arguing that it would provide services to rural and regional areas and create more certainty for settings with regard to trainee numbers and funding. The consensus appeared to be that rotations should not be for less than six months. Others felt they should be twelve months; while one submission favoured two year rotations.

While supporting mandated rotation lengths, one submitter believed they would be best suited to generalist medicine posts; a college supported trainees having two rotations of six months, though not necessarily sequentially; and two other colleges felt the length of the rotation should depend on the specialty.

One of the states argued that for the concept to succeed, trainees best suited to rural/regional training should be selected. Another submission noted that the support of the colleges would be required for it to be implemented.

On the other hand, some stakeholders argued that mandated, lengthy rotations -may either reduce the likelihood of a trainee meeting all the requirements for fellowship; interfere with existing

training schedules; or make rural/regional posts less available. One of the state jurisdictions does not support mandating the length of rotations in rural and regional settings.

One submission argued that one year rotations would not provide clear pathways for trainees, suggesting the STP should instead consider establishing rural training networks, where doctors can return to metropolitan centres as needed. One of the colleges believes the system already has flexibility to allow the length of the rotation to suit the needs of both the setting and the trainee.

Contribution to salary/Indexation of the salary contribution

A number of submissions noted the growing difference between the amount of the fixed contribution (\$100,000 per post) and the actual cost of hosting a trainee, however support for an increase in the contribution or indexation was contingent on existing numbers of training places being retained.³⁵

Some of the suggested improvements to the current contribution/funding system included:

- scaling funding in favour of rural/regional posts or posts that have higher costs;
- allowing both full and partial funding of salaries;
- preferential funding for specialties in short supply;
- apportioning funding according to the needs of the post, rather than its location;
- increasing funding for psychiatry positions, as expanded settings are currently disincentivised from hosting trainees;
- improving funding for supervisors, which is viewed by some as being more important to the success of the STP than the size of the salary contribution;
- increasing funding for training in community health settings, especially Aboriginal Community Controlled Health Organisations and remote clinics;
- addressing the specific costs that sometimes apply to regional placements without a general increase in funding per FTE; and
- assessing applications from settings to host STP positions according to whether the setting can afford to make up the difference between the trainee's salary and the STP contribution.

A private health care provider argued that the salary contribution creates a bias in favour of the public sector, as it does not account for the fact that private hospitals do not receive funding from government to offset the difference between the salary contribution and a trainee's actual salary.

A number of stakeholders supported indexation of the salary contribution, given the increasing gap between the salary contribution level and actual registrar salaries. One college believes the salary contribution needs to be indexed at the rate of inflation, at a minimum, but without compromising the existing number of posts.

Some submissions argued that if indexation is to be introduced, any funding deficit could potentially be made up from savings in other elements of the program, such as support project funding, administration costs or PICS funding, or by combining training posts where possible.

Regular review of posts

There was strong support for the regular review of training posts to ensure they meet workforce and geographic distribution requirements. Opinions about the optimal frequency of post reviews varied widely and included:

³⁵ It should be noted that the STP does not have an indexed funding allocation through the Health Workforce Fund.

- annually;
- bi-annually;
- triennially (using a rolling review program, so that not all posts are reviewed at once);
- every three to four years;
- every three to five years;
- four yearly; and
- five yearly.

Options put forward for the method of conducting post reviews included that each review should be either:

- a collaborative process, involving the department, the jurisdictions and the colleges;
- coordinated by the department, with stakeholders represented;
- guided by “comprehensive, authoritative and consistent” workforce data; or
- conducted through an online survey of trainees, supervisors and managers.

Rural loading

On the whole stakeholders felt that the loading should be scaled according to the location of the post, or a similar factor. However, submissions generally did not canvass how these increases should be funded. It is also unclear from submissions whether stakeholders support an increase in the overall level of the rural loading, or an arrangement whereby increases in one location would be offset by reduced payments in other locations.

Some stakeholders did not agree that the rural loading should be scaled according to the location of the training post.

Other suggestions for improving the rural loading system included the following:

- there should be greater oversight of how the loading is used;
- the payment of the loading should be considered on a case by case basis as some training settings located in metropolitan (RA-1) regions, such as Gosford, require trainees to move to a new area;
- an increase to the loading for rural/regional/remote posts could be funded by reducing the salary contribution for RA-1 posts;
- some settings have greater needs based on the area’s socio-economic status, rather than its location; and
- the loading should take into account unique geographical issues in some states.

Support projects

This issue was primarily of concern to colleges, as the bodies receiving the funding. A number believe there should not be any changes to the present system. One college stated that colleges have an understanding with the department that support projects will benefit all trainees. Another argued that it is not practical to offer support projects focussed on STP trainees only. Non-college stakeholders tended not to comment on this matter.

A number of submissions suggested more transparency is needed. One state health department argued for the introduction of a case management model. Some colleges believe collaborative support projects between colleges should be explored.

Generalist training

ACCRM and other medical specialist organisations define ‘Rural Generalism’ according to the Cairns Consensus Statement on Rural Generalist Medicine, which refers to the provision of medical care with a broad scope by doctors in the rural context, including advanced skills ordinarily associated with consultant specialist practice services as appropriate to meeting the needs of their rural communities.

Most stakeholders that addressed the STP being used to increase generalist specialist training support the idea. Comments include:

- if more generalists can be trained for rural/regional areas, networks of generalists and sub-specialists could be developed;
- there should be a special focus on posts in community health settings, sub-regional and rural locations; and
- most broad training of general practitioners with advanced skills training should take place in rural/regional settings, with rotations into metro settings.

Some stakeholders oppose the suggestion, arguing that:

- generalist training is contrary to the STP objective of providing training for specialists;
- specialties and subspecialties are needed to deal with complex patients;
- generalist training in surgery is best achieved over the life of the training program;
- generalist training is well supported already; and
- a greater number of ATSI doctors work as GPs or as generalists, whereas there is a need for further specialty training.

The department notes that the STP is not currently targeted towards supporting general practice training and does not focus on advanced skills acquisition for fellows of any medical specialist college.

Given the current tight fiscal environment, the department believes it would be challenging to expand the scope of the STP to support advanced skills training for GPs or future rural generalists. The department considers that the Australian General Practice Training Program is better placed to contribute to the development of a National Rural Generalist Training Pathway. The STP, with its focus on medical specialists other than general practitioners, will complement the rural generalist pathway by helping to generate a good mix of future rural doctors to meet community needs.

Training networks

A number of submissions suggested the STP should be used to create rural training networks or training hubs. Suggested approaches include:

- “regionalised longitudinal training programs” to ensure critical mass for trainees, with rotations in sub-speciality units in metro areas;
- regional training pathways, under which trainees are based at a regional centre, then travel to other locations such as metropolitan facilities and expanded settings, for training as required;
- local training coordinators who would coordinate a trainee’s rotations between rural/regional settings, concentrate on specialties of particular need and undertake many of the administrative tasks currently performed by colleges;
- setting aside STP funding to enable multiple settings to form an integrated training network that addresses areas of workforce need; and
- “hub” centres that make it easier for private sector hospitals to use STP funding.

One state health department noted that creating hub centres “depends on critical mass, availability and range of rotations/ experiences, and good and accessible supervision.” Another feels that training networks would not be appropriate for all specialties.

Dedicated funding of trainees

Though there was support amongst stakeholders for the STP being used to fund the training of registrars of Aboriginal and Torres Strait Islander background, some included the caveat that trainees should meet college requirements before being selected.

Indeed, some stakeholders submitted that more is needed, including:

- more spending on education at lower levels to assist Indigenous-background students to attend university;
- training should recognise the specific cultural needs of the trainee and the community they will be serving;
- there should also be funding for trainees that have a specific interest in working in Indigenous communities, regardless of background; and
- additional incentives should be provided to posts that accept ATSI trainees.

A number of submissions also support the STP funding trainees from rural/remote or other backgrounds.

One stakeholder argued that there should be population parity across all fields of medicine, as well as a greater focus on local recruitment to fill positions, rather than through hospitals. It also noted that Indigenous students face more complicated barriers to medical education than others, such as having to rely on identified funding and not having access to the same connections, academic support, research experience or clinical exposure as their competitors/colleagues. It recommended “the establishment of dedicated Aboriginal and Torres Strait Islander specialist training positions across all medical colleges.” It claimed ATSI doctors are under-represented in all specialties, not just areas of predicated undersupply.

Classification of settings

There are significant differences of opinion on whether the Australian Standard Geographical Classification (ASGC) system for classifying settings, which is currently in use, should be replaced with the Modified Monash Model (MMM).

The ASGC system is by and large supported, with some caveats, though it appears to be generally acknowledged that the MMM system is better at distinguishing between small rural and remote locations, particularly in RA2-3 areas. One college, for example, argued that it provides for “greater specificity” than the AGSC system. Another submission contended that neither system is “sufficiently robust to manage the complexities” of a training program.

G: STP Operational Framework 2016



Australian Government
Department of Health

Specialist Training Program (STP) Operational Framework

Created June 2012 (Updated July 2016)

Introduction.....	.....
History.....	.....
Aims and Objectives.....	.....
Outcomes.....	.....
Governance.....	.....
– The Department of Health.....	.....
– Medical Specialist Colleges.....	.....
– Training Settings and Employers.....	.....
Program activities .....	.....
– Reserve Lists.....	.....
– Unsuccessful EOIs.....	.....
– Eligibility.....	.....
– Funding.....	.....
– Private Infrastructure and Clinical Supervision (PICS).....	.....
Additional Information.....	.....
– Access to the Medicare Benefits Schedule.....	.....
– Proposals for Support Funding.....	.....
– Medical Indemnity.....	.....
– Long term leave arrangements for trainees.....	.....
Contact Details.....	.....

The Government has extended the STP to cover the 2017 academic year on the same basis as 2016. The specialist medical colleges will be allocated the same number of training posts and the funding levels for the various components of the program will remain at 2016 levels.

Introduction

The delivery of well-supervised, high quality specialist training opportunities is a collaboration between the Commonwealth, States and Territories and training organisations including the Medical Specialist Colleges of Australia (the Colleges) and private and community health sectors. The Specialist Training Program (STP) seeks to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals where trainees can obtain skills and benefits from learning experiences to meet the professional standards required of their discipline that are not generally available in conventional training arrangements.

History

The Commonwealth has been supporting the provision of specialist training arrangements in rural and outer metropolitan areas since 1997 with the establishment of the Advanced Specialist Training Posts in Rural Areas (ASTPRA) measure in the 1997-1998 budget. This early work was complemented and significantly expanded through a 2006 Council of Australian Government's decision to fund training places in settings other than public teaching hospitals. This initiative became known as the Expanded Specialist Training Program (ESTP). At the same time funding was provided through the COAG National Action Plan on Mental Health (2006-2011) to fund psychiatry training, delivered through the Psychiatry Training Outside Teaching Hospitals (PTOTH) program. Further COAG investment was agreed to in 2008 through the Hospital and Health Workforce Reform - Health Workforce package.

Under the 2009-2010 Budget Health Measure Workforce program these specialist training programs were brought together into a single program.

Previous programs consolidated into the current STP:

- (a) the Expanded Specialist Training Program (ESTP);
- (b) the Outer Metropolitan Specialist Trainee Program (OMSTP);
- (c) Advanced Specialist Training Posts in Rural Areas (ASTPRA);
- (d) the Pathology Memorandum of Understanding (Path MoU);
- (e) the Overseas Trained Specialist Upskilling Program;
- (f) Psychiatry Training Outside Teaching Hospitals (PTOTH); and
- (g) Supporting best practice and workforce in pathology and diagnostic imaging.

The 2009-2010 Budget also included the “Improving the Quality of Services and Addressing Workforce Shortages – Supporting best practice and workforce in pathology and diagnostic imaging” initiative. This initiative continued funding for training specialists which was previously supplied under the Pathology Memorandum of Understanding and has been implemented under the STP.

On 15 March 2010 the Government announced the National Health and Hospitals Network initiative “Expand and Enhance the Specialist Training Program”. This provided resources to increase the number of specialist training places to be made available under the Program to 900 by 2014 ongoing, and allowed for resources to support the private sector via a clinical supervision and infrastructure allowance.

Aims and Objectives

The aims and objectives of the STP are to:

- (a) increase the capacity of the health care sector to provide high quality, appropriate training opportunities to facilitate the required educational experiences for specialists in training;
- (b) supplement the available specialist workforce in outer metropolitan, rural and remote locations; and
- (c) develop specialist training arrangements beyond traditional inner metropolitan teaching settings:
 - (i) with rotations to accredited training posts in health care settings that include private hospitals; specialists’ rooms; clinics and day surgeries; Aboriginal Community Controlled Health Service (ACCHS); publicly funded health care facilities which can provide training opportunities not previously available, particularly in areas of workforce shortage (such as regional, rural and community health settings); and non-clinical settings (such as simulated learning environments);
 - (ii) with training in these settings fully integrated with and complementing training occurring at the major public teaching hospitals; and
 - (iii) that provide training for Australian specialist trainees, overseas trained doctors (OTDs) and specialist international medical graduates (SIMGs) in pursuit of Fellowship of the relevant College within the boundaries of Australia.

The aims and objectives of the Program must be achieved without an associated loss to the capacity of the public health care system to deliver services.

Outcomes

Expected outcomes for the STP include:

- (a) specialist trainees rotating through an integrated range of settings beyond traditional inner metropolitan teaching hospitals, including a range of public settings (including regional, rural and ambulatory settings), the private sector (hospitals and rooms), community settings and non-clinical environments;
- (b) increased number and better distribution of specialist services;
- (c) increased capacity within the sector to train specialists;
- (d) improved quality of specialist training with trainees gaining appropriate skills not otherwise available through traditional settings;
- (e) developing system wide education and infrastructure support projects to enhance training opportunities for eligible trainees;
- (f) improved access to appropriate training for overseas trained specialists seeking Fellowship with a College;
- (g) increased flexibility within the specialist workforce;
- (h) development of specialist training initiatives that complement those currently provided within the States and Territories; and
- (i) establishing processes which enable effective and efficient administration of specialist training posts, with reduced complexity for both stakeholders and the department.

Outcomes will be monitored through progress reports on posts provided to the Department by the Participants.

Governance

The STP is designed to be a collaborative approach to specialist training, with the engagement and participation of all the major stakeholders, including the Colleges, State and Territory health departments, public health services, the private health sector and the specialist trainees (registrars), through their representative bodies.

The Department of Health:

- (a) Oversight of the STP, including delivery of the program by the medical specialist colleges, is the responsibility of the Department.
- (b) The Department maintains policy authority and management responsibility for the STP Expression of Interest (EOI) to be conducted in 2016-17.
- (c) In its role the Department will facilitate the development of appropriate training for specialists to address future training and workforce needs and to enable expansion to new settings including primary, community and mental health, aged care and the private sector.

- (d) The Department will provide information to the public in relation to the Specialist Training Program.
- (e) The Department will develop evaluation and review processes in order to enhance the efficiency and effectiveness of training for the specialist workforce.

Medical Specialist Colleges:

The medical specialist colleges are key partners in the delivery of high quality specialist training due to their role in setting professional standards, accrediting training settings and the coordination and support for education and training of future College Fellows. The Colleges also play a vital role in providing national oversight and consistency to medical specialist training. Under this program:

- (a) all training opportunities offered need to meet the standards set by the relevant College and be considered by the College to deliver educational value. This will be achieved through only funding accredited training posts and through seeking advice from the Colleges on all posts to be delivered under the program; and
- (b) Colleges directly engaged under this Program will be required to establish training arrangements for trainees which better link training to opportunities not available in major public hospitals.

The Commonwealth currently funds 12 Specialist Medical Colleges for the management of specialist training posts including:

- Australasian College for Emergency Medicine (ACEM);
- Australasian College of Dermatologists (ACD);
- Australasian College of Sport and Exercise Physicians (ACSEP)
- Australian and New Zealand College of Anaesthetists (ANZCA);
- Royal Australasian College of Medical Administrators (RACMA);
- Royal Australasian College of Physicians (RACP);
- Royal Australasian College of Surgeons (RACS);
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG);
- Royal Australian and New Zealand College of Ophthalmologists (RANZCO);
- Royal Australian and New Zealand College of Psychiatrists (RANZCP);
- Royal Australian and New Zealand College of Radiologists (RANZCR); and
- Royal College of Pathologists of Australasia (RCPA).

In addition to funding training posts in a broad range of settings, the Program provides funds, via the specialist medical colleges for a range of support activities, including:

- (a) developing system wide education and infrastructure support projects e.g. Video conferencing and delivery of a Specialty Specific Video Lecture Series to enhance

training opportunities for eligible trainees, with a particular focus on supporting training posts and positions in regional and rural areas and those in private settings;

- (b) developing support projects aimed at SIMGs to assist these doctors gain Fellowship in a timely and efficient manner e.g. SIMG Orientation Resource Kits or provision of a Fellowship Attainment Coordinator; and
- (c) developing networks for training i.e. formal agreements between training settings for registrars to rotate for defined periods in which all trainee entitlements will be maintained.

Training Settings and Employers:

State and Territory Governments and public health services are also key partners in the delivery of specialist training arrangements. They are the providers of the majority of funded training places and specialist trainees are usually employees of the state health system. Under this program jurisdictional Health Departments (or the equivalent level of management in their health sector) will be asked to provide advice on the merits of individual EOIs seeking to provide a training post, from the perspective of the availability of registrars to fill the posts identified and areas of workforce need.

Private health care organisations/private health care settings are critical to achieving an expansion of training opportunities across Australia. To achieve this objective the private sector needs to be engaged in the establishment of posts in collaboration with the public sector to facilitate the transfer of registrars for the purposes of training. Where the registrar undertaking training remains in the employ of a public teaching hospital, these funds must flow to the employer to enable that hospital to 'backfill' the position, thereby ensuring there is no reduction in the capacity of the public teaching hospital to deliver services. Such arrangements will also facilitate maintenance of the trainee's entitlements, such as medical indemnity, workers compensation, superannuation, long service leave, etc.

Program activities

Through the STP the Commonwealth seeks to establish and support a variety of training posts which form part of an integrated program of learning for specialist trainees pursuing a fellowship program. Available training posts can be full-time or part-time with multiple trainees rotating through a single training post. Alternatively, training posts can be designed to support individual trainees through their full fellowship program, particularly in rural and regional areas. The exact nature of the training post will be determined by its value to overall training in pursuit of becoming a specialist.

Specialist training posts established under the program will be supported across the 2012-17 academic years if they continue to meet the eligibility criteria and the aims and objectives of the STP. An EOI process to identify suitable specialist training posts to add to the overall network will be publicised through the Department's website. The EOI will be conducted by the Department in 2016-17.

Reserve Lists

Training settings that lodge an EOI and are assessed by the colleges and jurisdictions to be potential suitable STP posts will be placed on the Reserve List to be managed by the relevant specialist medical college. Posts on the Reserve List may be funded in the event that a successful post does not go ahead. The colleges will be responsible for managing the Reserve List in consultation with the Department.

Unsuccessful EOIs

There is no appeals process. Decisions are final. Organisations which have not been added to the Reserve List through the EOI process, may seek feedback from the Colleges. Noting that decisions will have been made on a complex range of considerations. These considerations include the support of a post by both the jurisdiction and the relevant College.

Eligibility

The following organisations are eligible to apply for funding in accordance with the aims and objectives of the STP, and their relevant roles and responsibilities:

- (a) Medical education providers, including but not limited to Specialist Medical Colleges recognized by the Australian Medical Council;
- (b) State and Territory Health Departments, local hospital networks and regional hospitals;
- (c) Private health care organisations/private health care settings;
- (d) Aboriginal Community Controlled Health Services; and
- (e) Community Health Organisations

What is not eligible for funding under the STP?

- (a) Post-fellowship training.
- (b) General Practice training.
- (c) Direct costs associated with accreditation of training posts.
- (d) Training posts funded under the STP may not be occupied by overseas trainees employed by hospitals in other countries seeking a rotation through expanded settings within Australia.
- (e) Training posts which are not considered to be new posts. A position will not be considered new if it has been funded by another organisation for more than 12 months within the last three years. Additionally, a position that was funded by another organisation within the last 12 months will need to conclusively demonstrate that its funding is not ongoing. This allows for short term funding from organisations such as charitable trusts. In this context, positions funded by the applicant organisation or a state and territory government will not be considered new and will be ineligible for STP support.

Individual trainees are not eligible to apply for funding. Trainees should liaise with their relevant college and/or specific health care facility if they wish to participate in the STP.

Funding

Funds are available under the STP for:

- (a) training posts in eligible settings, with funding to include a salary contribution for trainees (including SIMGs) rotating through these posts. This contribution flowing to the employer of the trainee(s) occupying the post at a rate of \$100,000 per annum (GST exclusive) pro rata, per full time equivalent (FTE); and
- (b) rural loadings, up to \$20,000 per annum (GST exclusive) pro rata per FTE, to support eligible posts in Australian Standard Geographical Classification – **Remoteness Areas (ASGC-RA) 2 -5**;
- (c) development of system wide education and infrastructure support projects, managed by participating specialist medical colleges, to enhance training networks, with a particular focus on rural and regional training arrangements.
- (d) developing support projects aimed at SIMGs to assist these doctors to gain Fellowship in a timely and efficient manner; and
- (e) activities associated with provision of clinical supervision and training infrastructure in the private sector:
 - (i) clinical supervision at \$30,000 (GST exclusive) pro rata per FTE per annum
 - (ii) private infrastructure at \$10,000 (GST exclusive) pro rata per FTE, once only in any 3 year period
- (f) One off funding for training posts in the event that surplus funds are available at individual participating specialist medical colleges. Posts which are funded as a result of this will not be precluded from ongoing funding under the STP at a future date.

Specialist medical colleges activities include:

- (a) Management of a set of training posts including selecting from reserve lists as appropriate;
 - (i) ensuring the rotation of trainees through these posts is not detrimental to the capacity of the public health care system to deliver services;
 - (ii) establishing contract and financial management processes in order to:
 - reduce the complexity of the contract management system;
 - ensure funding for trainee salaries is directed appropriately, i.e. that the employer of the trainee is recompensed for the time that the trainee spends in the expanded setting; and
 - ensure trainee entitlements are maintained, such as medical indemnity, superannuation, workers compensation etc.

- (b) Developing networks for training which:
- (i) Integrate the training posts into the relevant College's training network;
 - (ii) integrate the training occurring beyond the traditional teaching hospital with training provided by the local state or territory health service providers;
 - (iii) evaluate the health service delivery requirements of regions around Australia to identify other suitable training posts to add to the overall network; and
 - (iv) develop systems which ensure that:
 - providers of training posts included in the network are equipped with information necessary for the sustainability of the posts;
 - a method for thorough and ongoing evaluation of all posts within the network is implemented; and
 - cross College training occurs with the agreement of both relevant Colleges.
 - (v) Create new generalist training pathways for medical graduates.
- (c) Developing support projects to enhance training networks by:
- (i) developing and delivering strategic support programs to ensure success and sustainability of the expanded training posts for trainees;
 - (ii) developing support projects aimed at SIMGs to assist these doctors gain Fellowship in a timely and efficient manner; and
 - (iii) Ensuring governance arrangements which provide strategic oversight and responsibility for support project activities are implemented.
 - (iv) Support projects may not include:
 - direct payments to supervisors or trainees within a training network; or
 - expenses associated with the direct accreditation of specific training sites.
- (d) Developing networks within large private hospitals. This work may require inter-college arrangements and foster inter-disciplinary approaches to specialist training to:
- (i) facilitate and coordinate specialist training in expanded settings that have multiple registrar positions under the Program;
 - (ii) oversee trainees and their rotations in approved training positions and ensure that trainees receive the appropriate education and support required to successfully undertake training in the private sector;

- (iii) develop a centralised process for the management of specialist training positions in larger private settings to assist settings in maximising their effect;
- (iv) develop means to ensure the training in each private setting/s integrates into the public training programs; and
- (v) ensure funding does not cover or replace existing arrangements for specialist trainee coordination positions, such as currently exist within the public sector.

Private Infrastructure and Clinical Supervision (PICS):

The private infrastructure and clinical supervision (PICS) allowance was introduced to the STP as part of the 15 March 2010 National Health and Hospitals Network initiative *Expand and Enhance the Specialist Training Program*. This provides funding support for activities associated with clinical supervision and training infrastructure from the beginning of the 2011 academic year for all private sector training posts funded under the program.

The PICS allowance recognises the cost of delivering training in the private sector with funding designed to contribute to meeting these costs. Funds are provided to the training settings to assist in the provision of a high quality training environment for both trainees and supervisors.

The Royal Australasian College of Administrators (RACMA) currently administers this funding. Eligibility for the PICS allowance will be determined at the time of the original STP application or EOI based on the eligibility requirements. All eligible applicants will be advised of their eligibility.

Please note: The definition of "Private" relates to the facility and its ownership. A private setting is not a publicly owned facility treating private patients.

Additional Information

Access to the Medicare Benefits Schedule

Under the Medicare Benefits Schedule (MBS), eligible persons who elect to be treated privately may be entitled to receive a Medicare rebate for clinically relevant services performed by the practitioner. Bulk billing arrangements may also apply to these services. Practitioners should refer to the MBS for the full explanation of Medicare arrangements including eligibility requirements, entitlements, and the list of eligible services including rebate levels.

Medicare Australia provider enquiry line - 132 150.

Proposals for Support Funding

Proposals for specialist college support funding will be evaluated by the Department, taking into consideration each proposal's capacity to meet the overall aims, objectives and outcomes of the STP and the availability of program funds. Proposals will be assessed on the range of potential projects to be undertaken, the rationale for potential projects to contribute to training in the expanded settings and the governance arrangements within the

organisation to determine the allocation of support funds to particular projects. Approval of proposals will be subject to available funds.

Proposals which seek funding for support projects aimed at SIMGs must assist these doctors to gain Fellowship in a timely and efficient manner and will be required to indicate the number of SIMGs who require such assistance throughout a calendar year, their location, type of support required and likely success rates for achieving Fellowship within an academic year.

Medical Indemnity

- (a) The Commonwealth does not prescribe the manner in which a specialist trainee should be covered for medical indemnity insurance while undertaking training in an expanded setting however, it does require that the trainee is covered. Expanded settings and specialist trainees participating in the STP will need to satisfy themselves that the specialist trainee is covered in relation to medical indemnity insurance when undertaking training in the expanded setting.
- (b) In some circumstances the state or territory within which the training is occurring may extend public hospital medical indemnity insurance to the specialist trainee while in the expanded setting. Under other circumstances the expanded setting may need to take out separate medical indemnity insurance to cover trainees. The trainee themselves may need to, or choose to, take out their own medical indemnity insurance to cover themselves while training in the expanded setting.
- (c) It is recommended that settings and specialist trainees make enquiries with their relevant state or territory health department to ascertain the necessary arrangements relating to their individual circumstances.

Long term leave arrangements for trainees

- (a) Employers of trainees who are participating in the STP must ensure that access to leave entitlements such as maternity leave and personal leave are maintained for the duration of the placement.
- (b) Management of unfilled posts due to extended leave (including maternity leave) should take into consideration the length of time that the post will be unfilled and the training requirements of the trainee who will be accessing the leave. In some cases, it may be appropriate for the training post to be unfilled for a short period and then resume as a shared or part-time role.
- (c) As a guide, training posts that will be unfilled for greater than 6 months should have another registrar recruited to fill the vacancy.
- (d) STP salary funds are not intended to fund the period of personal leave. The salary contribution must flow to the employer of the trainee, as either a backfill arrangement or for the direct salary costs of the trainee if they are employed by the facility where they are undertaking their expanded training.

Contact Details

The Director
Postgraduate Training Section
Health Training Branch
Health Workforce Division

Department of Health
GPO Box 9848,
Canberra ACT 2601

specialist.training@health.gov.au

Website for the Department of Health Specialist Training Program:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/work-spec>

Priority Framework

The Specialist Training Program (STP) is designed to provide opportunities for medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals, in pursuit of becoming a fellow of a recognised specialist medical college.

The aims and objectives of this program are to:

- increase the number of registrars through the system participating in vocational training; and
- support quality training posts that provide an educational experience that reflects current health care delivery and builds the overall training capacity in the system, by extending specialist training into new healthcare settings.

Eligibility

Training posts which support either Australian specialist trainees or can support the upskilling of Specialist International Medical Graduates (SIMGs) are eligible to submit an EOI for funding under the STP. For posts to be eligible for STP they must:

- be accredited, undergoing or planning to undertake accreditation by the relevant specialist medical college;
- have a recruitment strategy to ensure a trainee is available to commence training in the 2017 academic year; and
- be a new position representing a genuine expansion of training (not previously filled).

Priority Settings

The priority settings for the 2017 STP Expression of Interest are consistent with the 2014 STP application round and are outlined below.

- **The Private health sector:** For the purposes of STP, training sites which can be defined as eligible private sector settings are those which do not derive their operational funding directly from a state or territory government.
- **Regional, rural and remote areas:** settings located in Australian Standard Geographical Classification (ASGC) – Remoteness Areas (RA) 2-5.
- **Non-hospital settings including Aged Care, Community Health and Aboriginal Medical Services:** training posts which involve assisting population groups with acute health needs to receive appropriate services and effectively manage chronic disease to maintain good health. These may include, but are not limited to residential and community settings, as well as outreach arrangements.

Only posts which represent 1 FTE or a minimum of 0.5 FTE in the above settings will be prioritised for funding. Posts with 0.5FTE (if not part-time) must also be comprised of another 0.5FTE of demonstrated, comprehensive networked training arrangements. A comprehensive networked arrangement is a formal agreement between training settings for registrars to rotate for defined periods in which all trainee entitlements will be maintained.

As the EOI to be undertaken in 2016-17 is aimed at providing the colleges with new 'Reserve List' posts that will be used to fill vacancies that occur in 2017 it is not necessary to identify specialties that will be given priority. Generally a vacancy occurring in a specialty will be replaced by a post in the same specialty. Previous STP specialty priorities have been reflected in the allocation of posts to each of the colleges.

Posts which can demonstrate attributes of quality training, a distinct educational imperative and integration with the public specialist training network will be highly regarded.

H: EOI Assessment Guidelines

Expression of Interest: College Assessment Guidelines

The Specialist Training Program (STP) is designed to provide opportunities for medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals, in pursuit of becoming a fellow of a recognised specialist medical college.

The aims and objectives of this program are to:

- increase the number of registrars through the system participating in vocational training; and
- support quality training posts that provide an educational experience that reflects current health care delivery and builds the overall training capacity in the system, by extending specialist training into new healthcare settings.

In completing an assessment of an EOI colleges will need to refer to the STP Operational Framework and Priority Framework.

Eligibility

The on-line EOI process should exclude those organisations and training posts that are ineligible from submitting an EOI under the STP.

However, as a first step in the assessment process, the College should confirm that the organisation/training post is eligible.

a) Eligible Organisations

Eligible organisations for training posts are:

- State and territory health departments, local hospital networks and regional hospitals;
- Private health care organisations / private health care settings;
- Aboriginal Community Controlled Health Services (ACCHS); and
- Community health organisations.

b) Eligible Training Posts

The proposed training post must be new, as defined in the Operational Framework.

The training post must represent 1 FTE or a minimum of 0.5 FTE.

Assessment

In completing an assessment of an EOI the College should address the following:

- Where the proposed training post is located (ASGC RA 1 or RA 2-5);
- Type of training post (e.g. Private/Public);
- Educational or training merit of the proposed post; and
- Jurisdiction assessment of workforce need.

a) Where

The assessment of the proposed location of the training post should take into account:

- The ASGC Remoteness Area category/categories of the post
- The distribution of the FTE across the ASGC RA categories.

For those posts located in ASGC RA 2-5 the assessment should be ranked high whereas if it was in RA 1 it would be low.

The distribution of the FTE across RA 1 and RA 2-5 would modify this assessment result. For example, a 0.5 FTE in RA 1 with 0.5 FTE in RA 2-5 may result in assessment of medium. A high assessment of this proposed post on this factor may still occur if it is essential that the training must include rotations to a RA 1 setting.

b) Type

The assessment of the proposed type of training settings should take into account whether the setting is a:

- Private setting;
- Non-hospital settings including aged care, community health and ACCHS and Aboriginal Medical Services.

For those posts located in private or non-hospital settings the assessment should be ranked high whereas if it was in a public hospital it would be low. This aligns with the program objectives to provide training in expanded settings.

The distribution of the FTE across public and private/non-hospital settings would modify this assessment result. For example, a 0.5 FTE in public with 0.5 FTE in private may result in assessment of medium. A high assessment of this proposed post on this factor may still occur if it is essential that the training must include rotations to a public setting.

c) Educational merit

In previous STP application rounds colleges were asked to rate the educational merit of each application. Factors that colleges may have taken into account include: whether the post is accredited or could easily be accredited; quality of supervision; educational activities; innovation; and training experiences.

Colleges should use the same approach in the assessment of the educational merit of each EOI to determine a rating of highly suitable, suitable or not suitable. The meaning of each assessment rating is:

- Highly suitable: very good educational merit;
- Suitable: good educational merit
- Not suitable: poor educational merit and not to be supported for STP funding.

d) Jurisdiction

Each of the states and territories will make an assessment of each EOI for their jurisdictions and determine an overall rating of highly suitable, suitable or not suitable. The meaning of each assessment rating is:

- Highly suitable: Specialist training post is in need at the facility outlined in the EOI and highly relevant to the STP priority framework;
- Suitable: There is a need for more training positions in this specialty in the state/territory, the EOI meets the core STP eligibility criteria and is located in at least one of the three STP priority settings.

- Not suitable: Training positions in this specialty are not required in the relevant state/territory and/or it is not located in at least one of the three STP priority settings.

e) Overall Assessment

It is necessary to make an overall assessment of each EOI to determine whether it is successful and will be added to the Reserve List or unsuccessful and not added to the Reserve List.

One method of determining an overall assessment is to use a points system to aggregate the assessments of “where”, “type”, “educational merit” and advice from jurisdictions. This could then be used to rank the EOIs. For example:

Assessment	3 Points	2 Points	1 Point
Where	RA 2-5	FTE spread across RA 2-5 and RA 1	RA 1
Type	Private or non-hospital settings	FTE spread across Private or non-hospital setting and public hospital	Public hospital
Educational Merit	Highly suitable	Suitable	Not Suitable
Jurisdiction	Highly suitable	Suitable	Not Suitable

The maximum score that an EOI could obtain is 12 and the minimum is 4.

However, any EOI that receives a not suitable assessment on educational merit and/or in the jurisdictional advice would be rated as unsuccessful and would not receive any STP support. The remaining EOIs could then be ranked on their score and added to the College’s Reserve List.

*NB- this is an example only of a points-based ranking system and its adoption is not compulsory. Colleges may wish to discuss modifications or alternative approaches with the department.

Advice to EOI organisations

At the completion of the overall assessment process organisations that submitted an EOI should be advised by email of the outcome of the assessment process. This advice should indicate whether the EOI has been added to the Reserve List or has been unsuccessful.

Selection from the Reserve List

It is suggested that when Colleges are selecting from the Reserve List to fill a vacancy in 2017 the approach should be:

1. Identify posts on the Reserve List that are the same specialty as the vacant post;
2. Of those posts, identify those in the same state/territory; and then
3. Select the highest ranked post.

If there are no posts in the same state/territory then select the highest ranked post in that specialty. If there are none in that specialty then select the highest ranked post on the Reserve List.