Discussion Paper:
Review of the
Specialist Training Programme
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Introduction

The Specialist Training Programme (STP) is an initiative aimed at supporting 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.

Under a previously announced expansion of the STP, available specialist training posts grew from 360 to 900 full time equivalent positions (FTEs) by 2014. The STP places premiums on the geographic distribution of trainees and meeting the demand for trainees, without compromising on the quality of training.

The Supporting Emergency Medicine Workforce Programme (also known as the Emergency Medicine Programme or EMP) is an initiative that seeks to improve emergency department medicine by expanding training capacity for doctors to become fellows of the Australasian College for Emergency Medicine (ACEM), upskilling a range of emergency care workers and growing the number of front line emergency service deliverers.

On 19 March 2015, the Minister for Health, the Hon Sussan Ley MP, announced that there would be consultation with specialist medical colleges and other stakeholders about reforms to the STP and EMP that would take place from 2017. Ms Ley stated that the aim of the review would be to:

... 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.1

Broadly stated, the objectives of this 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, such as Aboriginal and Torres Strait Islander specialists, specialists in rural areas and shortages in particular specialties.

This will be a two-phased, evidence-based review, conducted by the Department of Health (the department):

1. Stakeholder feedback will be sought from written submissions in response to this discussion paper, face-to-face meetings and discussion at National Medical Training Advisory Network meetings.
2. Concurrently, the department, with the assistance of a consultant, will develop potential methodologies for the allocation of training posts from 2017 and beyond.

This discussion paper is not intended to pre-empt the review process but rather to engender debate amongst stakeholders. It highlights issues relating to the design of the STP and the EMP and presents some possible options for changes to the operation of the programme. This component of the review is separate from the consideration of how training places should be allocated between and within specialties, which will be informed by the data modelling phase of the review, and negotiated with colleges.

Input from stakeholders on operational matters they have identified but which are not included in the discussion paper is welcomed. Information gathered during the review will

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be used as a platform for further consultation with stakeholders and form the basis of advice to the Minister in early 2016.

The design of the discussion paper allows stakeholders to consider the issues of importance to them.

Part 1 explains the background to the review, how it will be conducted and how to make a submission in response to this discussion paper.

Part 2 sets out information about the STP, including its history and aims, to establish the context of the discussion in Parts 3 and 4.

Part 3 examines whether the current design of the STP is promoting its aims, concentrating on the more important features of the STP. It raises the following issues:

- Is the programme meeting its goals, particularly those of placing trainees in rural and remote settings and developing training options in expanded settings, such as private medical centres?
- Under the current system, STP-funding includes a contribution to the trainee’s salary but does not necessarily cover all costs associated with the post. Is this system operating effectively or should changes be made so that it better promotes the aims of the programme?
- Should the rural loading component of STP-funding be changed to ensure it is being used to compensate rural and regional settings for additional expenses incurred by having a trainee?
- At the moment it appears that support programmes funded by the STP are being used for the benefit of all trainees and that very few are for the sole benefit of STP trainees. Should the Operational Framework be changed so that those support programmes benefit STP-funded trainees more?
- Does the Australian Standard Geographical Classification – Remoteness Area system of determining whether a setting is in a rural or regional area meet the needs of the STP or should the Modified Monash Model location system be adopted?
- Are the key performance indicators against which specialist medical colleges report clear, reasonable and relevant and providing the department with useful information?
- Are Private and Infrastructure Clinical Supervision programme funds being used to compensate supervisors for lost income suffered when they are engaged in supervising trainees and so unable to see patients, as intended?

Part 4 looks at the future of the STP and raises the following issues:

- The programme is effectively at its maximum number of posts, making it difficult for it to address areas of shortage by adding new posts each year. Is there a need for a regular review of training posts, including the 360 legacy posts that are holdovers from pre-STP programmes, to ensure placements are addressing areas of community need within the health system?
- Does the variable length of a rotation in a training post provide sufficient opportunity for a trainee to experience a rural or remote setting? What effect would increasing and/or standardising the length of rotations in rural and regional settings be likely to have on specialists working in those areas after they have completed their training?
• One of the aims of the STP is to increase specialist training conducted in rural and regional settings. Should changes be made to funding arrangements to promote that aim, such as making it a requirement of STP-funding that training takes place in a rural or regional setting? Alternatively, could a portion of STP-funding be earmarked for full fellowships that are tied to rural placements?

• Should new approaches be developed that promote training being “based” in rural areas, with rotations out to metropolitan areas, if necessary, to acquire particular skills?

• The Mason Review recommended that the STP “should provide indexed funding for its training posts.” Assuming the size of the STP-funding pool is not increased, can indexation be implemented without a reduction in the total number of posts, for instance, by diverting support funding?

• Recent studies have found that Aboriginal and Torres Strait Islander health workers make an important contribution to the health of Indigenous people. Can Aboriginal and Torres Strait Islander health be promoted by earmarking a suitable amount of STP funds that are available to support vocational training of Aboriginal and Torres Strait Islander doctors, regardless of the speciality in which they wish to train?

• Cultural safety training is an important tool for creating an effective and responsive medical professional. How can STP support programmes better support culturally safe learning environments?

Part 5 is a short summary of the Emergency Medicine Programme. It sets out the history of the three EMP initiatives that are being considered in this review and how the Emergency Medicine Training Programme (the Training Programme) operates, including its funding elements and administration. Part 5 also raises options for the integration of the Training Programme and the STP.

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Part 1. The review process

1.1 Background to the review

The Specialist Training Programme (STP) is an initiative aimed at supporting 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 Supporting Emergency Medicine Workforce Programme, or Emergency Medicine Programme (EMP), is aimed at improving emergency department medicine by expanding training capacity, upskilling a range of emergency care workers and growing the number of front line emergency service deliverers. The EMP is covered in Part 5 of this Discussion Paper. It consists of a number of initiatives, three of which will be considered in this review:

- an emergency medicine training programme (the training programme), which funds training posts for doctors wishing to become fellows of ACEM;
- the Emergency Department Private Sector Clinical Supervisor programme (the EDPSCS), which supports emergency medicine training in private hospitals; and
- the Emergency Medicine Education and Training programme (EMET), which enables ACEM Fellows to deliver training in emergency departments to non-specialist medical staff, particularly in regional and rural areas.

On 19 March 2015, the Minister for Health, the Hon Sussan Ley MP, announced that “a consultation process would begin with colleges and other stakeholders about reforms [to the STP and EMP] to take place in 2017.” Ms Ley stated that the aim of the review would be to:

... 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.³

In August 2014, the Department of Health (the department) published Health Workforce Australia’s report Australia’s Future Health Workforce – Doctors, which presents long-term, national workforce projections for doctors to 2030. The research identified a “significant inequity” in access to specialists, which, based on projections of future needs, will continue.⁴

The objectives of this review are to:

- assess the effectiveness and efficiency of the management of the STP and the EMP, including:
  - the selection of training posts;

The funding models used by the STP and the EMP;
the success of support projects and the need for future projects;
the ability of the programmes to increase training in expanded settings;
the short and long term effect of training on health outcomes in rural and regional areas;
ongoing monitoring by the department and colleges of training posts; and

- recommend future programme reforms to enable the STP and the EMP to better meet Australia’s future specialist medical workforce needs, including, if needed:
  - revised guidelines to address any identified shortcomings in the effectiveness of the programme;
  - how support for training positions can be used to enhance distribution of training posts;
  - how workforce planning projections should inform the distribution of training posts; and
  - the role of the STP and the EMP in the medical training pathways.

1.2 About the review

This will be a two-phased, evidence-based review, conducted by the department. The department is leading this work, as its core business includes medical workforce planning and projections and health workforce distribution policy and programme design. Stakeholders will be closely involved in the redesign, including specialist medical colleges and training settings. The National Medical Training Advisory Network (NMTAN) will also be asked to assist. Stakeholder feedback will be sought in response to a discussion paper, through face-to-face meetings, written submissions, and discussion at NMTAN meetings. The department will not release this Discussion Paper for public comment.

A consultant will be appointed to assist the department on data modelling to:

- complete an assessment of the capacity of colleges, public and private sectors, and regional and rural areas to support the future delivery of the STP and the EMP; and

- develop a potential methodology for the allocation of training posts from 2017 and beyond, with a focus on addressing identified workforce shortages.

Responses to this Discussion Paper will be used as a platform for further consultation with stakeholders and form the basis of advice to the Minister in early 2016.

This Discussion Paper presents ideas and options for improvements to the management and processes of the STP and the EMP, in addition to the primary aim of the review of incorporating workforce planning data to target areas of identified workforce shortage.

The department is aware that some medical colleges have developed their own, innovative approaches to how they train specialists. Input from stakeholders on ways in which these programmes can be improved that go beyond those raised in this Discussion Paper is welcomed. Submissions can address any topic, whether it is raised in this paper or not, such as the way in which the STP and the EMP supports the training of specialists, how funding can be used to provide services to the community and how it can be used to ensure services are available in remote settings. Section 4.5 sets out two examples of innovative approaches to training that may be of relevance to the STP in the future.
1.3 Making a response to the Discussion Paper

Respondents who would like all or part of their submission to remain in confidence should provide this information marked as such in a separate attachment. Automatically generated confidentiality statements in emails do not suffice for this purpose.

Information provided by organisations on their business frameworks will remain in confidence. This information should be submitted as a separate attachment. Information provided in response to this Discussion Paper will not be published on the Department of Health’s website. Legal requirements, such as those imposed by the Freedom of Information Act 1982, may affect the confidentiality of your submission.

Submissions should be sent to Michael.Azize@health.gov.au, with the subject heading “Submission in response to Discussion Paper”
Part 2. The Specialist Training Programme

2.1 The history of the Specialist Training Programme

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

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

The rationale for new Australian Government investment in specialist training was summarised by the Medical Specialist Training Steering Committee, in its report, Expanding Settings for Medical Specialist Training:

... there is a need to expand the specialist training capacity of the health system in light of the significant increase in medical graduates from 2011 and the pressure this increase in graduate numbers will place on existing supervisors, particularly in light of the ageing and participation rates of current supervisors.5

In 2008, COAG committed to additional investment via the Hospital and Health Workforce Reform - Health Workforce package. Other training programmes funded by the Government were the Outer Metropolitan Specialist Trainee Programme, the Overseas Trained Specialist Upskilling Programme and the Pathology Memorandum of Understanding, which in 2009-2010 was continued as a programme supporting best practice and workforce in pathology and diagnostic imaging.

Upon its commencement on 1 January 2010, these different programmes were amalgamated into the STP, a consolidated platform for Commonwealth grants supporting medical specialist training initiatives.

It was announced that the STP would grow to increase the number of available specialist training posts from 360 to 900 FTEs by 2014. In doing so, the STP placed a premium on the geographic distribution of trainees and meeting the demand for trainees without compromising on the quality of training. This brought private sector and rural and regional settings into the training equation in a way they had not been used before. The STP provided resources to support the private sector through the Private Infrastructure and Clinical Supervision programme (PICS) [See Section 3.5: Private and Infrastructure Clinical Supervision Programme].

The Tasmanian Health Assistance Package was announced on 12 June 2012 to support the training and retention of specialist doctors in the Tasmanian public health system. It is being administered under the STP but falls outside the scope of the review.6

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5 Medical Specialist Training Steering Committee, Expanding Settings for Medical Specialist Training, October 2006, p. 1.
6 More detailed information about the Specialist Training Programme can be found at the Department of Health website, at Specialist Training Programme.
2.2 Aims of the STP

The full aims and objectives of the STP are set out in Attachment A: Specialist Training Programme (STP) Operational Framework:

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 Programme must be achieved without an associated loss to the capacity of the public health care system to deliver services.7

2.3 About the STP

The main stakeholders in the STP are:

- the Commonwealth government and the Australian community;
- state and territory governments;
- specialist medical colleges;
- public health services;
- the private health sector;
- community-controlled health services; and
- doctors in training and specialist trainees, through their representative bodies.

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

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7 Specialist Training Programme (STP) Operational Framework (the STP Operational Framework), January 2013, p. 5, Attachment A.
The STP only funds new training positions and it does not fund positions that have been funded by another source for more than twelve months in the previous three years. The process for selecting posts for funding is discussed in more detail in Section 3.3.

The STP uses a “college administration” model. That is, the department provides funding for an approved post directly to the relevant specialist medical college, which is then responsible for administering posts in accordance with an agreement with the department. Funding is not provided directly to the setting. At present, the department has STP funding arrangements with twelve specialist medical colleges. The department also provides financial support to the college to cover the costs of administering each post.

Among other things, the funding arrangements require colleges to be responsible for:

- disbursing funds to settings;
- overseeing the conduct of settings; and
- reporting to the department on progress against key performance indicators (KPIs).\(^8\)

Total funding to support each training post is around $100,000 to $153,333 per FTE per year [see Part 3: The current design of the Specialist Training Programme]. In many cases more than one trainee will rotate through a training post over the course of a year and a registrar will undertake training at a range of posts.

Total funding for the STP for the period 2010 to 2016 (including allocated spending for 2016) is $665 million. While 932 posts were funded in 2014, only 900 have had a trainee. This represents 924.3 funded positions, with 818.2 FTE filled. Vacancies generally occur where a post has been approved but cannot be filled.

As well as funding specialist training posts, the STP provides funds for a range of support activities, including:

- private sector clinical supervision and training and training infrastructure for all private sector STP training posts under the PICS [see Section 3.5: Private and Infrastructure Clinical Programme];
- developing strategic and sustainable support projects to enhance training opportunities for STP-funded trainees; and
- developing support projects aimed at Specialist International Medical Graduates (SIMGs) to assist these doctors gain fellowship to a college in a timely and efficient manner.

It is estimated that the STP funds around 5-7 per cent of specialist training posts nationally. The maps on the following pages show:

- the 2014 STP primary placement training facilities, using the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) categories (insets display the indicated major cities at a greater level of magnification) and
- the same training facilities using the Modified Monash Model classification system.

It should be noted that only the location of the primary training facilities are mapped, not the training posts themselves. Of the facilities displayed, 173 STP posts were distributed over more than one training facility. The additional sites associated with these posts are therefore not displayed. Additionally there were 154 training facilities that had one or more training posts from the STP in 2014. These 154 facilities accounted for 699 STP posts. The number of STP posts within a given facility is not represented on the maps.

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\(^8\) KPIs were set by the Department in consultation with medical colleges prior to the commencement of the STP.
Part 3. The current design of the Specialist Training Programme

3.1. Meeting the goals of the STP

The goals of the STP are set out above.

In 2013, the Review of Australian Government Health Workforce Programmes (the Mason Review) concluded that the STP “has been highly successful in extending vocational training into new settings, particularly in the rural and private sectors.”

In 2014, the Australian National Audit Office released a performance audit report, *Administration of the Medical Specialist Training Programme*, stating:

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.

As noted above, 932 STP posts (924.3 FTE) were funded for the 2014 academic year. Of these, 900 posts (818.2 FTE) had a trainee during the year. Table 1 shows funded posts by college and by state and territory.

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<th>QLD</th>
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<th>VIC</th>
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<th>SA</th>
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<td><strong>104</strong></td>
<td><strong>42</strong></td>
<td><strong>932</strong></td>
</tr>
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</table>

Table 1: Funded posts by college and state and territory

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11 While 932 posts were funded in 2014, only 900 posts have been filled, representing an FTE of 818.2.
The STP is consistently oversubscribed. For example, in 2014, 486 applications were received for 150 posts.

3.1.1 Placement of training posts

Placing trainees in rural and remote settings and developing training options in expanded settings, such as private medical centres, are two of the main objectives of the STP. Medical college reports for 2014 indicate that 409 training posts, or 44 per cent, had an element of training in ASGC-RA categories 2 – 5. The most recent college reports to the department for the 2014 academic year show that 37 per cent of FTEs are in RA2 – RA5 categories and 44 per cent are in private sector settings.

The DoctorConnect website, since amended, formerly described the ASGC-RA system:

ASGC-RA is a geographic classification system that was developed in 2001 by the Australian Bureau of Statistics (ABS), as a statistical geography structure which allows quantitative comparisons between ‘city’ and ‘country’ Australia.

The purpose of the structure is to classify data from census Collection Districts (CDs) into broad geographical categories, called Remoteness Areas (RAs). The RA categories are defined in terms of ‘remoteness’ - the physical distance of a location from the nearest Urban Centre (access to goods and services) based on population size. A primary advantage of the new classification system is that the remoteness structure is updated each census, which commenced with the census year 2001. It was updated recently on 8 November 2007 after the 2006 census.12

Table 2 shows movements in the FTEs allocated to the broad categories of RA1 and RA2-5 for each funding round. Table 3 shows the percentage of training posts in each RA category for the 2014 academic year.13

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13 Table 3 differs from the maps above, in that it shows training posts by RA category, whereas the maps show the location of the training facilities themselves.
Table 2: Allocation of FTEs by RA category for each funding round

<table>
<thead>
<tr>
<th>Year</th>
<th>RA1</th>
<th>RA2-5</th>
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<tbody>
<tr>
<td>2010</td>
<td>223.02</td>
<td>130.66</td>
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<td>2011</td>
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<td>12</td>
<td>70</td>
</tr>
<tr>
<td>2013</td>
<td>92</td>
<td>58</td>
</tr>
<tr>
<td>2014</td>
<td>82</td>
<td>78</td>
</tr>
</tbody>
</table>

Table 3: Percentage of STP-funded training posts in each RA category for the 2014 academic year

- RA1: 63%
- RA2: 22%
- RA3: 10%
- RA4: 3%
- RA5: 2%

Table 2: Allocation of FTEs by RA category for each funding round

Table 3: Percentage of STP-funded training posts in each RA category for the 2014 academic year
Table 4 sets out the percentage of FTEs allocated to settings in RA1 and RA2-5 areas for each funding round from 2011 to 2014. College reports for the 2014 academic year indicate that of the 924.3 FTE posts funded, 63.4 per cent were in RA1 settings and 36.6 per cent in RA2-5 settings.14

These statistics could be taken as indicating that the STP has been, by and large, a success in promoting training in rural and remote settings. However, given the specific objectives of the STP, which supplements training opportunities provided in tertiary public hospitals, the rural and regional impact may not have been as great as expected. As noted above, the STP has allocated funding in 2014 for 932 training posts (924.3 FTE), of which 32, or 3.4 per cent, remained unfilled for the year. The unfilled posts are distributed as follows:

- 17.92 posts (56.18 per cent) are in RA1 settings;
- 10.13 posts are in RA2-RA5 settings (31.75 per cent); and
- 3.85 posts involve rotations between RA1 and RA2-5 settings (12.09 per cent).

This suggests that specialist medical colleges may have more difficulty in filling posts in rural and regional areas than they do posts in metropolitan areas.

Table 5 sets out the percentage of FTEs allocated to public and private sector settings in each funding round, over the course of the STP.

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14 The 2010 allocation reflects those posts carried over from other pre-existing programmes in the 2011 funding round.
Table 5 indicates that each year, with the exception of 2011, roughly an equal number of places have been allocated to public and private sector settings. Of the 924.3 FTE posts funded in 2014, the colleges reported that 56.6 per cent were in the public sector and 43.4 per cent were in the private sector.

Table 6 (over page) sets out the allocation of posts by college and by public/private split for the 16 facilities with the highest number of STP posts.

Questions:

1. Is the STP meeting its aims and objectives, as set out in the *Operational Framework*? Particular attention should be paid to the objectives of increasing capacity to provide training opportunities in expanded settings and supplementing the specialist workforce in rural and remote locations.

2. What changes, if any, should be made to the aims and objectives of the STP to maintain and grow the programme in the future?

3. Should there be greater emphasis on generalist training?

4. Is the *Operational Framework* of the STP still relevant and appropriate?

5. What changes, if any, should be made to the *Operational Framework* to improve the programme in the future?

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<th>Year</th>
<th>Public FTE</th>
<th>Private FTE</th>
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<td>2014</td>
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Table 5: Private sector and public sector placements by funding round (%)
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<th>ACSP</th>
<th>ANZCA</th>
<th>CICM</th>
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<th>RANZCO</th>
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<td>13</td>
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</tbody>
</table>

| PUBLIC (%) | 38.75  | 0      | 0      | 57.58  | 44.44  | 50.00  | 64.19 | 54.75 | 65.00  | 96.66  | 36.15  | 60.00  | 56.25 | 59.96 |
| PRIVATE (%)| 61.25  | 0      | 0      | 42.42  | 55.56  | 50.00  | 35.80 | 45.25 | 35.00  | 3.34   | 63.85  | 40.00  | 43.75 | 40.04 |

Table 6: College allocations and public/private split for Top 16 facilities by STP posts
3.2. Funding

STP funding has six elements:

- a contribution to the trainee’s salary;
- a rural loading to support posts in RA2 – RA5 categories;
- a payment to the colleges for the cost of administering a post;
- a payment for support projects; and
- a payment under PICS for clinical supervision; and
- a payment under PICS to support infrastructure upgrade needs of private sector providers.

3.2.1 Contribution to salary

The STP contribution is set at $100,000 per annum (GST exclusive) per FTE. If a post is not a full FTE, a pro rata contribution is made. The rural loading is $20,000 per annum (GST exclusive). The timing of the payment to the setting may vary between colleges. The PICS clinical supervision payment is $30,000 (GST exclusive) per annum per FTE. The PICS private infrastructure payment is $10,000 (GST exclusive) per FTE, paid only once in a three year period. PICS payments are made on a pro rata basis.

The contribution model recognises that the community (through taxpayers) should not meet the full costs of training a specialist doctor. There are other beneficiaries of the training, including employers, who benefit from the development of their future workforce; the profession, which has an obligation to develop future specialists; and the individual, who will join one of the most highly paid and respected professions in our society.

The STP contribution to a trainee’s salary is sufficient to enable new training posts to be established, but would not cover all costs associated with the post. Essentially, the STP sets a price for each post and it is up to each setting to make the initial determination to host an STP training post, with the understanding that the setting will be required to fund the difference between the STP contribution and the trainee’s full salary. The STP funding also recognises that the full cost of a training post can vary between settings; with the more regional settings likely incurring a higher cost to maintain the post, and posts in private sector settings cost more to maintain than posts in the public system. Accordingly, STP funding includes a rural loading based on the ASGC-RA category of the setting, as well as contributions for administrative costs and support projects and PICS payments.

There are also likely to be differences between the costs of funding training in different specialties. This is not taken into account by the flat rate of funding used by the STP.

On one hand, having the setting make the initial determination whether it can afford to fund its share of the cost of the training post is one of the strengths of the present funding model. It places a strong, initial onus for determining what training is needed on the bodies operating at the “coal face” of medical services. On the other hand, it may dissuade some settings from applying for needed posts, as they may not be able to fund that difference.

One approach adopted by rural and regional settings to address that potential problem is to create training networks that share posts between multiple settings.

The STP funding model can be compared to that in place for the Commonwealth Medical Internships (CMI) initiative. The purpose of the CMI is:
... to fund additional internship places in private hospitals, rural hospitals where coordinated by private hospitals and other non-traditional settings, which could include general practice and other primary care settings.\textsuperscript{15}

The CMI is limited to international full-fee paying graduates of on-shore Australian medical schools, as all domestic medical graduates are guaranteed a state or territory internship position under a COAG Agreement made in July 2006.

The Commonwealth Government committed funding for up to 100 places over four years from 2013, with a budget of $40 million. CMI-funded interns are expected to undertake rotations in rural hospitals. In 2014, not all 100 CMI places were required, as there were not sufficient eligible applicants for all the available intern places.

Under the CMI initiative, private settings apply for funding in what is, essentially, a tendering process with open pricing. Importantly, CMI funding meets all the identified costs of the intern but on a competitive basis. The average CMI payment is around $125,000 per intern. This contrasts with the STP model, where the salary contribution is set at $100,000 per post and has been since the programme was introduced.

It is not clear that the tendering model used by the CMI has lowered the cost of training an intern. When placing a tender, hospitals indicate that they are able to make an “in-kind” contribution to the cost. This might be through using existing infrastructure or some other cost-saving measure, though it is generally only a small component of the total cost of training. In some cases, hospitals are able to utilise economies of scale gained either from having a number of training posts funded by the CMI or from having established training systems in place. In one instance, an applicant submitted a tender that flagged lower training costs if it was allocated more posts. Hospitals taking CMI-funded interns for the first time have extra costs from establishing themselves and hospitals in different parts of the country have different costs.

One effect of the CMI open tender model is that the Commonwealth has been able to more easily identify expensive proposals and provide applicants with the opportunity to revise their tenders to be more competitive.

It should be considered whether the fixed amount of the salary contribution made under the STP is restricting more remote settings from being able to apply for and host a post. If one of the main aims of the STP is to place trainees in an expanded range of settings beyond traditional public teaching hospitals, especially in rural and regional areas, consideration has to be given to changes to the current funding model that further promote that aim.

Competition generated from an open-tender process may have this result. However, the STP has a number of other objectives which need to be balanced against the cost of individual posts.

A further difference between the two programmes is that, in contrast to the CMI initiative, demand for STP-funded training posts exceeds the available supply. That is, there are more applicants than places for STP-funding, whereas in the CMI there are more places available than eligible applicants. The overall effect of the STP adopting a full payment model like the CMI programme could be that costs may rise above $100,000, leading to fewer training posts being available. The likelihood of this outcome increases if it is correct that it costs more to train a specialist than an intern.

\textsuperscript{15} Commonwealth Medical Internships Programme Guidelines 2015, August 2014, see Commonwealth Medical Internships Programme, p. 5 (accessed 28 May 2015).
One way to do this might be to make the STP model more flexible, say by providing funding in excess of $100,000 to settings that demonstrate higher training costs due to location. However, assuming that the total amount available under the STP does not increase, adoption of that model may mean the number of posts available has to be reduced from the present 900. Alternatively, in order to retain the same number of posts, rather than continue the present system of a set STP contribution of $100,000 per post per annum, amounts could be varied so that $100,000 would remain the average. Some posts would receive a higher than average contribution towards salary and some a lower than average contribution. The salary contribution could be based on the ASGC-RA category of the setting, with RA1 settings receiving the lowest contribution and RA5 settings the highest.

This model does not take into account costs to the Commonwealth that result from specialists and registrars, through their supervisors, billing their services through Medicare. That issue should be examined as part of this review. Consideration should also be given to whether billing costs vary between specialties and, if so, whether and how this can be factored into the contribution to salary in the STP.

Questions:

6. Does the fixed-contribution to salary model of STP funding promote the aims and objectives of the STP? Particular attention should be paid to the way in which the contribution is calculated and the same contribution being made for each post.

7. What, if any, changes should be made to this aspect of the funding model to improve its operation?

8. Should costs to Medicare through registrars billing services through supervisors be taken into account in changes to the funding model?

9. If the costs to Medicare vary between specialties, should that be taken into account in the funding model and, if so, how?

3.2.2 The rural loading

One of the main objectives of the STP is increased specialist training in rural, regional and remote areas. This objective is supported by the rural loading element of the STP contribution. The purpose of the rural loading is to compensate settings for any additional expenses incurred by settings in having a trainee in a rural STP Post.

It is expected that placing a trainee in a setting in an RA2-5 area involves greater costs than putting the same trainee in a setting in an RA-1 area. It would not be unexpected if placement in an RA2-5 setting involved extra costs, such as:

- where a trainee attends a course in a city, there might well be additional costs of travel to a city, accommodation if they have to arrive the day before the course, accommodation for the duration of the course, meals and increased costs of having the trainee replaced during the course; and
- relocation and accommodation costs, especially if the trainee has a family and is seeking only temporary accommodation in the area. The setting might have to
assist in finding suitable accommodation, paying a rental deposit, assisting with broadband connection, phone, appliances and suitable furnishings.

At present the rural loading applies to any setting not in an RA1 category, which is basically a major city. RA2 indicates an Inner Regional area, RA3 an Outer Regional area, RA4 a Remote area and RA5 a Very Remote area. The rural loading is not scaled.

The rural loading was raised in the ANAO Report, which indicated that the loading was used to subsidise a range of expenses and that settings found the loading “was of substantial assistance” in attracting trainees to posts in rural and regional settings. That report also noted that some colleges will automatically pay the loading to the setting, whereas others requested evidence of the training taking place. One college reported that it needed to “confirm whether the rotations had in fact taken place as originally planned, and checks were not done on a regular basis.”

While the rural loading is used for a very wide range of expenses, it is not clear that all these expenses are relevant to a post being in a rural or regional location. It may be that the need for supplemental funding is really only in relation to relocation expenses and expenses with attending conferences or training events in other areas. On the other hand, trainees in rural settings may incur higher living costs, particularly when spousal employment opportunities and education costs are considered. It must be considered whether those costs should be offset with an increase in the salary contribution or through the payment of a travel and/or accommodation allowance.

Earlier, this Discussion Paper asked whether the present STP funding model should be made more flexible, so that increased funding is provided to settings demonstrating higher training costs. If adopted, the rural loading may become redundant.

Alternatively, changes to the rural loading could be made to promote the STP aim of increasing training posts in rural and remote areas and in expanded settings. For example, an increase to the amount of the rural loading, offset by a decrease to the STP contribution to salary for trainees in RA1 settings, may encourage more trainees to accept posts in rural and remote settings. This is assuming that rural and regional settings are having difficulties in attracting trainees and that the amount of the rural loading is a factor in mitigating that.

Questions:

10. Does the rural loading element of the STP support the aims and objectives of the STP? Particular attention should be paid to whether the current rural loading funding model supports the objective of increasing training in ASGC-RA2 - 5 locations.

11. What changes, if any, should be made to improve the rural loading system? Particular attention should be paid to changes to make it more relevant to a training post in a rural or regional setting, the way the loading is calculated and the way the rural loading is used by training settings.

17 ANAO Report, March 2015, p. 88.
18 ANAO Report, March 2015, p. 74.
3.2.3 Classification of settings

The ASGC system for classifying settings is described in Section 3.1.1: Placement of training posts above. Criticisms have been made of the application of the ASGC system to the General Practice Rural Incentives Programme, primarily that the ASGC leads to “perverse incentives for doctors to move to large, coastal towns” and it does not recognise “the challenges of recruiting doctors to small rural towns.”

The example given is that under the ASGC system a doctor has the same incentive to relocate to Townsville, a coastal town with a population of 172,000, as to Charters Towers, an inland town with a population of 8,000, as both fall into the RA3 (Outer Regional) classification.

In its 2015-16 Budget, the Commonwealth Government announced that the General Practice Rural Incentives Programme would no longer have the ASGC applied, but would move to the MMM location classification system. The DoctorConnect website describes the MMM as:

... a new classification system that better categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and town size. The system was developed to recognise the challenges in attracting health workers to more remote and smaller communities.

The MMM, it should be noted, was designed for use in incentive programmes, on a case-by-case basis, rather than for training programmes, such as the STP. The MMM has seven classification categories. In practical terms, its main difference from the ASGC system is that it separates the ASGC-RA2 and RA3 categories into four categories based on population. Its strengths and weaknesses (and those of its predecessor system) are discussed in some detail in the Mason Review.

There will be anomalies in any classification system. While most RA2 settings are quite distant from metropolitan areas, in some cases there is little practical difference between an RA1 and an RA2 setting. For example, Woy Woy, in New South Wales, is in the RA2 category, however, it is located around 15 minutes from Gosford, which is in the RA1 category, and many people commute from Woy Woy to Sydney for work each day. In contrast, Albury is an RA2 setting, however, it is located 340 kilometres from Canberra, the nearest RA1 setting.

It is reasonable to consider, in the context of the review, whether the MMM is more appropriate to the needs of the STP than the ASGC system. The MMM was specifically designed to allocate incentive payments to General Practitioners to work in rural areas. It was not designed for use with the system employed to train specialists, where trainees may train or rotate through various rural locations and in private sector settings, to gain wider experience.

Category MM1 in the MMM is the same as RA1. Although the other categories are different, that difference is not relevant if the rural loading is only paid to settings outside RA1. This raises the question whether the rural loading should be reserved for settings in the RA3, RA4 (Remote Australia) and RA5 (Very Remote Australia) categories, or MM3 (RA2 and RA3, with populations 15,000 to 50,000), MM4 (RA2 and RA3, with populations 5,000 to 15,000), MM5 (RA2 and RA3, with populations less than 5,000), MM6 (Remote) and MM7 (Very Remote). Both systems rely on drawing distinctions between categories. By having more categories

19 See DoctorConnect website (accessed 19 May 2015).
and allowing there to be “islands” of one category within another, the MMM makes finer distinctions than the ASGC system while, arguably, removing some of its anomalies.

Table 7 below shows the effect of a switch in the classification of posts from the ASGC-RA to the MMM. The difference is noticeable, though not huge, and reflects the finer gradations inherent in the MMM. However, if MMM2 is excluded from inclusion as a rural area for the purposes of the STP, in line with the recent changes to the rural incentive payments scheme, this could have a significant impact on the distribution of training posts.

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Table 7: Comparison of 2014 STP-funded posts under Australian Standard Geographical Classification – Remoteness Areas and Modified Monash Model systems [Note: The difference between ASGC-RA 2-3 and MMM 2-5 is 23.8]

One way in which the STP could be used to place trainees in settings in rural and regional areas is to scale STP funding according to the remoteness of the setting, with the most remote settings receiving more funding than less remote settings. While this still relies on a classification model, it removes much of the potential for anomalies that exist within a system that draws fine distinctions between metropolitan and inner regional areas.

Questions:

12. Does the present system for classifying settings as falling into a rural or remote area accurately identify settings that should be promoted through the STP priority funding guidelines?

13. If not, would the Modified Monash Model provide a better classification outcome?

14. Should rural loadings be scaled so that remote settings receive more funding than less remote settings?

\[21\] While the MMM1 area and the Australian Statistical Geography Standard (ASGS) RA1 area are identical, the figure for RA1 in this table is based on the ASGC model, which is the model used by the DoctorConnect website. The Department uses DoctorConnect to show the RA category of settings.
3.2.4 Support programmes

The STP recognises that, in addition to making a salary contribution, support programmes assist in the training of medical specialists, particularly those in rural, regional or remote areas and in private settings. In relation to support programmes, the Operational Framework states:

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.22

At the time the STP commenced there were few support programmes for trainees in rural and regional or private sector settings. Support programmes, such as those to fund the training of supervisors or to create libraries for use by rural trainees, have, therefore, been important in assisting colleges to establish the rural training networks necessary for the successful operation of the STP. Nonetheless, two questions that should be asked are:

A. Do support programmes promote the aims of the STP?
B. Should support programmes be replicated year after year or is it sufficient that they be updated as needed once they are established?

The department has examined the support programmes referred to in the most recent progress reports of specialist medical colleges, which were provided to the department as part of the colleges’ STP reporting requirements. They indicate that very few of the support programmes are directed specifically to STP-funded trainees or are targeted at expanded settings or rural and regional areas. By and large the programmes are aimed at

- trainees, as a group, rather than STP-funded trainees in particular;
- improving the skills of supervisors and Specialist International Medical Graduates (SIMGs), though one of the objectives of the STP is to support programmes to assist SIMGs gain fellowship to a specialist medical college; and
- providing eLearning modules or other forms of online training or information database.

While those programmes would likely assist STP-funded trainees, they benefit all trainees, as well as fellows of the colleges. Further, many of the programmes are ongoing, in that they run over the course of a number of funding years and will continue to exist well after 2016. There may also be issues requiring consideration of the Commonwealth’s funding ability, in view of the decisions of the High Court of Australia in the series of cases brought by Mr Ronald Williams against the Commonwealth in relation to its funding authority.23

This survey of the colleges’ progress reports produced scant evidence STP funding is being used for support programmes directed exclusively to STP trainees, for training in expanded settings or for trainees located in rural, regional or remote settings. Rather, the programmes referred to in the colleges’ reports appear to be geared more to fulfilling the wider needs of all trainees.

23 A summary of the decision in the 2014 proceedings can be found at High Court of Australia (accessed 3 August 2015).
These support programmes no doubt have value for trainees, SIMGs, supervisors and the specialist medical colleges as a whole. However, it should be considered whether this use of STP funds is consistent with the aims and objectives outlined in the Operational Framework. Put another way, has the balance shifted from programmes that support STP-funded trainees to programmes that have a far wider application than the STP and promote its aims, which it must be remembered is funding them.

Some options that might address this concern, which could be implemented separately or in combination, are:

- requiring colleges to direct STP-funded programmes predominantly to STP-funded trainees in rural, regional and remote settings and private settings only;
- having colleges bid for funding for nominated programmes from a pool of money administered by the department that favours innovative training programmes;
- allowing ongoing trainee and supervisor support programmes in expanded and regional and rural settings only;
- reducing the amount available for funding support programmes; and
- making programmes accessible across colleges, so that they are available to all STP-funded trainees. Those programmes could be based on location, rather than specialty, or they could be made available as online programmes.

Questions:

15. Is the present system of funding support programmes appropriate and does it promote the aims and objectives of the STP?

16. What changes, if any, should be made to improve the support programme system? Particular attention should be paid to changes to make support programmes more relevant to trainees in rural and regional areas and to how the department determines the size of support payments.

3.2.5 Administration support payments

The administrative support payment element of STP funding is intended to assist specialist medical colleges to fulfil their duties under the college administration model used by the STP. It is based on a rate per post. The final amount paid is negotiated with the medical college, but generally it is not more than 10 per cent of the salary support element. Administrative support payments enable colleges to manage the STP and direct funding to training settings, a role they did not traditionally undertake before the programme was introduced.

The ANAO audit found that annual administrative funding, on a per post basis, has declined over time, indicating that efficiencies have been delivered by the programme.24 This is pleasing and suggests that the administrative element of STP funding could be one area in which a simpler, more streamlined approach to payments could be introduced. Specialist medical colleges with large numbers of training posts, for example, could be expected to benefit from economies of scale not available to smaller colleges.

24 ANAO Report, March 2015, p. 70.
No particular issues have been raised with the administrative support payment system. However, one possible improvement is to make the administrative element of STP funding a fixed amount plus a percentage for salary support based on the number of posts, or within a range, say the same payment for 100-130 posts. Further, some colleges may wish to sub-contract the administration of their training posts to another specialist medical college or to an outside body to take advantage of existing economies of scale, or create new ones.

Questions:

17. What changes, if any, should be made to the present system of calculating administration support payments?

3.2.6 Timing of payments to specialist medical colleges
At present, STP funding payments are made to colleges twice yearly, when the college provides its progress report on its use of STP funds for that period to the department. Some colleges have asked whether there is scope for this system to be changed to better match the colleges’ expenditure of funds to training settings. For example, the department could make four payments a year, with two payments not linked to a progress report, thereby not increasing the colleges’ reporting requirements.

In March 2015, the ANAO audit found that, at the time of reporting, colleges were holding collective surpluses of $56.31 million, or 16.4 per cent of total STP funding. The department responded by withholding a total of $23.89 million in funding in the next financial year. Such a change would better match colleges STP revenue and expenditure, reducing the likelihood of colleges accumulating excessive surpluses.

It should be acknowledged that specialist medical colleges should hold minimal reserves of STP funds, with interest earned on those reserves correspondingly low. From a government perspective, grant payments should match the expenditure profile of grant recipients.

Questions:

18. Can improvements be made to the current system of making STP payments to colleges twice-yearly?

19. If so, what changes should be made?

25 ANAO Report, March 2015, p. 82.
3.3. Selection of training posts

3.3.1 The selection process

The optimal selection of training posts to address the specialist training needs of the health care system is crucial to the successful operation of the STP. While the assessments of the STP by the Mason Review and ANAO Audit were favourable, how this vital aspect of the programme operates in the future must be a key issue for the review.

The current process for selection of training posts that receive STP funding is as follows:

<table>
<thead>
<tr>
<th>Step 1</th>
<th>In consultation with key stakeholders, the department determines the Operational Framework and Priority Framework of the programme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Application for posts are made to the department by an eligible entity, that is any health care provider, facility or organisation that can provide training for medical specialist trainees in an expanded range of settings beyond traditional public teaching hospitals.</td>
</tr>
<tr>
<td>Step 3A</td>
<td>The relevant specialist medical college rates each application according to the department’s frameworks, but particularly assessing whether applications “meet the standards set by the relevant College and ... deliver educational value.”</td>
</tr>
<tr>
<td>Step 3B</td>
<td>At the same time, state and territory health departments also rate each application, using the department’s guidelines, but particularly looking at “the availability of registrars to fill the posts identified and areas of workforce need.”</td>
</tr>
<tr>
<td>Step 4</td>
<td>The department consolidates and reviews the colleges’ and state and territories’ ratings.</td>
</tr>
<tr>
<td>Step 5</td>
<td>The highest ranked applications are approved by a senior departmental officer, under a delegation from the Minister. A Reserve List is created to cover posts that are not selected for funding.</td>
</tr>
<tr>
<td>Step 6</td>
<td>STP funds are provided to specialist medical colleges for approved posts.</td>
</tr>
<tr>
<td>Step 7</td>
<td>If a post is not filled, where possible the college promotes an applicant from the Reserve List.</td>
</tr>
</tbody>
</table>

26 STP Operational Framework, January 2013, p. 4.
27 STP Operational Framework, January 2013, p. 5.
The STP priorities for 2014 were developed in consultation with stakeholders (see Attachment B: STP 2014 Priority Framework).

This system could be considered overly complex, inflexible and restrictive of the ability of specialist colleges to meet their training needs, thus preventing FTE targets being met. One approach might be to place greater responsibility for the management of posts in the hands of the specialist colleges, as they are the bodies who receive the funding and administer the STP. This was the approach taken with the EMP in 2015, when the Australian College of Emergency Medicine (ACEM) assumed the task of selecting training posts to be funded under the programme. ACEM developed its own priority framework, in consultation with the department, and had sole responsibility for promotion of the funding round, receiving applications and assessing applications before choosing the 22 posts to be funded.

Using the ACEM model as a starting point, a more streamlined, college-based process could work in the following way:

| Step 1 | The department, in consultation with state and territory health departments, and the specialist medical colleges determines the guidelines for allocating STP-funded posts, with consideration of workforce planning.
|        | The department would determine the number of posts to be allocated to each college in line with projected shortfalls of specialists in the medium term.
| Step 2 | The college and the department enter into agreements to provide STP funding for a set number of posts that will be selected by the college.
| Step 3 | State and territory health departments provide advice to the colleges on areas of need.
| Step 4 | The settings apply to the specialist medical colleges for posts. A setting may have to make multiple applications to different colleges depending on the posts it is seeking to have filled.
| Step 5 | The college determines what posts should receive funding, in accordance with the criteria set by the department and advice from state and territory governments. A Reserve List is also created to enable colleges to replace posts that are not able to recruit trainees.
| Step 6 | If a post is not filled, where possible the college promotes an application from the Reserve List.

Under this approach the department would retain overall policy and oversight responsibilities for the STP. Further, settings would have a greater role in advocating for
more training. The specialist medical colleges, as well as their training roles outlined above, would have responsibility for:

- managing the relationship with health care settings directly;
- addressing the geographic imbalances in training;
- increasing the use of private settings for training;
- facilitating long-term placements in rural and regional settings; and
- developing processes to allow trainees to complete their specialist training in rural areas.

As noted in the earlier discussion of funding, one of the strengths of the current STP selection model is that settings are the main determinant of their own training needs. It is the settings that advise the colleges what training is needed and seek the colleges’ accreditation of the posts, effectively “pushing” them to make those decisions. Settings would continue this level of input under the college-based model.

### 3.3.2 Placement of training posts

In 2014, a Western Australian study of graduates from the Rural Clinical School of Western Australia (RCSWA) found that graduates from urban backgrounds who spent a year at the RCSWA were nearly four times more likely to be working rurally up to 10 years post-graduation than those not exposed to the RCSWA. This and other similar studies showed that participants in the Rural Clinical Training and Support (RCTS) Programme from rural areas were significantly more likely to practise in rural after completing their training.

While these studies do not prove conclusively that trainees who undertake rotations in rural areas would practise in rural areas after qualifying, they could be seen as strong indicators of a link between trainees having experience in rural areas and their decision to practise in a rural area. The Western Australian study also provides support for the benefits of longer rotations in rural settings.

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Questions:

20. Considered as a whole, does the present system of selecting training posts for STP funding promote the aims and objectives of the STP?

21. What changes, if any should be made to the present system of selecting training posts for STP funding? Particular attention should be paid to changes that would make the system simpler and more responsive to the workforce needs of the broader community, as indicated through increasingly better workforce projections overseen by the National Medical Training Advisory Network.

22. Are changes necessary to any particular aspects of the present system of selecting training posts for STP funding, as opposed to the system as a whole?

23. If so, what are those aspects of the present system and what changes should be made?

3.3.3 Trainees of an Aboriginal or Torres Strait Islander background

The Australian Indigenous Doctors Association estimates there are 204 doctors of Aboriginal or Torres Strait Islander origin. Anecdotally, a very small percentage of specialist medical trainees are Aboriginal or Torres Strait Islander peoples. These numbers suggest there is a need for identified training positions for trainees from an Aboriginal or Torres Strait Islander background.

At present colleges are not required to keep such statistics, however, without accurate information on the number of trainees of Aboriginal or Torres Strait Islander background and where they are undertaking their training, it is difficult to know whether they should have identified training positions, where they should be placed and how this might work. Using the STP to promote the number of Aboriginal or Torres Strait Islander trainees is discussed in more detail in Section 4.3 below.

Questions:

24. Are identified training positions for registrars of Aboriginal or Torres Strait Islander background required?

25. If so, how should such a project be implemented?

26. Should colleges be required to keep statistics on the number of specialist medical trainees of Aboriginal or Torres Strait Islander background and where they are undertaking their training?

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3.4. Reporting by colleges and settings

Since 2012, STP agreements have required specialist medical colleges to report to the department against KPIs which were developed in consultation with the colleges.

Key Performance Indicators

A. Contracts in place for all existing STP posts.
B. Contracts for new STP posts under development as soon as Agreement with the Department is formally varied.
C. Maximise opportunities for funding by minimising vacancies.
D. Number of posts in expanded health care settings.
E. Strategic support projects increase trainees’ and specialist international medical graduates (SIMGs) access to appropriate training.
F. All STP posts are appropriately accredited for training.
G. Trainees rotate through network.
H. Evidence of STP training linking with state/territory training.
I. Representation at regular meetings with STP Participants and the Commonwealth. Meetings/teleconferences following acceptance of progress reports by the Commonwealth.
J. Data about STP post activities is to be reported to the Department in line with reporting requirements and when requested, using e.g. spreadsheets that are provided and reporting on KPIs.

The ANAO Report 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 programme.

Attachment C: Key performance indicators was prepared by the ANAO and sets out the KPIs, how they are reported and how they are linked to one of the desired outcomes of the STP. The ANAO further found that most reporting against the KPIs was generally on time and that whilst the settings did not find the requirements excessive, there were some inconsistencies in the information reported. This is thought to be as a result of KPI definitions and interpretation, which colleges have sought clarification on from the department from time to time.

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31 ANAO Report, March 2015, p. 86.
Inconsistent interpretation of the KPIs makes it difficult for the department to evaluate the success, or otherwise, of the STP. As noted above, the KPIs were prepared in consultation with the specialist medical colleges, which ideally would have reduced the risk of misinterpretation. To remedy this situation going forward, the KPIs should be more clearly defined and discussed, to create a shared understanding of the terms, supported through a working party convened to draft a glossary.

KPIs should be designed to extract information that allows the department to determine whether STP funds are being used appropriately and effectively and whether the STP is meetings its stated aims. However, some current KPIs may not be useful in informing this. For example, one of the KPIs asks colleges to state the “number and percentage of trainees who passed all training requirements while in an STP post” (See Attachment C2: Blank Progress Report form). In response, one specialist medical college stated that it could not respond as it does not record whether trainees have passed rotations until after the rotation had ended. Also, some indicators may be redundant, such as reporting that all posts have to be appropriately accredited for training, as this is a prerequisite for all STP-funded posts.

Questions:

27. Are the key performance indicators against which colleges must report clear, reasonable and relevant?

28. If not, in what ways could they be improved?

3.5. Private Infrastructure and Clinical Supervision Programme

As stated above, the PICS element of STP funding is made up of two elements:

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

Where the post is not a full FTE, the contribution is paid on a pro rata basis.

The PICS programme:

... 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.\(^33\)

It was developed in 2010 following stakeholder feedback on ways of improving the training of specialists in the private sector, through the Enhanced Medical Education Advisory Committee (EMEAC). The EMEAC was established in June 2007 to provide the department with expert advice on medical specialist training programmes in non-traditional settings. Its design reflects sensitivities common at the time; that private sector costs are not separately

\(^33\) STP Operational Framework, January 2013, p. 8.
funded under health care agreements between the Commonwealth and the states and territories. PICS payments became a means of encouraging private sector settings to apply for posts in the STP.

As with the STP, policy control of the PICS programme resides with the department. The PICS programme is administered by the Royal Australasian College of Medical Administrators (RACMA), rather than the specialist medical college relevant to the post. This was considered appropriate, as this new, targeted funding element did not fit neatly into the other agreements, as well as being administratively convenient. In most cases this model necessitates the department entering into two agreements in relation to the same post: one with the college administering the post, the other with RACMA for its management of the PICS contribution. In its most recent report to the department, RACMA advised that it has 176 funding agreements in place for 385 training posts in eligible PICS settings.

This model can be contrasted with the STP system for rural loadings. Both payments supplement the STP contribution to a trainee’s salary and both are designed to support training in an expanded setting, however, rural loadings are administered by the relevant specialist medical college.

RACMA’s most recent report to the department indicates that occasionally a post in a public setting is replaced by a post in a private sector setting, or vice versa. The new post may also be in a different RA category. RACMA advises that it sometimes is not made aware of these changes till after the PICS budget has been set. Consequently, the post may become eligible for a PICS contribution, which previously had not been budgeted for, in turn affecting RACMA’s STP budget.

Anecdotal evidence provided to the department indicates that some settings have used the clinical supervision funding for recruitment costs, while others have used it to train supervisors. This is not necessarily inappropriate, as the Operational Framework and the agreement between the department and RACMA to administer the PICS programme does not specify how PICS funding is to be used. The agreement contains a general requirement that RACMA should “achieve the specific aims” of the PICS programme and the STP.

It was the department’s expectation that the clinical supervision component of PICS funding would be used to compensate supervisors for lost income suffered when they are engaged in supervising trainees and so unable to see patients. PICS supports the STP objective of promoting the placement of trainees in private sector settings, however, the department is obliged to ensure that the Government is receiving value for money from the programme. Consideration should be given to whether the present system is unduly complex and redundant and whether its administration costs are too high. There are several possible ways the management of the PICS programme might be simplified and costs reduced, which could be applied singly or in combination:

- the uses to which contributions can be put could be made clearer;
- decisions on the use of the clinical supervision component of PICS funding could be left to the discretion of the person supervising the trainee. The reasoning is, if PICS funding is intended to be used as compensation to a specialist for lost income, it is, in effect, a form of salary and as with any salary payment, it is a matter for the supervisor what he or she wishes to do with their own money;
- the clinical supervision and infrastructure components of funding could be combined to make one funding element, paid annually and on a pro rata basis, at the beginning of the agreement; and
• the management of a PICS funding contribution could be placed in the hands of the specialist medical college that administers the post, creating a more streamlined decision-making process and remove the need for two agreements, as is the case with the rural loading.

Questions:

29. Do the present uses to which PICS payments are put promote the aims and objectives of the STP?

30. What improvements, if any, could be made to the present system for administration of the PICS programme? Particular attention should be paid to the system for calculating PICS payments and the guidelines for the use of PICS funds.

3.6 Specialist International Medical Graduates (SIMGs)

One of the aims and objectives 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.  

International medical graduates play a significant role in the delivery of health care in Australia, especially in areas of identified workforce shortages. The Australia’s Future Health Workforce – Doctors report noted that “51 per cent of general practitioners working in outer regional areas being overseas trained.” While noting that NMTAN has adopted the principle that doctors who train in Australia should be given first preference in training positions, the report made it clear that:

Any measures that actively restricted medical migration would need to be counterbalanced with policies that facilitated the domestically trained workforce fulfilling the geographical distribution requirements.  

In reviewing the STP, therefore, the role of SIMGs in addressing shortages in remote and regional areas, must be taken into consideration, especially as this is currently one of the aims of the programme. These issues are covered in more detail in Health Workforce Australia 2014: Australia’s Future Health Workforce – Doctors.

Any proposals dealing with SIMGs must, of course, be careful not to be discriminatory. In 2014, the ACT Civil and Administrative Tribunal found that the ACT government had both directly and indirectly discriminated against an international medical graduate (though not a

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34 STP Operational Framework, January 2013, p. 3.
specialist) by placing his application for internship in the lowest category for consideration - Applications from SIMGs.37

Questions:

31. Should special measures be put in place to address the role of specialist international medical graduates in the STP programme?

32. If so, what should those measures be?

37 Wang v Australian Capital Territory (Discrimination) [2015] ACAT 5, ACT Civil and Administrative Tribunal. A final decision on whether the ACT Government acted reasonably has not been made as at 20 June 2015.
Part 4. The future of the STP

4.1 The design of the STP

If the aim of the STP is to have more training posts in rural and regional areas and in expanded settings, consideration should be given to changes to the design of the programme that promote that aim. Three options to do this are discussed below, though others may, of course, be possible.

4.1.1 Regular review of STP posts

From the programme’s inception in 2010 until 2014, a round of applications for STP funding has been conducted each year. Until the target of 900 posts was met in 2014, this approach gave the programme flexibility, as the commencement of new STP posts allowed it to be responsive to the training needs of the community and the health system. However, with the programme meeting its maximum number of posts, this flexibility no longer exists.

One way in which flexibility could be restored, without increasing the number of posts, is for there to be regular reviews to determine whether the current allocation of posts to colleges and settings is optimal. At present, once a post has been allocated it effectively becomes an ongoing post. Little consideration seems to be given to whether the speciality still requires that post or if there is a greater need for the post in another setting, whether in the same speciality or in another one.

The reconsideration of posts to ensure their better allocation is in line with the Minister’s statement that the review will “focus on in depth workforce planning”.

One suggested approach to any review would be to conduct a two-level analysis. The first, “higher-level”, analysis would address the allocation of posts to colleges. As noted in Section 1.2: About the review, one phase of the review will be data modelling to develop a potential methodology for the allocation of training posts to colleges, which will particularly focus on shortages in specialties in the future. The secondary-level analysis would be a review of the mix of training settings with consideration of whether the geographical placement of training posts is appropriate.

In terms of its scope, it seems sensible that the review of posts should include the 360 legacy posts that are holdovers from pre-STP programmes, as well as those posts created under the STP, otherwise the benefits of reconsideration would be reduced by around a third. Administratively, if reviews are undertaken, it is probably not practicable for all 900 posts to be reconsidered at the one time. The triennial review of posts is considered reasonable, so that all posts would be reviewed, in batches, over a three or five year period.
Questions:

33. Should there be a regular review of training posts to ensure they represent the optimal use of STP funds?

34. Should that review apply to all training posts or some?

35. If so, how should those reviews be conducted, what should be their focus and how often should they occur?

4.1.2 The length of rotations in training posts

The length of a rotation in a training post can vary greatly between settings. Reporting by specialist medical colleges to the department suggests that it is not uncommon for trainees to engage in short-term rotations of six months or less. For example, in 2014, 434 posts had two or more trainees during the year, with those posts recording a total of 1,118 trainees.

There are two questions that should be asked about the effect of rotations of six months or less:

A. Do they provide sufficient opportunity for a trainee to experience a rural or remote setting?

B. Do they provide a strong enough incentive for a trainee to move to a rural setting, compared to the guarantee of a longer period, such as twelve months?

If the answer to both of those questions is “No”, it may provide evidence that short rotations hinder the STP meeting one of its overall aims: to foster trainee specialists working in rural and remote areas and areas of workforce shortage with a view to their working in those areas once fully qualified.

The length of a placement and how it may affect training of specialists was raised by the Mason Review:

The program has also generally only supported one year placements for registrars and, under its current structure, has somewhat limited potential to provide a genuine solution to the need to construct clear and coordinated training pathways for graduates interested in pursuing rural careers. While health care settings that successfully apply for an STP place gain a registrar, the impact on long-term workforce recruitment of trainees has not yet been demonstrated and is likely to be reduced by the relatively short-term nature of most STP posts.

The stated goal of the STP was to have 900 training posts in place by 2014. Though 900 posts have been allocated, not all have been taken up. The attractiveness of short rotations may well have been a factor in the willingness of trainees to accept a post in a rural and regional area. However, it is suggested that the question that should probably be asked is:

Does having 900 posts take precedence over the wider aims of the STP?

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38 The Mason Review, April 2013, p. 96.
The review should consider what effect increasing and/or standardising the length of rotations in rural and regional settings is likely to have on the take up of posts in those areas. It may act as an in-built, pre-selection screen for suitable trainees. That is, a trainee who accepts a longer placement in a rural or regional setting may be the one that is most keen on working in those places once he or she attains fellowship. If this resulted in fewer posts being filled, the money saved could be used to fund a larger contribution to the salary of trainees, in turn making postings in rural and regional and expanded settings more attractive.

As noted above (see Section 3.3.2: Placement of training posts) there is evidence of a link between trainees having experience in rural areas and their later practising in rural areas, as well as support for trainees being given longer rotations in rural settings.

The possible clinical effects, positive and negative, of having trainees spend longer periods in rural and regional settings should also be examined. It may be that the evidence shows that it would be detrimental to the health system if mandating rotations of six months or more mean that fewer trainees took up posts in rural and regional settings. It may also inhibit the trainees’ development if they do not experience a variety of settings.

Questions:

36. Would mandated longer rotations in rural and regional areas and in expanded settings promote the aims of the STP better than the present system?

37. If so, how long should rotations be?

38. Are there any clinical concerns that might arise from longer rotations in rural and regional areas and in expanded settings?

4.1.3 Tying funding to rural and regional placements

A possible change to the design of the STP that could be used to promote its aims is to tie funding to a requirement that at least a significant part of the training take place in a rural or regional setting. To be most effective the funding would follow the trainee through his or her postings, rather than the funding remaining with the post. This is not to suggest that a lengthy placement in a metropolitan setting may be essential to the training of a specialist, just that the one of the aims of the STP is for training to take place in rural and regional areas and expanded settings.

One model for such a change can be found in the Australian General Practice Training (AGPT) programme. The AGPT is:

[a] postgraduate vocational training programme for medical graduates wishing to pursue a career in general practice and/or rural and remote medicine in Australia.39

Registrars accepted for AGPT funding are expected to train in varying locations, including rural medical centres that service Indigenous communities or people from socially

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disadvantaged groups. Where the AGPT model differs from the STP model is that the funding follows the trainee throughout his or her training.

An alternative way of implementing this might be to split the STP, so that a portion of the total funding goes toward funding full fellowships that are tied to rural placements.

The Mason Review made the following comment in relation to specialist training in Australia:

> Although widely regarded as a successful initiative, as discussed above there is no clear pathway for graduates interested in working in the type of settings supported by STP (i.e. rural and private) to enable them to plan to undertake placements in this program. This problem persists beyond STP and the lack of structured pathways into vocational training outside general practice is often cited as an issue by junior doctor representative groups.40

As noted above, the distribution of STP posts is based on need, as identified by state and territory health departments and in accordance with the Priority Framework developed by the department, in conjunction with stakeholders. Tying funding to rural placements could be seen as one way of developing effective rural training pathways.

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Questions:

39. Would tying funding to a requirement that a trainee undertake a placement in rural and regional areas promote the aims of the STP better than the present system?

40. If that system was implemented, should it be coupled with the funding following the trainee through his or her placements?

41. Are there any clinical concerns that might arise from the implementation of such a system?

42. Is it possible to “base” more training posts in rural and regional “hub” centres, so that specialists can perform most of their training outside metropolitan hospitals?

43. If so, would such an approach be feasible for some specialties and not others?

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40 The Mason Review, April 2013, p. 11.
4.2 Indexation

The Mason Review recommended that the STP “should provide indexed funding for its training posts.” It concluded, correctly, that, under present arrangements, funding may be fully committed by 2014, noting “it will be difficult for the program to continue to extend specialist training into new settings without further resources.”

Considering the future of the health system as a whole, the Mason Review commented:

Even if substantial reform is undertaken, it is likely that the increasing demand for health services will result in a shortage of doctors and nurses [which] has consequences for government policy in terms of training, information, role reform and incentives used to encourage a more even distribution of health professionals across Australia.

Any increase to programme funds, and the amount of any increase, is not set. The Commonwealth 2015 Budget forecast Consumer Price Index (CPI) growth over the four years of the forward estimates of 2.5 per cent. Where a programme is indexed, the level is generally assumed to be less than CPI. Accordingly, for the purposes of this Discussion Paper an indexation rate of 1 per cent has been assumed. Further, government priorities may change and any potential funding may be allocated to other budget initiatives. Very few health grant programmes are currently indexed. This operates like an “efficiency dividend”, requiring services to be delivered more efficiently over time and harvesting the community’s share of this efficiency.

Table 8 (over page) looks at the possible effect on the STP, if it were to be indexed. For the purposes of this Discussion Paper, it is assumed that:

- the programme is indexed at a rate of 1 per cent per annum;
- this is the only increase to the total amount of the pool;
- changes to the STP arising from the review being in 2017, so that the first year in which indexation applies is the 2018 academic year; and
- the amount available for salary support is $90,000,000, plus indexation.

The table shows:

- Column A: The academic year;
- Column B: The total amount available in the salary support fund in each of the academic years shown, indexed at 1 per cent commencing in 2018;
- Column C: The amount of the salary support contribution per post, if it is indexed at 1 per cent and the number of posts is capped at 900;
- Column D: The number of training posts that can be funded if the salary support contribution is capped at $100,000;

41 The Mason Review, April 2013, p. 96.
42 The Mason Review, April 2013, p. 72.
44 For example, the Wage Cost Index could be used, rather than CPI.
45 This figure is used for illustrative purposes. For ease of calculation it is based on there being 900 posts, each receiving a salary contribution of $100,000.
- Column E: The amount of the salary support contribution per post, if it is indexed at 2.5 per cent; and
- Column F: The number of training posts that can be funded if the salary support contribution is as per Column E but the salary support fund is as per column B.

<table>
<thead>
<tr>
<th>A. Year</th>
<th>B. Salary support fund indexed 1 per cent</th>
<th>C. Salary support contribution ($100,000) indexed at 1%</th>
<th>D. Number of posts that could be funded (B ÷ $100,000)</th>
<th>E. Salary support contribution ($100,000) indexed at 2.5%</th>
<th>F. Number of posts that could be funded with 2.5% indexation (B ÷ E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$90,000,000.00</td>
<td>$100,000.00</td>
<td>900</td>
<td>$100,000.00</td>
<td>900.00</td>
</tr>
<tr>
<td>2018</td>
<td>$90,900,000.00</td>
<td>$101,000.00</td>
<td>909</td>
<td>$102,500.00</td>
<td>886.82</td>
</tr>
<tr>
<td>2019</td>
<td>$91,809,000.00</td>
<td>$102,010.00</td>
<td>918.09</td>
<td>$105,062.50</td>
<td>873.85</td>
</tr>
<tr>
<td>2020</td>
<td>$92,727,090.00</td>
<td>$103,030.10</td>
<td>927.27</td>
<td>$107,689.06</td>
<td>861.06</td>
</tr>
<tr>
<td>2021</td>
<td>$93,654,360.90</td>
<td>$104,060.40</td>
<td>936.54</td>
<td>$110,391.28</td>
<td>848.38</td>
</tr>
</tbody>
</table>

Table 8: Effects of indexation of salary support contributions at 1 per cent and 2.5 per cent

Based on these assumptions, particularly that there will be no or only a modest increase in the amount of STP funding available for salary support, Table 8 shows that even indexation to allow the STP contribution to salary to keep up with forecast CPI growth would lead to a significant reduction in the total number of posts.

Increasing the salary support element of STP funding is one way of achieving the aim of encouraging trainees into rural and regional and private settings. The same goal might also be achieved by using any additional funding gained from indexation to increase rural loading funding by a fixed amount, rather than to index STP salary support. This may still create a shortfall that has to be addressed from other STP funds, but it would also result in greater certainty about the amount to be covered by the setting. It should be remembered that STP funding has never been intended as a full payment of the cost of training a specialist, but rather it is a contribution to that cost.
Questions:

44. What would be the likely effect of indexation of the STP funding contribution on the availability of trainee posts?

45. If indexation resulted in fewer training posts, would this be an acceptable trade-off?

46. If indexation resulted in fewer training posts being available, what changes, if any, should be made to address the shortfall, assuming additional funds is not available in the future, such as reducing payments for support projects or for costs associated with administering the STP?

4.3 A dedicated Aboriginal and Torres Strait Islander traineeship

The challenges facing Australia in relation to Aboriginal and Torres Strait Islander health are well known. On 29 October 2014, the Assistant Minister for Health, Senator the Hon. Fiona Nash, when announcing the Government’s $3.1 billion commitment to Indigenous health funding for the next four years, stated:

Several recent studies have found that the contribution of Indigenous health workers in tackling diabetes, mental illness, maternal and infant care and palliative care have made a real difference to the health and wellbeing of many Indigenous people …

Without Aboriginal and Torres Strait Islander Health Workers, the gap in the health outcomes between Aboriginal and Torres Strait Islander people and other Australians would be ever wider than it is today.46

On this subject, the Mason Review stated:

The most significant health workforce issue, particularly in the area of general practice medicine, is not one of total supply but one of distribution, which is to say inadequate or non-existent service provision in some rural and remote areas, and to populations of extreme disadvantage, most particularly the Aboriginal and Torres Strait Islander communities and some outer metropolitan communities. 47

The Australian Indigenous Doctors Association states there are currently approximately 204 doctors of Aboriginal or Torres Strait Islander origin. 48 For comparison purposes, 76 653 registered medical practitioners were employed in the medical workforce in 2012.49

Anecdotally, an even smaller percentage of specialist medical trainees are Aboriginal or Torres Strait Islander peoples. It is open to the Government to use the STP to address this


47 The Mason Review, April 2013, p. 6.


situation, at least in part. It can do this by earmarking funding for indigenous specialist training and/or by establishing benchmarks for indigenous training places that colleges and settings can work towards.

STP funding is granted on the basis of individual training posts. However, the Operational Framework states “training posts can be designed to support individual trainees through their full fellowship program, particularly in rural and regional areas.” It, therefore, may not be inconsistent with the intention of the STP for a college to seek funding for the training of a specific specialist.

If that is the case, the department could determine that its overall health workforce strategy would benefit from it making the funding of traineeships for a person of Indigenous background a priority. Accordingly it could earmark a suitable amount of STP funds for a post of that nature. This could be a contribution of the trainee’s full salary or a partial contribution. A traineeship of that nature appears consistent with the STPs objective “to supplement the available specialist workforce in outer metropolitan, rural and remote locations”. The application would, of course, have to meet the usual considerations for funding, as set out above.

The STP 2014 Priority Framework states:

The Department and its assessment partners will give preference to posts which demonstrate … their capacity to be filled with Indigenous trainees.  

Questions:

47. Assuming all other selection factors are satisfied, would using STP funds to provide for the complete training of an Aboriginal or Torres Strait Islander specialist be consistent with the aims and objectives of the STP and why?

48. Should similar consideration be given to funding the complete training of a specialist from any other section of the community, for example, a trainee from a rural or remote background?

49. If so, why and what sections of the community should be considered?

4.4 Supporting cultural safety

Cultural safety is important in creating an effective and responsive medical professional. A recent presentation by STP funded trainees at a college conference highlighted the importance of cultural safety in working with Indigenous patients. The STP does not require cultural safety training to be provided to trainees and it does not provide funding for cultural safety programmes.

Cultural safety education has been defined as:

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50 STP Operational Framework, January 2013, p. 5.
An understanding of how a person’s culture may inform their values, behaviours, beliefs and basic assumptions…. [It] recognises that we are all shaped by our cultural background, which influences how we interpret the world around us, perceive ourselves and relate to other people.52

However, an understanding of cultural safety training should not be restricted to “awareness”. Training should also involve understanding of providing culturally appropriate care to people of other religions, races, socio-economic background and with mental health issues.

The department, universities and a number of specialist medical colleges already provide aspects of cultural training for specialists and trainees. For example, the Royal Australian College of General Practitioners and Mental Health Services both promote Indigenous cultural awareness training and the Australian College of Dermatologists has introduced a mandatory education module on Indigenous health as one of its STP-funded support programmes.

Cultural safety could be promoted through a dedicated support programme. This could be made more efficient if the support programme is prepared by one specialist medical college but made available to all colleges. The recent Curtin University work to inform culturally safe curriculum for health students can also be provided to colleges for this purpose.

Questions:

50. Should cultural safety training be made a compulsory component of training of a registrar in an STP-funded post?

51. If so, how should cultural safety training be delivered? Should it be part of an STP-funded support programme, an aspect of training at the setting or should that question be left to specialist medical colleges, universities or settings?

52. What, if any, would be the implications of such a change to the STP system as a whole?

4.5 Innovative approaches to changes to the STP

As noted above, the department is seeking input from stakeholders on innovative reforms to the STP that go beyond those raised in this Discussion Paper.

Below are just two examples of innovative approaches that have come to the department’s attention.

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52 Centre for Cultural Diversity in Ageing [available at Cultural Diversity website] quoted in Cultural awareness education and cultural safety training, the RACGP National Faculty of Aboriginal and Torres Strait Islander Health, April 2011, available at Royal Australasian College of General Practitioners (accessed 11 May 2015).
Case study 1: A suggested approach to funding Indigenous trainee positions from the Australasian College of Dermatologists

In consultation with indigenous groups, the Australasian College of Dermatologists (ACD) established a training position for an Aboriginal or Torres Strait Islander person that was filled in 2015. The position is presently located in Victoria.

During negotiations for STP funding for 2016, the ACD suggested that funding should be tied to a roving first year indigenous training position, rather than to an ongoing training position at a particular facility. This would not be an additional training position, but would be one of the college’s existing 27 posts.

If the ACD continues to receive STP funding support for this roving position from 2017, it is its intention that it would be moved to a new jurisdiction each year.

In keeping with the Australian Medical Council’s Accreditation Standards, the Indigenous trainee would not be offered a position unless the ACD can guarantee four years of funding and training. The first year of training would be supported by STP-funds and the other three years may be funded through the public hospitals, though this depends on what facility the trainee is allocated to.

The ACD argued that this approach would:

- allow indigenous doctors not living in the same state as the original STP position to apply for a traineeship in their home state;
- give all states equal access to a trainee; and
- ensure trainees learn and work closer to their home communities.

The College has outlined that funding being tied to an individual would result in only one Indigenous trainee being funded over a four year period. Associating funding with the individual would also necessitate multiple transfers of funds, as trainees rotate through positions during the four years of their training.

The ACD has used support programme funding to create an education module on Indigenous health and culture. The module is mandatory for all trainees before they can attain a fellowship with the college. It has also prepared context-specific, cultural competency training for SIMGs. As well as online learning modules, the training involves an e-group, meetings, webinars and a mentoring programme. It should be noted that this mix of training support programmes is not unique among specialist medical colleges.
Case study 2: Use of a trainee in an RA3 setting

A specialist working in an RA3 setting has suggested that STP funding be used to support a full training post in that setting and in nearby towns for the full five years it takes for a trainee to attain college fellowship.

At present, the setting has two trainees. One is STP-funded, the other is state-funded. The state-funded trainee is required to live in the state capital and commute to the setting for a six month period.

The specialist believes that this system reduces the chances of the trainee remaining in a rural setting after he or she has attained fellowship, as research shows that undergraduate and post-graduate training in a rural or regional setting improves retention in those areas (see Section 3.2.3: Classification of settings). In his view, an STP funding commitment would enable the position to be viable. Further, he argues that the existing six month rotations were insufficient, giving trainees only “an experience” of rural practice.

The specialist acknowledged that some training has to take place in the capital city, however, he argues the trainee would swap with another STP-funded trainee in the capital when it returned there to complete its training.
Part 5. The Emergency Medicine Programme

5.1. The history of the Emergency Medicine Programme

In 2010, the then Government announced the More doctors and nurses for Emergency Departments initiative, which was aimed at increasing the health system’s capacity to train emergency department specialists, nurses and support staff, as well as training general practitioners in emergency medicine.

The Supporting Emergency Medicine Workforce Programme (also known as the Emergency Medicine Programme or EMP) is an initiative that seeks to improve emergency department medicine by expanding training capacity for doctors to become fellows of the Australasian College for Emergency Medicine (ACEM), upskilling a range of emergency care workers and growing the number of front line emergency service deliverers. The three major elements of the EMP are:

- The emergency medicine training programme (the Training Programme), which funds training posts for doctors wishing to become fellows of ACEM. The Training Programme is established and governed by a funding agreement between the department and ACEM, entered into in 2011. The Training Programme’s aim is to “improve the supply of suitably qualified staff in the Australian emergency medical workforce.”

- The Emergency Medicine Education and Training programme (EMET), which enables ACEM Fellows to deliver training in emergency departments to non-specialist medical staff, particularly in regional and rural areas. The aim of the EMET project is to boost the quality of care and increase access to emergency services for people living outside of urban areas.

- The Emergency Department Private Sector Clinical Supervisor programme (the EDPSCS), which supports the specialist training in private hospitals. The EDPSCS programme was established in 2011. The EDPSCS is administered through agreements between the department and the 10 private hospitals employing clinical training supervisors or staff specialist training coordinators.

The Training Programme and EMET are administered through a funding agreement between the department and ACEM. Other, minor elements of the EMP that are supported through the ACEM funding agreements include:

- support for the training and upskilling of SIMGs working in Emergency Departments; and
- promotion and support of Emergency Medicine Certificate and Emergency Medicine Diploma courses to non-specialist doctors working in Australian emergency departments.
5.2 The Training Programme

The Training Programme was introduced “to progressively reduce emergency department waiting times - with waiting times capped at four hours”. Its objectives, set out below, are stated in the funding agreement entered into between the department and ACEM in 2011:

The objectives and outcomes of the Program are to:

- deliver up to 270 fully trained emergency medicine specialist doctors over the next decade;
- boost training and supervision capacity in up to 129 public emergency departments nationally;
- provide greater capacity to train and upskill overseas trained doctors working in Australian emergency departments;
- provide increased capacity to build the Participant’s Certificate of Emergency Medicine course nationally; and
- provide support for the establishment of more emergency medicine specialist training positions in rural and regional areas of Australia by providing a rural loading incentive that will be available for up to fifty percent of the new emergency medicine specialist training positions funded under this Program.

Under the Training Programme, ACEM has been funded to deliver an additional 22 emergency medicine specialist training posts each year. The number of training posts funded has now risen to its capacity of 110 annually in 2015. With the addition of period funded posts (that is, those supported for limited periods with funds from surplus cash in the funding agreement), this has risen to 128 FTEs. As with the STP, Training Programme funding consists of salary support of $100,000 per annum per post, plus a rural loading of up to $20,000 per annum per post. These elements are pro-rated for non-FTEs.

In its latest progress report to the department, ACEM advised that as at 30 June 2015 it had filled 108 FTEs out of 128 available FTEs, including partially filled training positions. As with the STP, the Training Programme 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 rounds.

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Table 9 is based on statistics provided by ACEM. It shows that, as at the end of the 2014 academic year, a very small percentage of Training Programme funded training posts are in RA-4 and RA-5 areas. Those statistics also indicate that 70.3 out of 93 FTEs (75.6 per cent) were in public sector settings, with 22.7 FTEs in private sector settings.

5.3 Training Programme elements

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

- a contribution to the trainee’s salary;
- a rural loading to support posts in RA2 – RA5 categories;
- a payment to the college for the cost of administering a post;
- a payment under the Private and Infrastructure Clinical Supervision (PICS) programme for clinical supervision; and
- a payment under PICS to support infrastructure upgrade needs of private sector providers.

Under the STP, colleges are provided with support projects funding on a per post basis. However, this funding was not included in the original ACEM funding agreement, but some support projects are now funded through the college using surplus cash for this purpose.
As similar funding elements apply to both the Training Programme and the STP, it is likely the same issues arise in relation to each. Interested stakeholders should also examine those parts of this Paper and consider the questions asked there.

5.4 Administration of the Training Programme by ACEM

As noted above, the Training Programme is administered through a funding agreement between the department and ACEM.

Prior to the 2015 funding round, applications for Training Programme posts were considered by the department in the same way it considered applications for STP training posts. For the 2015 round, ACEM assumed a greater role in the administration of the programme, in accordance with the Funding Agreement.

While the department retains 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 Training Programme does not operate under an Operational or a Priority Framework.\(^{54}\) The prime reason for this is that only one specialist medical college is involved in its operation, making a separate, overarching Operational Framework and Priority Framework unnecessary. Consequently, the aims and objectives of the programme, its governance rules and other important administrative matters are set out in the funding agreement between the department and ACEM and the Deeds of Variation entered into from time to time. Nonetheless, some benefit may be gained from frameworks that sit outside the funding agreement, setting a course for the Training Programme.

5.5 Integration of the Emergency Medicine Training Programme with the STP

There are a number of noticeable similarities between the Training Programme and the STP:

- both are responsible for training specialists;
- the contribution towards a trainee’s salary, the rural loading, funding for administration and access to the PICS the same for both programmes;
- they are administered by specialist medical colleges under an agreement with the department;

\(^{54}\) The STP Operational Framework and the STP 2014 Priority Framework can be found at the department’s website at [Specialist Training Programme website](#).
• policy and overall management control of them lies with the department; and
• prior to 2014, the training programme was, by and large, administered in conjunction with the STP, using the STP Operational Framework and priority settings.

There are also some differences between them:
• ACEM has a greater role in the administration of the programme, as outlined above; and
• the Training Programme is not as focussed on expanding training to rural and regional and private sector settings as the STP.

It is suggested that, at a minimum, the integration of the Training Programme and the STP into one programme would require the creation of:
1. a single governance model with a new Operational Framework and Priority Framework that would apply to the new combined programme; and
2. a single fund, which would be distributed according to the single governance model.

Integration would most likely involve the retention of some aspects of the STP and some aspects of the Training Programme that would apply to the single, new programme. It would also mean all training posts—the 110 training programme FTEs and the 900 FTEs in the STP—would be considered in the same process under the same operational and priority frameworks.

Some significant advantages that could be gained from integration include the creation of a single application process, the removal of inconsistencies between the treatment of training posts in different specialities, and improvements to the programme’s ability to address areas of identified workforce shortage.

Questions:

53. What would be the benefits and detriments to the Emergency Medicine Training Programme if it is integrated with the STP?

54. Would there be benefits for the STP in adopting some aspect of how the Emergency Medicine Training Programme is delivered?
Attachments

A. Specialist Training Programme (STP) Operational Framework (January 2013)
B. STP Priority Framework
C. Key Performance Indicators
D. Questions asked in this Discussion Paper
ATTACHMENT A: Specialist Training Programme (STP) Operational Framework

Specialist Training Programme (STP) Operational Framework
Created June 2012 (Updated January 2013)

Introduction
The delivery of well-supervised, high quality specialist training opportunities is a partnership 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 Programme (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 Programme (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 and Ageing 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 Programme (ESTP);
b. the Outer Metropolitan Specialist Trainee Programme (OMSTP);
c. Advanced Specialist Training Posts in Rural Areas (ASTPRA);
d. the Pathology Memorandum of Understanding (Path MoU);
e. the Overseas Trained Specialist Upskilling Programme;
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 Programme”. This provided resources to increase the number of specialist training places to be made available under the Programme to 900 by 2014, and allowed for resources to support the private sector via a clinical supervision and infrastructure allowance.

Additionally, the funding associated with the medical components of the Government’s “More Doctors and Nurses for Emergency Departments” election commitment that was announced in 2010 is being administered under the STP.

The Australian Government’s 2011 Budget consolidated a large number of health and ageing programs into eighteen larger, flexible funding pools. The purpose is to improve the way the department manages its grants and other programs, reducing red tape, increasing flexibility and encouraging evidenced based funding for the delivery of better health outcomes for the community. From 1 July 2011, a total of 159 predominantly grant programs have been consolidated into 18 new Flexible Funds with Health Workforce initiatives consolidated within the Health Workforce Fund (HWF). The STP is now a component initiative of the HWF. The Government has made a continued commitment to specialist training places as one of the key priorities for the HWF.

**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
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 Programme 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. Evaluation of particular aspects of the program may take place from time to time.

**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 and Ageing:

Oversight of the STP, including delivery of the program by the medical specialist colleges, is the responsibility of the Department.
The Department maintains policy authority in determining the priorities for the annual STP application rounds. It will also be responsible for conducting the application rounds and assessment of applications including the final decision on which eligible training posts are suitable for funding.

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.

The Department will provide information to the public in relation to the Specialist Training Programme and assist with the coordination of applications for funding.

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:

- 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
- Colleges directly engaged under this Programme 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 Sports Physicians (ACSP);
- 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 Programme 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 applications seeking to provide a training post, from the perspective of the availability of registrars to fill the posts identified and areas of workforce need.

Local Hospital Networks provide overall support to specialist trainees participating in the STP with integration between training settings to ensure consistent regional health service delivery.

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.

Programme activities and application rounds
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 2012-15 academic years if they continue to meet the eligibility criteria and the aims and objectives of the STP. Open and/or targeted Application Rounds to identify suitable specialist training posts to add to the overall network will be publicised through the Department’s website. New applications for training places will be sought in an Application Round conducted by the Department in 2013. In 2013, 750 specialist training places will be supported; this will increase to 900 in 2014. The Priority Framework for each application round will be published in conjunction with the application form and Invitation to Apply (ITA) documentation.

Documentary evidence to be submitted with each Application for funding for a training post will be required in relation to:

a. a letter of support, detailing accreditation status of the training post by the relevant College;

b. written evidence of support from the local hospital network, regardless of the location of the proposed training post. If the registrar will be employed in the public health system rotating out to an expanded setting, written confirmation that there is agreement to release a suitable training registrar to fill the post will also be required;

c. other documents may be called for in the assessment of an application for funding as required, for example insurance policies and evidence of medical indemnity arrangements for trainee cover etc.

Reserve Lists

Applicants who meet the eligibility criteria for funding but are unsuccessful will be placed on a ranked 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 this process in consultation with the Department. Applicants who were on an STP Reserve List are encouraged to reapply in a new Application Round ONLY if they meet current eligibility criteria and fall under the current STP Priority Framework. Reserve lists are updated at the close of each application round and will have a validity of one year i.e the 2014 application round Reserve List will be in place from 1 January 2014 to 31 December 2014. Posts which were on previous Reserve Lists will not be automatically included on the new Reserve List unless they have applied in the current round.

Unsuccessful applications

There is no appeals process. Selection decisions are final. Organisations which have been unsuccessful in securing funds for a training post through the Application Round, may seek feedback from the Department. Although the Department has the final decision in relation to funding under the Specialist Training Programme, that decision will have been made on a complex range of considerations. These include the endorsement of a post by both the jurisdiction and the relevant College, as well as the capacity of the application to meet the priorities for the round and the overall level of funds available. At all times the Department will endeavour to provide unsuccessful applicants with comprehensive feedback from all stakeholders to permit applicants to refine future applications.
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. Accredited 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 applying for ongoing funding under the STP at a future date.

Specialist medical college activities include:

a. Management of a set of training posts identified through application rounds 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 Programme;

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 Programme. This will provide 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 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
Specialist Training Section
Health Workforce Training and Distribution Branch
Health Workforce Division
Australian Government Department of Health and Ageing

specialist.training@health.gov.au

Telephone: (02) 6289 9640
Facsimile: (02) 6289 8788

Mail enquiries/submissions:

Specialist Training Programme
MDP 154
GPO Box 9848
CANBERRA ACT 2601
ATTACHMENT B: STP 2014 Priority Framework

STP 2014 Priority Framework
The Specialist Training Programme (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.

A total of 750 posts are funded under the STP in 2013. The STP will support an additional 150 STP places through the 2014 application round, bringing the total to 900 posts that will be receiving funding under the STP.

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

- be accredited or undergoing accreditation by the relevant specialist medical college;
- be supported by the medical specialist college and local health network;
- have a recruitment strategy to ensure a trainee is available to commence training at the start of the 2014 academic year; and
- be a new position representing a genuine expansion of training (not previously filled).

Priority Settings for the 2014 Application Round
The priority settings for the 2014 STP application round are consistent with the 2013 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.

Within these settings, accredited specialist training posts which provide opportunities for registrars to train in priority areas will receive a preference during the assessment process. These are:

- Obstetrics and Gynaecology
- Ophthalmology
- Anatomical pathology
- Diagnostic radiology
- Radiation oncology
- Medical Oncology
- Geriatric medicine
- Psychiatry
- Generalist training – e.g. general and acute care medicine, general paediatrics, geriatric medicine, general surgery, general obstetrics and gynaecology, general pathology, general anaesthetics
- Dual training in general medicine and an additional specialty

The above priorities are largely (but not exclusively) identified through Health Workforce Australia’s *Health Workforce 2025 Volume 3* report and have been considered by the Medical Training Review Panel (MTRP).

**Further Application Weightings**

The Department and its assessment partners will give preference to posts which demonstrate:

- their capacity to be filled with Indigenous trainees (this will require written support from the relevant medical specialist college that the post will have an Indigenous health component and/or there is commitment to support an Indigenous trainee);
- trainee involvement with clinical academic research or teaching junior doctors and/or medical students;
- capacity for an individual trainee to complete the majority (>50%) of training requirements for fellowship in an on-going position in a rural/regional/remote setting i.e. potential to advance from 1st year/basic training to fully qualified. In order to meet training requirements this may include a rotation into a metropolitan setting. In order to support the main priorities for the round, applications which can demonstrate this potential must be in areas of workforce shortage to be given preference.

Notwithstanding the above, additional preferences may be granted for outer metropolitan settings where extraordinary circumstances warrant consideration. Posts which can demonstrate attributes of quality training, a distinct educational imperative and integration with the public specialist training network will be highly regarded.
## ATTACHMENT C: Key Performance Indicators

### Attachment C1: Table of KPIs, Australian National Audit Office, March 2015

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>How this is reported</th>
<th>Link to outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Contracts in place for all existing STP posts.</td>
<td>• Number of posts awarded / filled / vacancy rates.</td>
<td>• Increased number of specialists.</td>
</tr>
<tr>
<td>B. Contracts for new STP posts under development as soon as Agreement with the Department is formally varied.</td>
<td>• Number of trainees trained under STP.</td>
<td></td>
</tr>
<tr>
<td>C. Maximise opportunities for funding by minimising vacancies.</td>
<td>• Ratio of reserve posts: awarded posts that are funded.</td>
<td></td>
</tr>
<tr>
<td>D. Number of posts in expanded health care settings.</td>
<td>• Percentage of STP training that occurs in expanded settings.</td>
<td>• Specialist trainees rotating through an integrated range of settings.</td>
</tr>
<tr>
<td></td>
<td>• Percentage of STP training that occurs in rural settings.</td>
<td>• Better distribution of specialist services.</td>
</tr>
<tr>
<td>E. Strategic support projects increase trainees’ and specialist international medical graduates (SIMGs) access to appropriate training.</td>
<td>• Strategic support projects – timeliness and outcomes.</td>
<td>• Increased capacity within the sector to train specialists.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improved quality of training with trainees and SIMGs gaining appropriate skills not otherwise available through traditional settings.</td>
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<td></td>
<td></td>
<td>• Improved access to appropriate training for overseas trained specialists seeking Fellowship with the College.</td>
</tr>
<tr>
<td>F. All STP posts are appropriately accredited for training.</td>
<td>• Number of accredited STP training posts, compared with number of all training posts.</td>
<td>• Increased number of specialists (Fellows of Colleges).</td>
</tr>
<tr>
<td></td>
<td>• Number and percentage of trainees who have passed all training requirements while</td>
<td></td>
</tr>
<tr>
<td>Key Performance Indicator</td>
<td>How this is reported</td>
<td>Link to outcome</td>
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<td>---------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>G. Trainees rotate through network.</td>
<td>• Number and percentage of STP posts that are part of a training network.</td>
<td>• No specific outcome.</td>
</tr>
<tr>
<td>H. Evidence of STP training linking with state/territory training.</td>
<td>• Number and percentage of STP posts in expanded settings that are integrated with training provided by state health services.</td>
<td>• Specialist training initiatives that complement those currently provided within the States and Territories.</td>
</tr>
</tbody>
</table>
Attachment C2: Blank Progress Report form

ORGANISATION NAME: [name of college]

ACTIVITY NAME: Specialist Training Program (STP)

DELIVERABLE: Progress Report #

REPORTING PERIOD: [eg 1 July 2014 – 31 December 2015]

REPORT DUE DATE:

DATE REPORT RECEIVED:

BACKGROUND: The STP was established through the 2009-10 Budget. The STP consolidates a number of specialist training initiatives funded through the 2006 and 2008 COAG Mental Health and Health Workforce Reform measures. On 15 March 2010 the then Government announced the National Health and Hospitals Network initiative “Expand and Enhance the Specialist Training Program” and new funding for the STP was subsequently included in the 2010-11 Budget. The STP will more than double the number of Commonwealth funded positions available for medical graduates to undertake specialist training in private, community and rural settings from 360 in 2010 to 900 by 2014. In 2014, 12 specialist medical colleges will manage training posts in their respective specialties. Funding associated with the STP is derived from Outcome 12.1, BRE 731, Health Workforce Fund HWF009, Specialist Training Program, and Outcome 11.1, BRE 414 Psychiatry Training Outside Teaching Hospitals.

Currently, all STP Funding Agreements with colleges will continue until December 2015, with reporting requirements extending into February 2016.

The [name of college] is allocated $[amount] (GST exclusive) under Deed of Variation No. 6. The amount of $[amount] (GST exclusive) is payable on assessment and acceptance of this report.
### KEY PERFORMANCE INDICATORS:

<table>
<thead>
<tr>
<th>Progress Report</th>
<th>TARGET</th>
<th>ACTUAL</th>
<th>WORKFORCE SECTION COMMENTS</th>
<th>ASSESSMENT (SATISFACTORY/ UNSATISFACTORY)</th>
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</thead>
<tbody>
<tr>
<td>Number of posts awarded and filled.</td>
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<td>Percentage of posts vacant.</td>
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<tr>
<td>Number of trainees trained under STP.</td>
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<td>Ratio of reserve posts: awarded posts that are funded.</td>
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<tr>
<td>A list of the expanded settings with number of STP posts identified against each setting.</td>
<td></td>
<td>RA2-5 PRIVATE Non-Hospital Setting</td>
<td>Satisfactory</td>
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</tr>
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<td>Percentage of STP training that occurs in expanded settings.</td>
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<tr>
<td>Percentage of STP training that occurs in rural settings.</td>
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<td>Progress of each support project using traffic light indicator.</td>
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<td>Implementation and progress on each support project identified in</td>
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<tr>
<td>Progress Report</td>
<td>TARGET</td>
<td>ACTUAL</td>
<td>WORKFORCE SECTION COMMENTS</td>
<td>ASSESSMENT (SATISFACTORY/ UNSATISFACTORY)</td>
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<td>Number of accredited STP training posts, compared with number of all training</td>
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<td>posts.</td>
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<td>Number and percentage of trainees who have passed all training requirements</td>
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<td>while in an STP post.</td>
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<td>Number and percentage of STP posts that are part of a training network.</td>
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<tr>
<td>Number and percentage of STP posts in expanded settings that are integrated</td>
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<td>with training provided by state/territory health service providers.</td>
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<tr>
<td>STP posts as per spreadsheets.</td>
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<td>Spreadsheets completed</td>
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<td>ADDITIONAL COMMENTS / INFORMATION</td>
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<td>ASSESSMENT &amp; ACTION (including any risks identified):</td>
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<td>ASSESSMENT CONCLUSION:</td>
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<td>FINANCIAL INFORMATION</td>
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<td>AGREEMENT ID:</td>
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<td>ACTIVITY ID:</td>
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<td>OUTCOME: 8 Health Workforce Capacity</td>
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<td>TOTAL FUNDING: $[amount] (GST exclusive)</td>
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<td>FINANCIAL ASSESSMENT</td>
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<td>ASSESSMENT &amp; ACTION</td>
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</tbody>
</table>
### ASSESSMENT CONCLUSION:

All relevant documentation relating to this report and payment has been filed in accordance with Corporate Business Rule 2 – Information Management and Record Keeping on TRIM file [File No.] Assessments of all deliverables received and accepted to date have been authorised as appropriate and filed.

[name]

Grants Officer

Workforce Grants Section

### RECOMMENDATIONS

**That you:**

- **R1.** ACCEPT the Report provided by [college];
- **R2.** NOTE the report will be uploaded onto FOFMs;
- **R3.** AGREE to the payments of $[amount] (GST exclusive) and $[amount] (GST exclusive) be released in FOFMS.

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<table>
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<tbody>
<tr>
<td><strong>R1</strong></td>
<td>Accepted/Not accepted</td>
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<tr>
<td><strong>R2</strong></td>
<td>Noted/Not noted</td>
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<td><strong>R3</strong></td>
<td>Agree/Not agree</td>
</tr>
</tbody>
</table>

### NAME:

[name]
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<th>DESCRIPTION</th>
<th>FORM FIELDS</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Grants Officer</td>
</tr>
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<td></td>
<td>Workforce Gants Section</td>
</tr>
</tbody>
</table>

**SIGNED:**

**DATE**

**ATTACHMENTS:**

- Report
ATTACHMENT D: Questions asked in this Discussion Paper

Meeting the goals of the STP

1. Is the STP meeting its aims and objectives, as set out in the Operational Framework? Particular attention should be paid to the objectives of increasing capacity to provide training opportunities in expanded settings and supplementing the specialist workforce in rural and remote locations.

2. What changes, if any, should be made to the aims and objectives of the STP to maintain and grow the programme in the future?

3. Should there be greater emphasis on generalist training?

4. Is the Operational Framework of the STP still relevant and appropriate?

5. What changes, if any, should be made to the Operational Framework to improve the programme in the future?

Funding

Contribution to salary

6. Does the fixed-contribution to salary model of STP funding promote the aims and objectives of the STP? Particular attention should be paid to the way in which the contribution is calculated and the same contribution being made for each post.

7. What, if any, changes should be made to this aspect of the funding model to improve its operation?

8. Should costs to Medicare through registrars billing services through supervisors be taken into account in changes to the funding model?

9. If the costs to Medicare vary between specialties, should that be taken into account in the funding model and, if so, how?

The rural loading

10. Does the rural loading element of the STP support the aims and objectives of the STP? Particular attention should be paid to whether the current rural loading funding model supports the objective of increasing training in ASGC-RA2 - 5 locations.

11. What changes, if any, should be made to improve the rural loading system? Particular attention should be paid to changes to make it more relevant to a training post in a rural or regional setting, the way the loading is calculated and the way the rural loading is used by training settings.
Classification of settings

12. Does the present system for classifying settings as falling into a rural or remote area accurately identify settings that should be promoted through the STP priority funding guidelines?

13. If not, would the Modified Monash Model provide a better classification outcome?

14. Should rural loadings be scaled so that remote settings receive more funding than less remote settings?

Support programmes

15. Is the present system of funding support programmes appropriate and does it promote the aims and objectives of the STP?

16. What changes, if any, should be made to improve the support programme system? Particular attention should be paid to changes to make support programmes more relevant to trainees in rural and regional areas and to how the department determines the size of support payments.

Administration support payments

17. What changes, if any, should be made to the present system of calculating administration support payments?

Timing of payments to specialist medical colleges

18. Can improvements be made to the current system of making STP payments to colleges twice-yearly?

19. If so, what changes should be made?

Selection of training posts

Placement of training posts

20. Considered as a whole, does the present system of selecting training posts for STP funding promote the aims and objectives of the STP?

21. What changes, if any should be made to the present system of selecting training posts for STP funding? Particular attention should be paid to changes that would make the system simpler and more responsive to the workforce needs of the broader community, as indicated through increasingly better workforce projections overseen by the National Medical Training Advisory Network.

22. Are changes necessary to any particular aspects of the present system of selecting training posts for STP funding, as opposed to the system as a whole?

23. If so, what are those aspects of the present system and what changes should be made?

Trainees of an Aboriginal or Torres Strait Islander background

24. Are identified training positions for registrars of Aboriginal or Torres Strait Islander background required?
25. If so, how should such a project be implemented?

26. Should colleges be required to keep statistics on the number of specialist medical trainees of Aboriginal or Torres Strait Islander background and where they are undertaking their training?

Reporting by colleges and settings

27. Are the key performance indicators against which colleges must report clear, reasonable and relevant?

28. If not, in what ways could they be improved?

Private Infrastructure and Clinical Supervision Programme

29. Do the present uses to which PICS payments are put promote the aims and objectives of the STP?

30. What improvements, if any, could be made to the present system for administration of the PICS programme? Particular attention should be paid to the system for calculating PICS payments and the guidelines for the use of PICS funds.

Specialist International Medical Graduates

31. Should special measures be put in place to address the role of specialist international medical graduates in the STP programme?

32. If so, what should those measures be?

The design of the STP

Regular review of STP posts

33. Should there be a regular review of training posts to ensure they represent the optimal use of STP funds?

34. Should that review apply to all training posts or some?

35. If so, how should those reviews be conducted, what should be their focus and how often should they occur?

The length of rotations in training posts

36. Would mandated longer rotations in rural and regional areas and in expanded settings promote the aims of the STP better than the present system?

37. If so, how long should rotations be?

38. Are there any clinical concerns that might arise from longer rotations in rural and regional areas and in expanded settings?

Tying funding to rural and regional placements

39. Would tying funding to a requirement that a trainee undertake a placement in rural and regional areas promote the aims of the STP better than the present system?
40. If that system was implemented, should it be coupled with the funding following the trainee through his or her placements?

41. Are there any clinical concerns that might arise from the implementation of such a system?

42. Is it possible to “base” more training posts in rural and regional “hub” centres, so that specialists can perform most of their training outside metropolitan hospitals?

43. If so, would such an approach be feasible for some specialties and not others?

Indexation

44. What would be the likely effect of indexation of the STP funding contribution on the availability of traineeships?

45. If indexation resulted in fewer training posts, would this be an acceptable trade-off?

46. If indexation resulted in fewer training posts being available, what changes, if any, should be made to address the shortfall, assuming additional funds is not available in the future, such as reducing payments for support projects or for costs associated with administering the STP?

A dedicated Aboriginal and Torres Strait Islander traineeship

47. Assuming all other selection factors are satisfied, would using STP funds to provide for the complete training of an Aboriginal and Torres Strait Islander specialist be consistent with the aims and objectives of the STP and why?

48. Should similar consideration be given to funding the complete training of a specialist from any other section of the community, for example, a trainee from a rural or remote background?

49. If so, why and what sections of the community should be considered?

Supporting cultural safety

50. Should cultural safety training be made a compulsory component of training of a registrar in an STP-funded post?

51. If so, how should cultural safety training be delivered? Should it be part of an STP-funded support programme, an aspect of training at the setting or should that question be left to specialist medical colleges, universities or settings?

52. What, if any, would be the implications of such a change to the STP system as a whole?

The Emergency Medicine Programme

Integration of the Emergency Medicine Training Programme with the STP

53. What would be the benefits and detriments to the Emergency Medicine Training Programme if it is integrated with the STP?

54. Would there be benefits for the STP in adopting some aspect of how the Emergency Medicine Training Programme is delivered?