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

DRAFT REPORT

16 AUGUST 2016
Findings of the Review of the STP & EMP – Draft Report

Contents

Executive Summary .......................................................................................................................... 1

1 Background to the Review ........................................................................................................... 7
   1.1 The Specialist Training Program ......................................................................................... 7
      1.1.1 The history of the Specialist Training Program .............................................................. 7
      1.1.2 Aims of the Specialist Training Program ......................................................................... 8
      1.1.3 About the Specialist Training Program ......................................................................... 8
   1.2 The Emergency Medicine Program ..................................................................................... 11
      1.2.1 History of the Emergency Medicine Program ............................................................... 11
      1.2.2 Aims of the Emergency Medicine Program ..................................................................... 11
      1.2.3 About the Emergency Medicine Training Program ....................................................... 11
   1.3 The review process ............................................................................................................... 13
      1.3.1 Operational reforms ...................................................................................................... 14
      1.3.2 Data analysis .................................................................................................................. 15
   1.4 The Integrated Rural Training Pipeline ................................................................................. 15

2 Reforms to the Specialist Training Program .............................................................................. 17
   2.1 Overview .............................................................................................................................. 17
   2.2 Administration of the Specialist Training Program .............................................................. 17
   2.3 Allocation of training places ............................................................................................... 22
      2.3.1 Background .................................................................................................................... 22
   2.4 Process for allocating training posts to specialties ............................................................... 22
   2.5 STP training post targets ..................................................................................................... 25
   2.6 Reviewing and selecting training posts by colleges ............................................................. 27
   2.7 Expressions of interest to host STP trainees ......................................................................... 30
   2.8 Rural classification system for the STP ............................................................................. 31
   2.9 Dedicated Indigenous training posts .................................................................................... 32
   2.10 Specialist International Medical Graduates (SIMGs) ........................................................ 33
   2.11 Reporting by colleges ......................................................................................................... 34

3 Funding of the STP and EMP ..................................................................................................... 37
   3.1 Current STP and EMP funding ............................................................................................. 37
   3.2 Future funding for the STP and EMP ................................................................................. 37
      3.2.1 Background .................................................................................................................... 37
   3.3 Salary contribution ............................................................................................................... 39
Findings of the Review of the STP & EMP – Draft Report

3.4 Rural loading .............................................................................................................40
3.5 Support project funding ........................................................................................41
3.6 Administrative and Governance funding...............................................................45
3.7 Private Infrastructure and Clinical Supervision (PICS) Allowance............................46
4 Proposed reforms to the Emergency Medicine Program..........................................49
  4.1 The Emergency Medicine Training Program .........................................................49
    4.1.1 Background .....................................................................................................49
    4.1.2 Proposed reforms to the ETP .........................................................................49
  4.2 The Emergency Medicine Education and Training Program ................................50
    4.2.1 Background .....................................................................................................50
    4.2.2 Proposed reforms to EMET ..........................................................................51
  4.3 The Emergency Department Private Sector Clinical Supervisor Program ..............52
    4.3.1 Background .....................................................................................................52
    4.3.2 Proposed reforms to the EDPSCS .................................................................53
ATTACHMENTS ...........................................................................................................55
  A: Summary of Responses to Specialist Training Program Discussion Papers ............57
  B: Table of Stakeholders sent Discussion Papers .....................................................64
  C: STP FTEs by College, ASGC-RA Category and Public-Private (2015) ......................67
  D: STP Posts by College and State and Territory (2015) ............................................68
  E: Process for the allocation of training posts by college where detailed data is available 69
  F: Process for allocating training posts where detailed data is not available (Non-modelled specialties) ........................................................................................................74
  G: Table of Department’s Findings and Proposals .....................................................75
Executive Summary

On 19 March 2015, the Hon. Sussan Ley MP, Minister for Health and Minister for Sport, announced that there would be consultation with specialist medical colleges and other stakeholders about reforms to the Specialist Training Program (the STP) and the Emergency Medicine Program (the EMP) to take place from 2017.

The review would:

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

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

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

The STP funds an estimated 5 to 7 per cent of all specialist training posts nationally.

Aims and objectives of the STP

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

The EMP is a set of three initiatives aimed at improving the quality of emergency medicine services:

- the Emergency Medicine Training Program (the ETP), which supports the training of prospective emergency medicine specialists;
- the Emergency Medicine Education and Training program (EMET), which provides clinical education, training and supervision by specialist emergency physicians (Fellows of the Australasian College for Emergency Medicine) to the doctors and clinical teams

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


Findings of the Review of the STP & EMP – Draft Report

working in hospitals and emergency care services in rural, regional and remote Australia who are not specifically trained in emergency medical care; and

• the Emergency Department Private Sector Clinical Supervisor program (the EDPSCS), which provides support for training emergency medicine specialists in the private sector.

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

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

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

Health has made substantial progress towards achieving the key STP targets and objectives … Further, college reporting indicates that the STP has been successful in utilising non-traditional settings to expand the number of specialist training opportunities.  

At the same time, there has been a wide variety of views about how the STP and EMP could be improved. A summary of responses to the discussion papers is at Attachment A.

The key issues identified to date during the review are that:

• the administration of the STP is overly prescriptive for a mature program and, in some cases, this affects its ability to respond to training needs;
• workforce data informing the program requires updating;
• the process for allocating training posts to colleges is unclear;
• while the programs have increased the amount of time trainees spend in rural and regional areas, most of their rotations are still in metropolitan settings;
• some changes to funding are needed to provide greater support to trainees in rural and regional settings;
• stakeholders are seeking an increase to the core salary contribution provided for registrar placements, however, most colleges would prefer to maintain the number of training posts, rather than there be fewer posts resulting from a significant increase in the salary contribution; and
• although colleges consider funding of support projects beneficial, it is one area in which savings could be made.

As well as examining the operations of the STP and EMP, the review is looking at the process used to allocate training places. The department undertook an analysis of some sections of the medical specialty workforce using information from the colleges and the jurisdictions and building on the

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Findings of the Review of the STP & EMP – Draft Report

Health Workforce Australia report *Health Workforce 2025 – Medical Specialties – Volume 3* (HW 2025 Volume 3).

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

KPMG’s analysis of the program has not found major problems with the current distribution of training places, at least in terms of the overall national supply of specialists. However, they did suggest some reforms on how training posts could be selected to ensure those posts best meet the aims and objectives of the STP. KPMG’s proposed allocation methodology provides a system to help ensure the allocation of places is supported by the available evidence. At this stage, the application of this system should not lead to significant changes in the number of training posts allocated to each specialty. This indicates that the department’s existing allocation method has functioned well and generally addressed workforce needs. It is timely, however, to consider adopting an updated approach that can inform program delivery as the specialist workforce develops in the future.

Based on the evidence and stakeholder feedback captured during the review process, the department has made findings and developed a number of reform proposals for further discussion with stakeholders prior to finalising suggested positions for Government consideration. Overall, its suggested approaches to its findings are aimed at making the STP and EMP more efficient and effective with the same funding, by:

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

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

In brief, the department’s primary findings, to date, are:

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

  Consideration should also be given to extending funding agreements between the department and colleges to a period of three or four years, to increase certainty in the sector and allow long-term training plans to be created.
Findings of the Review of the STP & EMP – Draft Report

- **Allocation of training posts and addressing workforce shortages:**
  In announcing the review, the Government made it clear that it would look at matching investment to identified areas of potential specialist shortage. Based on the department’s workforce analysis, and with the assistance of KPMG, the department has developed a suggested process for allocating training places in the STP and determining which posts best meet the required aims and objectives.

  It is important that colleges address workforce shortages and maintain their focus on posts in expanded settings when selecting settings to host training posts. With that in mind, the department suggests training post targets should be set for each college at the start of the funding agreement period. The targets could be based on the updated data modelling and the more refined allocation process developed during the review. The review found that training posts tend to effectively become permanent once established. To address this problem, colleges could assess all existing posts against principles set by the department.

  If the department’s proposal that colleges be given the responsibility for selecting training posts is approved, this may place administrative burdens on settings from having to deal with each college separately whenever new training posts are allocated. This could be alleviated by the department conducting a single call for expressions of interest (EOIs) to host STP, ETP and Integrated Rural Training Pipeline (IRTP) training posts (see section 1.4 below for an explanation of the IRTP). State and territory health departments would be provided an opportunity to comment on EOIs. Colleges would need to consider this feedback in selecting those posts for STP support, in combination with their view on the educational value of the setting.

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

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

- **Proposed expenditure:**
  Many stakeholders argued to the review for an increase in the financial support provided to settings hosting training posts. This appears to be particularly keenly felt by rural settings. Financial support has not increased since the program commenced and it was argued that the gap between the salary contribution and the cost of hosting a trainee is increasing each year. In the current tightened financial situation it is not possible to increase payments significantly. However, the department feels consideration could be given to modest increases to the salary contribution and rural loading elements of STP and ETP funding. Colleges might also be given greater flexibility in the amount of the rural loading, within upper and lower limits set by the department, provided it is used to meet the aims and objectives of the STP.

  The department does not anticipate an increase in the overall proposed STP/EMP expenditure, so savings have to be found in the existing expenditure to support any increases within the different elements of the STP and EMP.

  One approach might be to decrease funding for educational support projects. The department is considering recommending that the amount allocated to colleges for support projects be
Findings of the Review of the STP & EMP – Draft Report

decreased and divided into two pools: a “direct funding pool” and a “discretionary funding pool”. Colleges could be allocated an annual amount from the direct funding pool to develop STP-related educational projects, in a similar way to how support project funding operates now. They would bid competitively to have extra support projects funded from the discretionary funding pool. The department will encourage cooperation between colleges on delivering support projects, where possible. Applications for funding from the discretionary funding pool would be independently assessed by a sub-group of the Committee of Presidents of Medical Colleges (CPMC), according to principles outlined in the STP Operational Framework. This group could also assess those projects proposed by colleges that use the direct funding pool, noting that this should not be more burdensome administratively to the CPMC.

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

- **Specific Changes to the EMP:**
  Major changes to the allocation of training places in emergency medicine are not proposed. However, if the broader changes suggested in this report are adopted, it would be necessary for the operations and administrative arrangements of the ETP to be amended to make them consistent with the revised framework for the STP, with the exception that ACEM would continue to not receive support project funding and private training posts would be ineligible for PICS funding.

  While in general the EDPSCS has been implemented successfully, there is some evidence participating private hospitals would benefit from a more direct relationship with ACEM. This could assist with staff recruitment and enhance trainee support. The EDPSCS could thus be aligned with other aspects of the EMP and made more responsive to emerging opportunities in the private sector if ACEM takes over its direct administration from 2018. It already manages the ETP and EMET, so a synthesising of the management of the three arms of the EMP would create efficiencies and increase the effectiveness of the programs.

A full list of the department’s findings and suggested reforms is at Attachment G.
Findings of the Review of the STP & EMP – Draft Report

1 Background to the Review

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

...focus on in depth workforce planning to better match investments in training with identified specialties of potential shortage and areas that may be oversubscribed into the future.5

Broadly stated, the objectives of the review are to:

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

The department is nearing completion of its review of the STP and the EMP. Its findings to date and how it believes those issues can be addressed are set out below in Parts 2, 3 and 4 of this Report.

1.1 The Specialist Training Program

1.1.1 The history of the Specialist Training Program

Since 1997, successive Commonwealth Governments have implemented initiatives to support the training of specialist medical officers outside metropolitan areas. The rationale for Government investment in specialist training was:

... 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.6

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

In 2008, COAG committed to additional investment via the Hospital and Health Workforce Reform – Health Workforce package. Upon its commencement on 1 January 2010, a range of programs were amalgamated into the STP.7

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

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6 Medical Specialist Training Steering Committee, Expanding Settings for Medical Specialist Training, October 2006, p. 1.
7 As well as the above programs, the Outer Metropolitan Specialist Trainee Program, the Overseas Trained Specialist Upskilling Program and the Pathology Memorandum of Understanding were incorporated into the STP.
Findings of the Review of the STP & EMP – Draft Report

...a range of public settings (including regional, rural and ambulatory settings), the private sector (hospitals and rooms), community settings and non-clinical environments.\(^8\)

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

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

1.1.2 Aims of the Specialist Training Program

The aims and objectives of the STP are articulated in the existing STP Operational Framework:

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

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

1.1.3 About the Specialist Training Program

The main stakeholders in the STP are:

- the Commonwealth government;
- state and territory governments, and through them public health services;
- specialist medical colleges;
- the private health services sector;

Findings of the Review of the STP & EMP – Draft Report

- community-controlled health services; and
- doctors training to be specialists.

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

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

1. In each selection round eligible entities apply to the department to host an STP-funded training post.
2. Applications are rated by the relevant specialist medical college and state and territory health departments against an operational framework. Colleges also consider whether settings meet “the standards set by the relevant College and ... deliver educational value.”9 The jurisdictions also look at “the availability of registrars to fill the posts identified and areas of workforce need.”10
3. The department consolidates and reviews the colleges’ and states and territories’ ratings.
4. The highest ranked applications are approved by a senior departmental officer, under a delegation from the Minister.
5. A Reserve List of posts that are not initially selected for funding is created.
6. The department enters into a funding agreement with the college for it to fill the allocated training posts. Posts are identified by individual numbers.
7. If a post is not filled, where possible, the college promotes an applicant from the Reserve List.

Each year since the program commenced, the department has extended its funding agreements with the colleges in 12 month increments to provide for the additional posts that were introduced each year and associated funding changes.

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

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

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

- trainees gain skills in balancing the needs and treatment of patients with multiple conditions;

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9 STP Operational Framework, January 2013, p. 4.
10 STP Operational Framework, January 2013, p. 5.
Findings of the Review of the STP & EMP – Draft Report

• rural, regional and remote health care presents different challenges compared to urban areas;
• trainees have to handle conflict of interests and maintain ‘boundaries’ with people in a small community; and
• educational benefits in terms of continuity of care for patients and in continuity of supervision.

The department’s funding agreements with colleges for 2016 were for a total of 870.4 FTE, though through the use of “period” posts (temporary posts supported for limited period using surplus funds) colleges have agreements with settings for 951.8 FTE. Attachment C shows the STP posts contracted by the colleges by Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) system classification. Attachment D sets out the number of contracted training posts each college has, their location by state or territory and whether they are in the private or public sector in 2015:

• 64.34 per cent of FTEs were in RA1 settings and 35.66 per cent in RA2-5 settings;
• 44.69 per cent of training posts have some component in an RA2-5 setting;
• 57.72 per cent were in public settings and 42.28 per cent were in private settings; and
• 85.62 per cent of contracted FTEs were filled.

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

There are five funding elements to the STP:

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

Thirteen colleges participate in the STP, though the department has funding arrangements with only twelve specialist medical colleges. The STP only funds new training positions and it does not support positions that have been funded by another source for more than twelve months in the previous three years. The STP does not fund post-fellowship training by a specialist. The

11 It should be noted that one FTE can be distributed across a number of settings, including settings in different RA categories and in public and private facilities.
12 ANAO Report, March 2015, p. 82.
13 The Australian and New Zealand College of Anaesthetists administers the College of Intensive Care Medicine’s STP-funded posts.
department estimates that it funds around 5-7 per cent of specialist training posts nationally; the balance being funded by the jurisdictions.

1.2 The Emergency Medicine Program

1.2.1 History of the Emergency Medicine Program
In 2010, the then Government announced the More doctors and nurses for Emergency Departments initiative, which is aimed at increasing the health system’s capacity to train emergency department specialists, nurses and support staff, as well as training general practitioners in outer suburban and rural areas where emergency medicine specialists are not always available.\(^{14}\)

1.2.2 Aims of the Emergency Medicine Program
The EMP aims “to progressively reduce emergency department waiting times - with waiting times capped at four hours”.\(^{15}\) It seeks to do this by expanding training capacity for doctors to become fellows of ACEM, upskilling a range of emergency care workers, growing the number of front line emergency service deliverers and supporting supervisors in private sector settings. There are three major elements to the EMP:

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

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

- The Emergency Department Private Sector Clinical Supervisor program (the EDPSCS), which supports specialist training by making a contribution to the employment of clinical training supervisors or staff specialist training coordinators in private hospitals. The EDPSCS was established in 2011. It is administered through agreements between the department and the private hospitals.

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

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


Findings of the Review of the STP & EMP – Draft Report

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

Table 1 shows the spread of ETP contracted training posts by ASGC-RA category and jurisdiction for 2015.

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<th>QLD</th>
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Table 1: ETP training posts (FTE) by RA category and jurisdiction, 2015 Academic Year

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

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

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

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

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

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

Unlike the STP, the ETP does not operate under an Operational Framework or a Priority Framework, primarily because only one specialist medical college is involved in its operation, meaning they are not necessary. Consequently, the aims and objectives of the program, its governance rules and
other important operational matters are set out in the funding agreement between the department and ACEM and the Deeds of Variation entered into each year.

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

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

... Australia’s first major, long-term national projections for doctors at the medical specialty level, presenting the best available planning information on our future medical workforce.\(^\text{16}\)

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

... to obtain feedback on the data and assumptions underpinning the workforce projections, as well as to obtain information on considerations for future workforce requirements that may influence the interpretation of the projections.\(^\text{17}\)

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

The report confirmed that while the supply of medical specialists was increasing, “significant inequity in service access – to specialties and in geographical regions – is likely to persist”.\(^\text{18}\) HWA highlighted three areas of imbalance that it felt needed to be addressed:

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

1.3 The review process

The review is being conducted in two, concurrent strands:

1. Operational reforms: The department has sought feedback on the operation of the STP and EMP through written submissions in response to discussion papers sent to key stakeholders on 4 September 2015, face-to-face meetings and input from nominated members of the NMTAN and contact officers from the jurisdictions provided by the HWPC.

2. Data analysis: The department, with the assistance of a consultant, KPMG, conducted a data analysis of medical specialist workforce requirements and developed a process


that could be considered for the selection and review of training posts from 2018 onwards.

1.3.1 Operational reforms

On 4 September 2015, the department released three discussion papers relating to, respectively, the STP and the ETP, EMET and the EDPSCS. The STP/ETP discussion paper was sent to all stakeholders and to other parties on request. It was also uploaded to the department’s website. The EMET and EDPSCS discussion papers were sent only to stakeholders involved in those programs. ACEM was also sent a list of questions relating to the EMP that was not sent to other stakeholders.

The STP/ETP discussion paper presented ideas and options for improvements to the management and processes of those programs.19 The department received 35 written submissions in response to the discussion papers, including from:

- all colleges involved in the STP, other than the College of Intensive Care Medicine;
- the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine;
- all state health departments, though not the territories;
- doctor representative groups, including the Australian Indigenous Doctors’ Association and the Australian Medical Association (AMA); and
- private hospitals and their main representative groups, Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA).

A full list of stakeholders who provided submissions and the discussion papers they received is at Attachment B.

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

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

A summary of responses to the Discussion Papers can be found at Attachment A.

The release of the first discussion paper was followed by a round of consultation with stakeholders on operational reforms in November and December 2015. The department met with all colleges

Findings of the Review of the STP & EMP – Draft Report

participating in the STP, as well as the APHA, CHA and the AMA. At the meetings the department discussed those stakeholders’ responses to the discussion paper and shared some of the options for reform to the program it was considering. In general, feedback from stakeholders on the proposed reforms to the program was favourable, though some colleges indicated that the particular nature of their disciplines made it hard for them to have more training take place in rural areas and expanded settings.

The next round of consultation began with the preparation of a further, short Discussion Paper, which set out the department’s proposed reforms to the operational aspects of the STP and EMP. It did not discuss the process for allocating training posts, as the department’s preferred proposal on that matter had not been settled at that stage.

In February 2016, the second Discussion Paper was sent to all jurisdictions, the Chair of NMTAN, Professor John Horvath, and ten members of the NMTAN Executive Committee who offered to provide comments on the STP and EMP, for feedback. Colleges were not provided with copies of the discussion paper, as it was sent to Associate Professor Nicholas Talley AO, the Chair of the CPMC, in his capacity as a member of the NMTAN Executive Committee. In any case, the proposals in the paper had been raised with the colleges in general terms in the initial Discussion Paper and during the first round of direct consultation. It is, therefore, felt that the colleges would be aware of them. Nonetheless, the department advised Professor Talley that he was free to circulate the discussion paper, or parts of it, to the specialist medical colleges for their views if he considered that was necessary.

Overall, feedback from the jurisdictions and NMTAN members on the proposals put forward by the department in the second Discussion Paper and the letters was constructive and favourable. The majority of the jurisdictions reiterated the view, expressed in their responses to the first Discussion Paper, that they should be consulted in decision-making on the placement of training posts, though one state was more critical of the department’s proposals.

The department also worked with colleges on the development of an EOI form. Feedback on the proposal was positive. As well as being used for EOIs, information obtained through the form can be used by the department in future planning of the STP.

1.3.2 Data analysis

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

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

The data analysis process and its results are discussed in more detail below in section 2.4 below.

1.4 The Integrated Rural Training Pipeline

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

The STP component will provide up to 100 new training posts in rural areas over two years, in addition to the current 900 training posts. The new STP posts will be restricted to RA 2-5 areas and should be designed to enable a specialist trainee to complete the majority of their training within a rural region, with only limited metropolitan rotations where this is necessary to meet fellowship standards. Up to 30 new regional training hubs will be set up under the IRTP to work with local
health services to help stream students through the pipeline. The program will also provide support for extra senior academic positions to drive clinical training and develop more supervisors in regional areas. This will ensure the quality of medical training is maintained. A lack of supervisors in regional areas was raised by stakeholders during consultation on the STP Review.

The additional training places will be allocated through a competitive process, based on the current review of the STP. Supported by the new Regional Training Hubs, rural healthcare settings will engage with their respective specialist colleges to identify local needs to inform the allocation of funding and development of new models of training. New places will be restricted to Australian Statistical Geography Standard RA 2-5 areas and should be designed to enable a specialist trainee to complete the majority of their training within a rural region, with only limited metropolitan rotations where this is necessary to meet fellowship standards.

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

2.1 Overview

Based on the evidence and stakeholder feedback captured during the review process, the department has made findings and developed proposals it feels will address its findings that it will put to stakeholders before they are submitted for consideration. Overall, its suggested approaches to responding to its findings are aimed at making them more efficient and effective with the same funding, by:

- increasing the colleges’ flexibility to manage the program;
- more training taking place in rural and expanded settings;
- maintaining the current number of training posts; and
- not funding training already being funded by the jurisdictions.

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

If accepted, these proposals will affect most aspects of the STP, but especially the way training posts are selected and reviewed and support funding. Colleges responded favourably to them when they were discussed during consultation. The jurisdictions and other stakeholders were generally supportive of them, though the states and territories were keen to maintain their key role in selecting training posts, as they felt they had the expertise and the greatest interest in posts being allocated to areas of workforce need. The concern expressed by jurisdictions should be addressed through the development of the online EOI process and subsequent assessment processes (see below).

The flow chart on page 18 shows the proposed format for the STP and how it will integrate with the IRTP.

2.2 Administration of the Specialist Training Program

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

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

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

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

**Department of Health**

- **Training posts**
  - Forecast excess/shortage
  - Current STP posts
  - Expanded settings
  - Consultations with Colleges, Jurisdictions, NMTAN subcommittee

**STP (900 posts)**

- Schedule to STP Funding Agreement
- Targets set for training posts for the next funding agreement:
  - College total
  - Specialty / Sub specialty
  - RA2.5
  - Private settings

**College implementation to meet STP targets**

**IRTP (100 posts)**

- Schedule to STP Funding Agreement

**IRTP**

- Allocation of posts to colleges for 2017 and 2018. EOI process to assist in the identification of potential IRTP-STP posts.
  - 2017: 50 posts
  - 2018: 50 posts

**College implementation to meet IRTP targets**

**Review of IRTP posts by Department**

(Before funding agreements end)

**Review of targets by Department**

New targets to be set for the next funding agreements

**New settings**

Department completes EOI process on behalf of all colleges, including assessments by both jurisdictions

**Advise posts whether they will remain in STP**

**Negotiate and enter new contracts with new posts, as necessary**

**Department completes EOI process on behalf of all colleges, including assessments by both jurisdictions**

**Colleges identify “new”/“replacement” posts to enable targets to be met**

**2017: 50 posts**

**2018: 50 posts**

**Targets met**
Findings of the Review of the STP & EMP – Draft Report

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

The department considers the following, more flexible, less prescriptive system of management for the STP that gives participating specialist medical colleges greater responsibility could address the findings of the review:

1. A determination of how many training posts will be allocated to each college and the targets the college should meet when it fills its posts would be made. Targets would be based on the department’s data analysis and the allocation process outlined in section 2.5 of this Report.

2. The department would develop broad guidelines for use by the colleges in selecting the 900 STP-funded training posts.

3. To provide an opportunity for new training settings, and to help fill all positions, there would be a call for EOI{s} from settings that wish to host an STP-funded post. State and territory health departments would be provided an opportunity to comment on EOI{s}. Colleges would need to consider this feedback in selecting those posts for STP support, in combination with their view on the educational value of the setting as well as meeting their STP targets.

Any revisions to the allocation of training posts to the colleges would occur at the end of each funding agreement with EOI{s} occurring every two years.

4. Three to four year funding agreements would be entered into with each participating college for it to deliver the program starting in the next academic year. Agreements would specify the colleges’ allocation of posts, its targets, the funding the college would receive, post review requirements, reporting requirements and ancillary matters.

5. Each college should review its training posts over the life of the funding agreement to ensure they are meeting the objectives of the STP, starting with any legacy posts and those identified by the department as potentially not meeting the STP’s aims and objectives. Targets set for colleges will be reviewed before the end of the funding agreement.

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

A similar management model was put forward as an option in both the first STP/ETP Discussion Paper and the second Discussion Paper and was generally favourably received by the colleges. Not surprisingly, it was strongly supported by the colleges during all phases of consultation. One college welcomed the proposed system, noting that, at present:
Findings of the Review of the STP & EMP – Draft Report

... certain sites not ranked particularly highly by the College (in terms of educational/training imperatives) [are] being ranked much more highly by the Department and getting preference for funding. The College appreciates that this has been due to other factors...such as health jurisdictional needs.

It recognised that:

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

Another stated:

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

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

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

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

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

1. the criteria for colleges to review existing posts and select future ones could include the local workforce need for the training post, with educational merits being just one factor (see section 2.5 below); and
2. states and territories being given the opportunity to comment on EOIs to host training posts by settings before colleges select a post for future support (see section 2.5 below).

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

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

While any new model will affect the number of training posts each college has, a preliminary examination of the effects of the model developed with KPMG indicates that the proposals will not significantly change the current allocation of training posts to colleges.

The current Operational Framework for the STP was drafted by the department in consultation with the jurisdictions and colleges. It can be updated after the proposed changes to the STP have been approved by the Minister.

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

While changes to funding agreements cannot be ruled out, annual extensions of all funding agreements are no longer considered essential, as the department would not be determining the posts and targets would only be set once for the course of the agreement.

Administration of the Specialist Training Program

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

The department suggests that consideration should be given to greater responsibility being put in the hands of the colleges, as they are the bodies that manage the training of fellows, accredit settings and are in the best position to efficiently fill vacant training posts. The department would still determine the number of training posts allocated to each college over the course of the funding agreement.

The following process for administering the STP outlined above could be considered:

- A determination of how many training posts would be allocated to each college and the targets the college should meet when it fills its posts would be made. Targets would be based on the department’s data analysis and the allocation process outlined in sections 2.3 and 2.4 of this Report.
- The department develops broad guidelines for use by the colleges in selecting the 900 STP-funded training posts.
- To provide an opportunity for new training settings, and to help fill all positions, there would be a call for EOIs from settings that wish to host an STP-funded post about every two years.
- Three or four year funding agreements would be entered into with each participating college for it to deliver the program starting in the next academic year. Agreements would specify the colleges’ allocation of posts, its targets, the funding the college will receive, post review requirements, reporting requirements and ancillary matters.
- Colleges would be required to review all their training posts over the course of the funding agreement to ensure they align with the STP and EMP objectives.
2.3 Allocation of training places

2.3.1 Background

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

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

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

- HW 2025 Volume 3 showed that as at November 2012 there was an imbalance between and within medical specialty workforces. It also stated that there was a geographic maldistribution, with shortages in regional and rural areas but a potential oversupply in metropolitan areas. This position was confirmed in the department’s release of the Australia’s Future Health Workforce report in December 2014. HWA’s projections indicated that the projected imbalance could be expected to continue into the future.

- The department has undertaken an analysis of the medical specialty workforce using information from the colleges and the jurisdictions. This work has built on the findings of HW 2025 Volume 3.

- KPMG has provided a report on the development of a methodology for the allocation of training posts to the colleges in 2018 and beyond, with a focus on addressing identified workforce shortages.

The purpose of the data analysis undertaken by the department was to identify the extent of any future undersupply or oversupply in medical specialties participating in the STP, which was then used to inform decisions about how many STP-funded training posts would be allocated for each specialty or subspecialty and their respective targets. In some cases, where detailed data was available, the department made calculations for sub-specialties, such as those listed in Table 2, rather than specialties. Accordingly, a reference to specialties in this report includes sub-specialties.

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

2.4 Process for allocating training posts to specialties

In announcing the review, the Minister made it clear that the process would look at matching investment to identified areas of potential specialist shortage. The department would like consideration to be given to approving the following process for determining the number of training posts that will be allocated to each specialty to address that aim:

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Findings of the Review of the STP & EMP – Draft Report

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

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

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

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

Table 2 shows the specialties, the colours assigned to them by HWA and each specialty’s assigned 2014 workforce undersupply percentage.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>2014 workforce undersupply colour and assigned percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia</td>
<td>5%</td>
</tr>
<tr>
<td>Anatomical pathology n.a.</td>
<td>5%</td>
</tr>
<tr>
<td>Cardiology n.a.</td>
<td>0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>5%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>5%</td>
</tr>
<tr>
<td>Endocrinology n.a.</td>
<td>5%</td>
</tr>
<tr>
<td>Gastroenterology and hepatology n.a.</td>
<td>0%</td>
</tr>
<tr>
<td>General medicine n.a.</td>
<td>10%</td>
</tr>
<tr>
<td>General surgery</td>
<td>5%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>5%</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>0%</td>
</tr>
<tr>
<td>Medical oncology n.a.</td>
<td>10%</td>
</tr>
<tr>
<td>Nephrology n.a.</td>
<td>5%</td>
</tr>
<tr>
<td>Neurology n.a.</td>
<td>0%</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>5%</td>
</tr>
</tbody>
</table>
Findings of the Review of the STP & EMP – Draft Report

<table>
<thead>
<tr>
<th>Speciality</th>
<th>2014 workforce undersupply colour and assigned percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>5%</td>
</tr>
<tr>
<td>Orthopaedic surgery n.a. (incl in general surgery)</td>
<td>0%</td>
</tr>
<tr>
<td>Other (clinical) pathology(a) n.a.</td>
<td>5%</td>
</tr>
<tr>
<td>Other surgery(b)</td>
<td>0%</td>
</tr>
<tr>
<td>Otolaryngology n.a. (incl in general surgery)</td>
<td>0%</td>
</tr>
<tr>
<td>Paediatrics and child health</td>
<td>5%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>10%</td>
</tr>
<tr>
<td>Radiation oncology</td>
<td>10%</td>
</tr>
<tr>
<td>Radiology</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 2: 2014 workforce undersupply colour and assigned percentage

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

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

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

- for those specialties determined to be in balance, the number of STP posts allocated would not change;
- for those specialities with an oversupply, that is, the margin is greater than 10 per cent, the allocation to the specialty would be decreased. The size of the decrease would be based on the percentage above 10 per cent. The most likely effect of this is that no STP posts would be allocated to the college; and
- for those specialities with an undersupply, that is, greater than minus 10 per cent, the speciality would be allocated additional STP posts. The number of additional posts would be based on the percentage above -10%. However, the actual number of additional posts needs to reflect reductions in other specialties as no more than 900 STP posts can be funded.

Attachment E sets out in more depth the proposed allocation process where detailed data on the specialty is available, along with tables showing how the allocation process would work for the three possible scenarios:

- a forecast undersupply in the specialty;
- a forecast oversupply in the specialty; and
- the forecast supply is within the margin of 10 per cent.
Specialties that were not analysed by HWA are assumed to be in balance. The proposed supply-demand assessment is based on the projected entrants and exits from the workforce. Following that step, the same approach as described above is applied for those specialities, depending on whether they are determined to be in undersupply, oversupply or in balance.

Attachment F sets out in more depth the proposed allocation process where detailed data is not available, along with a table showing how the allocation process would work.

Based on the above processes, Table 3 sets out the proposed allocation of training post to each college. The process for the allocation of posts by specialty is shown in Attachments E and F.

<table>
<thead>
<tr>
<th>College</th>
<th>Current STP Funded FTEs</th>
<th>Proposed STP Funded FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACD</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>ACEM</td>
<td>2</td>
<td>2</td>
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<tr>
<td>ACSP</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>ANZCA</td>
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<td>CICM</td>
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</tr>
<tr>
<td>RACMA</td>
<td>17.5</td>
<td>17</td>
</tr>
<tr>
<td>RACP</td>
<td>351.4</td>
<td>345</td>
</tr>
<tr>
<td>RACS</td>
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<td>70</td>
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<tr>
<td>RANZCO</td>
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<td>15</td>
</tr>
<tr>
<td>RANZCOG</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>RANZCP</td>
<td>160</td>
<td>160</td>
</tr>
<tr>
<td>RANZCR</td>
<td>47</td>
<td>82</td>
</tr>
<tr>
<td>RCPA</td>
<td>87</td>
<td>88</td>
</tr>
<tr>
<td>Total</td>
<td>870.9</td>
<td>900</td>
</tr>
</tbody>
</table>

Table 3: Allocation of training posts for new funding agreement by college

### Allocation of training posts to colleges

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

To address this, the department has developed a process, set out in Attachments E and F to this Report, for determining the number of training posts that will be allocated to each college.

### 2.5 STP training post targets

The department’s proposed process for filling STP training posts in the future would not require all existing posts to be terminated. On the whole, training posts funded under existing agreements would be expected to continue under the new agreements, however, a new post can be created in one of five ways:

- the number of training posts allocated to the college may be fewer than its current allocation, meaning posts cut from one specialty will be allocated to another;
Findings of the Review of the STP & EMP – Draft Report

- a current setting might not seek to host a training post at the end of its existing agreement with a college;
- a college might determine that an existing post does not meet the selection criteria for training posts (see section 2.5);
- the post may not meet the aims and objectives of the STP; and
- a post is introduced to replace a post that is unfilled at the time the allocation of training posts is made.

As explained above, the department is developing a proposal to allocate a certain number of training posts to each college which it would be expected to fill. To address the aim of the STP of having training posts in expanded settings, the department would need to set targets for training posts that the college would be expected to meet within that allocation.

Under this suggested approach, the department would set targets in the following areas that the STP aims to address:

- remoteness category 2-5;
- private setting; and;
- subspecialty.

Colleges would balance the allocation of training posts across the states and territories by taking into account the feedback the jurisdictions would provide on EOI applications about new settings and posts that are not anticipated to be continuing.

It is proposed that the same targets would apply in each year of the funding agreement. However, in some cases a college may need to make a significant adjustment to meet its targets. For example, a college that currently has only 15 per cent of training posts in ASGS 2-5 areas may be required to meet a target of 50 per cent. In such cases, consideration could be given to allowing the target to be reached by the last year of the funding agreement, giving the college sufficient time to make the necessary transition.

During consultation the colleges’ timeline for filling training posts was discussed. Most colleges indicated that they will require significant lead time between being advised of their allocations of STP training posts and the post being filled. A typical timeline has training posts being advertised in May or June, with the trainee taking up the position on the first Monday of February of the following year; the start of the academic year. This extended timeline exists because trainees may have to move from one setting to another, often having to find accommodation for their families or employment for partners; and contracts need to be entered into between the college and the setting and the trainee.

Based on the above analysis, Table 4 compares the proposed targets for each specialty with their current allocation of training posts.22

<table>
<thead>
<tr>
<th>College</th>
<th>Proposed STP Funded FTEs</th>
<th>Current STP Funded FTEs (Funding Agreement)</th>
<th>Rural FTE Target</th>
<th>Current Rural FTEs (Funding Agreement)</th>
<th>Private FTE Target</th>
<th>Current Private FTEs (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACD</td>
<td>27</td>
<td>27.0</td>
<td>22</td>
<td>19.64</td>
<td>22</td>
<td>19.82</td>
</tr>
</tbody>
</table>

22 Current FTEs are based on funding agreements between the department and medical specialist colleges for the 2015 academic year.
Table 4: Proposed rural and private setting targets for each college

<table>
<thead>
<tr>
<th>College</th>
<th>Proposed STP Funded FTEs</th>
<th>Current STP Funded FTEs (Funding Agreement)</th>
<th>Rural FTE Target</th>
<th>Current Rural FTEs (Funding Agreement)</th>
<th>Private FTE Target</th>
<th>Current Private FTEs (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEM</td>
<td>2</td>
<td>2.0</td>
<td>0(^{23})</td>
<td>0.00</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td>ACSP</td>
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<td>2</td>
<td>1.30</td>
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<td>4.00</td>
</tr>
<tr>
<td>ANZCA</td>
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<td>41.5</td>
<td>19</td>
<td>17.00</td>
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<td>6</td>
<td>5.00</td>
<td>11</td>
<td>10.00</td>
</tr>
<tr>
<td>RACMA</td>
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<td>11</td>
<td>9.70</td>
<td>7</td>
<td>6.50</td>
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<td>RACP</td>
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<td>143.96</td>
</tr>
<tr>
<td>RACS</td>
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<td>38</td>
<td>34.90</td>
</tr>
<tr>
<td>RANZCO</td>
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<td>RANZCOG</td>
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<td>14.55</td>
</tr>
<tr>
<td>RANZCP</td>
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<td>71</td>
<td>64.90</td>
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<tr>
<td>RANZCR</td>
<td>82</td>
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<td>24.80</td>
<td>17</td>
<td>15.90</td>
</tr>
<tr>
<td>RCPA</td>
<td>88</td>
<td>87.0</td>
<td>39</td>
<td>34.00</td>
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<td>62.90</td>
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<td>870.9</td>
<td>400</td>
<td>352.00</td>
<td>440</td>
<td>402.39</td>
</tr>
</tbody>
</table>

Process for setting training post targets
To address the aim of the STP to support training posts in expanded settings, the department suggests consideration should be given to the department setting targets for training posts that the college would be expected to meet within that allocation.

The colleges could be required to meet annual targets for:

- RA2-5 area;
- private setting; and;
- subspecialty.

These proposed targets would be based on the department’s data analysis and the process for determining the number of training posts allocated to each college proposed elsewhere in this report.

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

\(^{23}\) The rural FTE target for ACEM training posts in the STP is zero, however, its rural FTE target for the ETP is 55 FTE or 50 percent of all training posts.
Findings of the Review of the STP & EMP – Draft Report

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

The department’s September 2015 Discussion Paper asked stakeholders to suggest innovative reforms to the STP, and included examples of how a college and a setting had developed new approaches to training. In their responses to the Discussion Paper, some stakeholders referred to alternative training approaches. For example, one college explained how an STP-funded trainee was working with a specialist to upskill general practitioners in the care of patients with diabetes by attending consultations, discussing case management and training GPs and nurses in the care and management of patients. A number of jurisdictions suggested the STP could be used to establish pathways for trainee specialists in rural areas.

If the department’s proposals are accepted, one result of colleges reviewing their existing posts and any subsequent reallocation is the need to select new posts. The department proposes that colleges apply the following principles when selecting and reviewing training posts:

- There should be a spread of training posts in RA 2-5 areas: The importance given to this principle will depend on how difficult it will be for the college to meet its overall RA 2-5 target. The more difficult the target would be to reach, the greater the priority the college should give to posts in an RA2-5 area. This principle should be given greater priority than whether the post is in a private setting in the case of specialties that are considered to be in balance, as there is likely to be some maldistribution of posts.

- There should be a spread of training posts across public and private settings: The importance of this principle also results from the college’s need to meet its overall private post target.

- Posts should meet the area’s local workforce needs: The colleges would apply this principle based on comments provided by jurisdictions through the EOI process. For existing posts, colleges may take into account its importance for the state or territory. One measure of the importance of a post could be the percentage impact of the post on the total number of training posts in that specialty in that jurisdiction.

- Trainees should be able to spend a significant time in the post: Evidence shows that longer training placements generate better workforce distribution outcomes. On this basis, trainees should spend a significant period in each training post if they are to experience the post properly and provide a genuine benefit to the delivery of services to communities. This is especially important for posts in RA2-5 settings if the STP is to promote training in rural centres and trainees working in a rural centre once they have achieved Fellowship. In some cases, trainees spend as little as 0.1 FTE in RA2-5 settings.

- Generally speaking, a trainee should not spend less than three months in an STP post (or 0.25 FTE) without the specific approval of the department. This would not preclude the establishment and maintenance of regional training networks, with training provided across a group of settings within a larger region, but would be designed to avoid a high level of churn by trainees being placed in those areas.
Innovative approaches to training should be encouraged: The department feels that colleges and jurisdictions would be keen to use the STP to fund “outside the box”, innovative training models. This could be through the creation of rural-based training pathways or by establishing training initiatives that use STP-funded posts outside the standard teaching model. Developing new approaches is considered important in ensuring the STP improves patient care and provides trainees with a rounded training experience.

The post should have significant educational value: Training posts should, of course, have educational value. When applying this principle, colleges should consider the accreditation and track record of the setting. However, the department does not believe this should be the key factor in deciding whether or not to select a training post. Instead, the contribution of each post towards meeting the outcomes of the STP need to be the guiding principle.

Applying these principles would prevent colleges making decisions based purely on the educational merits of the post, as it is believed an analysis of that nature may preference settings in metropolitan and public hospitals over those in RA2-5 areas and private settings, which would, in turn, compromise the objective of the STP of having more training take place in rural and remote and expanded settings. That practice has been the subject of criticism from some states and territories. It would also ensure training posts fit in with the aims of the STP and that the review is implemented consistently across all colleges.

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

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

The department’s preferred option is the combined approach.

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

Consideration should be given to addressing this finding by requiring colleges to review current training posts over the life of the funding agreements. Colleges would review all their training posts to ensure they are meeting the objectives of the STP, starting with any legacy posts and posts that might not meet the aims and objectives of the STP, applying the following principles when selecting or reviewing training posts:

- there should be a spread of training posts across RA2-5 areas and in private settings;
- the post should meet the local workforce needs of the area in which it is placed based on
Findings of the Review of the STP & EMP – Draft Report

jurisdictional comment;
• trainees should not spend less than three months in a post, without the specific approval of the department; and
• the post should have significant educational value.

2.7 Expressions of interest to host STP trainees

Under the present administration system, settings are required to participate in only one funding round conducted by the department, irrespective of the specialty. One consequence of making colleges responsible for selecting training posts is that each would have to hold its own application round, with settings applying to each college separately.

To avoid a consequent administrative and financial burden on settings and, to a lesser extent, colleges, the department suggests that every two years a national EOI process should be conducted to provide an opportunity for settings that would like to participate in the program.

At present, entities wishing to host an STP-funded training post have to provide the department with:

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

The department feels this process can be streamlined. In consultation with the jurisdictions and the colleges, the department is developing an EOI template that requires settings to provide the minimum information necessary for the college to determine whether the EOI should be considered for support or not. Further examination by colleges may be necessary to enable the supported EOIs to be ranked or shortlisted for the next stage of selection. It is not intended that EOIs to host an STP post would be the same as formal applications, so they may not include all the information a college would need to satisfy itself that a setting should be given a training post. The department expects that where a college thinks it is necessary it will seek further information from the settings before funding a training post.

The department proposes that colleges and states and territories would be given access to the website to record comments on EOIs, with the jurisdictions looking at workforce needs at a local level. A college should take the jurisdiction’s comments into account when considering an EOI. The department would not specify how much weight it should give that view, however, it is unlikely a college would be able to establish a post that received no jurisdictional support.

Colleges were generally supportive of this proposal when it was tested with them during consultation.

Expressions of interest to host training posts

If the department’s proposal that colleges be given the responsibility for selecting training posts is approved, this could place administrative and financial burdens on settings from having to deal with each college separately.

The department proposes that this could be addressed by it taking expressions of interest from
settings that wish to host new STP-funded posts. A template for expressions of interest would be designed by the department in consultation with the colleges.

Colleges and states and territories could be given access to the website to record comments on EOIs, with the jurisdictions looking at workforce needs at a local level.

2.8 Rural classification system for the STP

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

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

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

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

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

Rural classification system

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

The Australian Statistical Geography Standard system should be used as the rural classification system for training posts under the STP and EMP as it is regularly updated to reflect population
2.9 Dedicated Indigenous training posts

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

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

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

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

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

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

Nonetheless, the department believes that increasing the number of Indigenous trainees should be an objective of colleges and the STP and EMP can be used to support that outcome. For example:

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

While the department does not suggest dedicated Indigenous training posts be included in STP targets, this does not prevent colleges assigning posts on their own initiative. The department will support them in doing so where it can. Further, colleges could be asked to report on how many STP-funded training posts have been filled by Indigenous trainees and on their efforts to increase the number of Indigenous Fellows. The performance of the colleges could be measured over the next agreement period and future targets could be considered once better data has been collected.
Dedicated Indigenous training posts
The department found during the review that there is little reliable statistical evidence on the number of Indigenous specialist trainees, but that it is believed to be a low number. Further, most colleges do not appear to have programs to promote specialist training amongst Indigenous doctors.

The department does not believe dedicated Indigenous training posts should be introduced as part of the STP, however, consideration should be given to requiring colleges to report on how many STP-funded training posts have been filled by trainees that have identified as being Indigenous and on what efforts they are undertaking to increase the number of Indigenous Fellows.

The STP support project funding could be used to support Indigenous specialist trainees complete their training.

2.10 Specialist International Medical Graduates (SIMGs)
One of the aims of the STP is to:

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

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

The importance of SIMGs in the delivery of specialist health care in Australia, especially in areas of identified workforce shortages and in rural areas was made clear during consultation. However, since the STP commenced in 2010 the number of Australian medical graduates has grown and there is a view in some quarters that they may soon be in oversupply.

Accordingly, the department believes there is no need for STP posts to be designated for SIMGs and this will not be one of the targets set for colleges. Of course, this does not mean SIMGs cannot seek and fill STP-funded posts, provided they meet other criteria; that would be a matter for the colleges and settings in their recruitment of trainees. This approach does not prevent colleges from proposing support projects aimed at assisting SIMGs.

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

The department proposes that designated training posts for SIMGs should not be included in training post targets set by the department.

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24 STP Operational Framework, January 2013, p. 3.
2.11 Reporting by colleges

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

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

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

The department, therefore, suggests that a streamlining of the current reporting requirements should be considered. The department could use the EOI process it is developing to allow for online, or web-based, reporting that assesses whether the college is meeting the aims and objectives of the programs. A better, redesigned reporting system could be used in the future evaluation of the STP and EMP.

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

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

The department feels consideration should be given to requiring colleges to provide reports covering:

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

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

<table>
<thead>
<tr>
<th>Reporting to the department</th>
</tr>
</thead>
<tbody>
<tr>
<td>The department has found that the present key performance indicators that colleges report against are unclear and inconsistently applied.</td>
</tr>
</tbody>
</table>

The department suggests that consideration be given to streamlining reporting requirements for
colleges to make them clearer and more relevant and to assess whether the college is meeting the aims and objectives of the STP and EMP.

The department’s funding agreements with colleges could require them to provide the department with the following reports:

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

The department suggests that it should also consult with colleges on developing standard definitions for KPIs to make them clearer and on providing enhanced and timelier statistical reports.
3 Funding of the STP and EMP

3.1 Current STP and EMP funding
The current funding elements of the STP are:

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

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

Proposed STP expenditure also includes funding for the Tasmania Health Assistance Package.

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

3.2 Future funding for the STP and EMP

3.2.1 Background
In its consultation with stakeholders, the department indicated that in the current, challenging fiscal climate, it was unlikely there would be additional funds available for the STP and the EMP and that any increase in funding for one element would need to be offset by a reduction in another.

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

In meetings with colleges the department also suggested funding for support projects could be reduced to offset any increase in funding for other elements, though this potential offset is limited due to its total funding of only $5.8 million.

Funds for the STP and EMP come from the overarching Health Workforce Program. The department’s proposed expenditure is achievable within the scope of the current allocation to STP and EMP within the Program. However, there are other demands on the investment in workforce programs in order to meet government priorities. A flow chart of how STP and EMP funding works is on page 38.
Findings of the Review of the STP & EMP – Draft Report

Flow Chart of Proposed STP and EMP Funding

Department of Health

Specialist Training Program

College Support

- Administration support

Post Support (900 STP, 110 ETP)

- Salary Support
- Rural Loading
- PICS (STP only)
- Support projects (STP only)
  - Direct funding pool
  - Discretionary funding pool

Emergency Medicine Program

EMET

- Training Hubs (approx. 40)

EDPSCS

Private Hospitals (8 at present)
The department’s proposals for funding individual elements of the STP are set out below.

### Funding of the STP and EMP

The review has proceeded on the basis that there will be no additional funding for the STP and EMP in future years. However, for the reasons set out below, there is strong support for increases to some components of funding, which the department feels should be accommodated, where possible, with offsetting reductions in other components.

### 3.3 Salary contribution

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

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

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

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

The STP was meant to support 900 posts from 2014. The proposed expenditure assumes the STP will fund a full schedule of 900 posts and that the ETP will fund 110 posts.

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

Therefore, the department suggests that consideration be given to some increase in the salary contribution, bearing in mind the expenditure constraints, as follows:
Findings of the Review of the STP & EMP – Draft Report

<table>
<thead>
<tr>
<th>Salary support funding (per post, per annum)</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100,000</td>
<td>$102,500</td>
<td>$105,000</td>
<td>$105,000</td>
</tr>
</tbody>
</table>

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

**Salary support contribution**

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

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

### 3.4 Rural loading

The majority of submissions to the department, from a range of stakeholders, favoured the scaling of the rural loading to provide greater support for trainees in more remote placements. One college argued that the present system did not recognise the costs associated with employing a trainee in a rural or remote location. Another stakeholder felt that the loading should be scaled to reflect the “substantial difference in the weight of professional responsibility upon trainees in regional centres and remote towns”. Some of the extra costs highlighted by stakeholders include personal and family relocation and travel to attend professional development courses. In some cases, it was argued, a doctor’s partner may not be able to find employment in a rural area, potentially placing stress on the trainee’s family or even dissuading them from taking up a rural position.

The STP has always had a strong regional and rural focus; that is, having posts in an RA2-5 area. At present, STP funding agreements specify a total of 352 FTE be in an RA2-5 area. The colleges reported that for 2015, 339.42 FTEs, or 35.62 per cent of total FTEs, have an element of training in a regional/rural area. It is proposed that this should be increased to 400 FTEs, or 44.44 per cent. That amount is the basis for the draft expenditure calculations in this Report.

The funding agreement with ACEM for EMP training posts includes a clause limiting the rural loading to half the 110 training posts supported. No change is proposed for this element.

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

- the total rural loading pool paid to each college would be increased to $22,500 in 2018 and $25,000 in 2019 and each remaining year of the funding agreement;
- the rural loading that could be paid to settings for the support of a trainee should be between $15,000 and $30,000 per year; and
- colleges would be given the option of varying payments according to need, within that range, including allowing funds to be used to support a rural / based trainee during a rotation to a metropolitan setting, rather than only being available when the trainee is in a rural area, as is the case now.
Rural loading funding over the course of the agreement would be:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural loading funding (per eligible post, per annum)</td>
<td>$20,000</td>
<td>$22,500</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

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

The department does not believe it is appropriate for the rural loading to be used purely for the settings’ purposes. Trainee support is a priority, and is likely to contribute to the ability of colleges to fill available rural places. The department does not propose that detailed guidelines on how the rural loading can be spent should be developed. However, consideration should be given to:

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

**Rural loading**

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

The department suggests that consideration should be given to:

- the total rural loading pool paid to each college would be increased to $22,500 in 2018 and $25,000 in 2019 and each remaining year of the funding agreement;
- allowing the rural loading payment to any particular trainee to be between a lower limit of $15,000 per FTE per year and an upper limit of $30,000 per FTE per year, at the discretion of the relevant college;
- allowing colleges to vary rural loading payments to trainees according to need but within the set limits, including allowing funds to be used to support a rurally based trainee during a rotation to a metropolitan setting;
- having colleges include clauses in their agreements with settings that require the setting to use the rural loading to meet the aims and objectives of the STP; and
- requiring colleges to identify how the rural loading funding is used in their reports to the department.

### 3.5 Support project funding

At present, colleges are allocated funds for:
Findings of the Review of the STP & EMP – Draft Report

... a range of support activities, including ... developing system wide education and infrastructure support projects [and] support projects aimed at SIMGs to assist these doctors gain Fellowship in a timely and efficient manner.25

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

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

Proposals for specialist college support funding will be evaluated ... taking into consideration each proposal’s capacity to meet the overall aims, objectives and outcomes of the STP and the availability of program funds. Proposals will be assessed on the range of potential projects to be undertaken, the rationale for potential projects to contribute to training in the expanded settings and the governance arrangements within the organisation to determine the allocation of support funds to particular projects.26

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

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

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

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

Discretionary funding pool: The discretionary funding pool is a common pool of funds that would be allocated to support priority projects that best meet the program’s objectives and align with the development of the profession. This pool would allow for more forward thinking projects to be

established, for example, ones helping to test new models of training or developing new distance learning systems.

Colleges would need to apply for funding for a support project from this pool. This would be a competitive process, so applications should be independently assessed. Peer assessment of projects in this pool would be undertaken by a sub-group of the CPMC, in the same way that college project proposals were assessed under the former Rural Health Continuing Education Program. This work could be linked with the CPMC’s role in delivering the new Rural Specialist Support initiative, generating some efficiency in program administration.

Approval would be a more rigorous task than endorsement of a direct funding pool project. The guidelines to be established with CPMC would seek to promote the most efficient use of funds and encourage cooperative projects and ones with a cross-college application.

This system would allow colleges to continue to provide support projects for STP trainees, but also encourages a level of cooperation that is currently not present. Support project funding would be significantly reduced from the current pool of funds.

Most colleges responded positively to the general proposal of two funding pools. Some also commented that there are support projects, such as mentoring, leadership and best practice projects, which have a potentially wide application and could be the subject of cooperation between colleges or be rolled out to a number of colleges, once developed.

One concern raised by colleges with fewer training posts was that they could be at a disadvantage in applying for funding compared to the larger colleges because of their smaller administrative capacity for preparing applications and because their projects would have a shorter reach, potentially making them less attractive than those of the larger colleges. The department believes these concerns can be addressed by developing a simple application form, in the guidelines for projects and through the use of an independent peer approver, such as the CPMC.

The CPMC has indicated that it considers this process “efficient” and that it can peer review prospective projects. However, it has argued that, given its limited infrastructure, it would require $65,000 per year “to ensure a quality outcome” in its assessment of support projects. This would be accommodated within the STP support project expenditure.

The department’s proposed STP expenditure makes $3,380,000 available for support project funding, a saving of $2.5 million per year. Under the department’s proposed expenditure for support project funding (Table 6) the direct funding pool would be made up of base funding for each college of $100,000 and an allowance of $1,208 per post. The department considers the proposed amounts would be sufficient to allow each college to run suitable support projects for its STP trainees under the direct funding pool.

The allowance per post set out in Table 6 is based on the allocation of training posts set out in this Report. The Discretionary Fund would be $1,030,000 and administration fees of $65,000 have been proposed for CPMC to fulfil its proposed role.
### Support project funding

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

Accordingly, the department feels consideration should be given to (commencing in the 2018 academic year) reducing funding for STP support projects and dividing it into two funding pools: a “direct funding” pool and a “discretionary funding” pool. The pool system could operate as follows:

- Total funding for STP support projects would be reduced from $5,880,000 per year to $3,380,000 per year.
- Each college would be annually allocated an amount from a direct funding pool of

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27 Support project funding is for 898 posts only, as ACEM, which has two STP posts, does not receive support project funding.

28 Includes Base Funding of $100,000 per college and allocation of $1,208 per post

29 2016 CICM funding is included in the agreement with ANZCA
$2,285,000, which would be included in the funding agreement with the college, made up of base funding of $100,000, plus $1,208 per post.

- A discretionary funding pool of $1,030,000 would be held by the department as a common pool of money.
- Colleges could apply for funding for a support project from the discretionary funding pool.
- Applications for funding from the discretionary funding pool could be peer-reviewed and approved by a CPMC sub-committee, in accordance with guidelines developed by the department.
- Guidelines for the allocation of discretionary funding pool moneys would encourage cooperation between the colleges on developing and providing projects to trainees.
- CPMC’s administration fees to review support projects could be subject to negotiation between it and the department, however, it would not be more than $65,000 per year.
- Support project funding proposals could be assessed according to:
  - their capacity to meet the overall aims, objectives and outcomes of the STP;
  - the availability of program funds;
  - 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.

3.6 Administrative and Governance funding

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

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

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

The evidence suggests there is likely to be little room to reduce administrative and governance funding, as the department’s proposed STP reforms would require the colleges to undertake additional tasks, including the management of PICS and the selection of training posts. Nor is there a case to increase administrative and governance funding. Further, colleges will not be provided with dedicated administrative funding for the implementation of the IRTP. Value for money in this investment will be enhanced by the delivery of new activities rather than reducing current funding.

On this basis, it is suggested that college administration funding remain at current levels, as follows:

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ANZCA administers STP posts for CICM. ACEM’s funding is provided under its EMP agreement.
Findings of the Review of the STP & EMP – Draft Report

<table>
<thead>
<tr>
<th>STP Administrative &amp; Governance</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<td></td>
<td>$5,872,859</td>
<td>$5,872,859</td>
<td>$5,872,859</td>
<td>$5,872,859</td>
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</tbody>
</table>

**Administrative and governance support funding**

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

The department feels that college administration funding support remain at current levels.

### 3.7 Private Infrastructure and Clinical Supervision (PICS) Allowance

The PICS allowance:

...provides funding support for activities associated with clinical supervision and training infrastructure. [It] recognises the cost of delivering training in the private sector with funding designed to contribute to meeting these costs. 32

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

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

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

Most stakeholder comments on the PICS allowance addressed its administration. However, a few argued for an increase in the contribution.

The program is administered by RACMA, rather than the college relevant to the post. This was considered appropriate as this new, targeted funding element did not fit neatly into the existing funding agreements, as well as being administratively convenient. In most cases it is necessary for a setting to enter into an agreement with RACMA for the PICS allowance and with a college in relation to the training post.

Feedback from stakeholders is that PICS is important and useful, one private hospital commenting that it would be hard for it to run quality training without the extra funding. However, consultation also revealed that stakeholders feel the purposes that PICS funds could be used for should be made clearer; one college, for example, uses the funding to purchase equipment for settings. The equipment may be essential and otherwise not available at the setting, however, it is available for use by trainees and specialists alike.

31 Note, this does include payments to RACMA to administer the PICS program or to ACEM to administer the ETP and EMET components of the EMP.

Findings of the Review of the STP & EMP – Draft Report

Based on responses to the discussion paper, the department suggested during consultation that the present system is unduly complex and redundant and that the administration costs of the program are too high. There was general agreement with this view, with some acknowledgement of the useful role RACMA has played in establishing this component of STP. However, colleges feel there is no longer a clear reason for that arrangement to continue and that it would not present a problem for them to administer the PICS contribution along with the other funding elements of the STP.

The department feels that consideration should be given to the management of the PICS allowance being placed in the hands of the college that administers the post. This would create a more direct decision-making process and remove the need for settings to enter into two agreements in relation to the one post.

Further, the administration of the PCIS allowance could be streamlined by its infrastructure and clinical supervision elements being combined in one payment of $30,000 per post, as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
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<tbody>
<tr>
<td>PICS funding (30,000 per eligible post, per annum, from 2018)</td>
<td>$30,000</td>
<td>$30,000</td>
<td>$30,000</td>
<td></td>
</tr>
</tbody>
</table>

It is also suggested that the scope of the use of PICS payments be changed to allow settings to use them for both clinical supervision and infrastructure. At present, PICS applies to 403 FTE, however, this may change with the proposed STP target of 440 FTE in rural settings.

While the department’s review did not find evidence of misuse of the PICS allowance, it is clear that the uses to which it can be put should be made clearer. In particular, the department suggests that colleges be asked to include clauses in their agreements with settings that require the setting to use the PICS allowance to meet the STP’s aims and objectives. Further, colleges could identify how PICS funding is used in their reports to the department.

Private Infrastructure and Clinical Supervision allowance

The department has found that the PICS program is important to private sector settings but that the purposes for which it can be used should be made clearer.

Consideration could be given to a streamlined model where the infrastructure and clinical supervision elements of funding would be a single payment of $30,000 per year per FTE and the program would be administered by the college responsible for the relevant post, not RACMA. This would be consistent with the principal of devolving greater management of the STP to the colleges. It would also simplify the administration of the program.

Colleges could:

- include clauses in their agreements with settings that require the setting to use the PICS allowance to meet the STP’s aims and objectives; and
- identify how the PICS allowance is used in their reports to the department.
4 Proposed reforms to the Emergency Medicine Program

4.1 The Emergency Medicine Training Program

4.1.1 Background

The background of the Emergency Medicine Training Program (ETP) is set out in section 1.2 above.

Tables 7 and 8 show the placement of ETP training posts by ASGC RA category, public/private status and state/territory and filled FTEs, for the 2015 academic year.

<table>
<thead>
<tr>
<th>FTEs per agreement between college and settings</th>
<th>RA1</th>
<th>RA2</th>
<th>RA3</th>
<th>RA4</th>
<th>RA5</th>
<th>Public</th>
<th>Private</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>62.85</td>
<td>44.65</td>
<td>14.5</td>
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<td>2</td>
<td>95.3</td>
<td>33.7</td>
<td>129</td>
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</tbody>
</table>

Table 7: ETP Training Posts by ASGC RA Category

<table>
<thead>
<tr>
<th>FTEs per agreement between college and settings</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
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<tr>
<td></td>
<td>3</td>
<td>34</td>
<td>4</td>
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<td>2</td>
<td>2</td>
<td>30</td>
<td>29</td>
<td>129</td>
</tr>
<tr>
<td>Filled FTEs</td>
<td>2.5</td>
<td>28.5</td>
<td>3.5</td>
<td>19.75</td>
<td>1.5</td>
<td>0</td>
<td>23.33</td>
<td>26.5</td>
<td>105.58</td>
</tr>
</tbody>
</table>

Table 8: ETP Training Posts by Stated and Filled FTEs

4.1.2 Proposed reforms to the ETP

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

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

and some differences:

- ACEM has a greater role in the administration of the program, as outlined above; and
- the ETP is not as focussed on expanding training to rural and regional and private sector settings as the STP. It was designed to contribute to a larger measure seeking to improve the timely delivery of care to patients in emergency departments across
Findings of the Review of the STP & EMP – Draft Report

Australia. Part of this strategy was increasing the qualified emergency medicine workforce, hence the additional 110 training posts.

Most stakeholders did not comment on the integration of STP and ETP, and those that did were generally not supportive. Reasons given for not supporting integration include that integration could have a negative impact on emergency care delivery in rural and regional areas and that it is not clear what benefits would be gained from integrating the programs.

As noted above, the proposed new system for selecting STP training posts is largely similar to that already in place in relation to the ETP. Therefore, the department suggests that the operations of the ETP only be changed to the extent necessary to replicate the proposed changes to the STP. This does not mean the programs should be integrated; the ETP would remain the subject of a separate funding agreement to the STP.

ACEM already has the primary role of selecting ETP training places that has been proposed for the STP, meaning few changes would need to be made to keep the two programs in line.

The Emergency Medicine Training Program
The department has found little support from stakeholders for the ETP to be integrated with the STP. Equally, it does not believe there is compelling evidence supporting this happening.

However, the department feels that consideration should be given to minor changes to the administration of the ETP to bring it into line with proposed changes to the STP, with the exception that ACEM would not be eligible for support project or PICS funding.

4.2 The Emergency Medicine Education and Training Program

4.2.1 Background
The EMET program was developed by the previous Government in July 2010 to help meet the four hour national target for emergency treatment. It provides additional training to staff in regional and rural hospitals that do not have a specialist emergency physician. Training sessions are open to doctors, GPs, nurses and paramedics. The intention is to boost the quality of care and increase access to emergency services for people living outside of urban areas.

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

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

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

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

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

Consideration should be given to limiting the number of EMET training hubs that will operate in the future to those that can be supported within the current base level of funds available for the program. ACEM has suggested that the base level of funding be $9.4 million per year. In recent years ACEM has invested significant surplus funds from the other components of the EMP into the EMET stream, but the base has only been derived from funding identified in the current funding agreement. The department suggests that it and ACEM further discuss the guidelines for selecting hubs and KPIs for the program from 2018.

By funding EMET the Commonwealth is supporting staff development, as distinct from training prospective specialists, in state and territory hospitals primarily. Consideration should be given to whether the Commonwealth considers this a proper use of its funds in the current fiscal climate. Staff development is, essentially, the role of the jurisdictions. Ending the EMET program would mean a considerable saving in funds to the STP/EMP and allow the department to increase a number of elements of current EMP funding.

As indicated, the Commonwealth invested in the EMET program as part of a broader contribution towards COAG-agreed efforts to reduce emergency department waiting times. The benefits arising from the EMET program are clear, however, it has to be asked whether the program would close if the Commonwealth ceased funding it.

ACEM’s report indicates the program has been successful in training persons in rural and regional areas and anecdotal evidence is that it has saved lives by improving the skills of a broad range of emergency staff. However, it does not provide evidence that EMET has met its stated goal of reducing emergency department waiting times. Refocussing the agreed outcomes for the program may be necessary to ensure the focus on delivering safe and appropriate patient services is highlighted, rather than the direct contribution towards waiting times.

Taking all these factors into account, the department considers EMET a valuable program and it is suggested that no changes should be made to its operations or funding at this stage.
Findings of the Review of the STP & EMP – Draft Report

However, to improve outcomes it is suggested that ACEM consult formally with key stakeholders, including service providers, colleges and other professional groups, on the future implementation of the program. Greater engagement with stakeholder groups should assist to ensure future EMET investment is well targeted and is better aligned to emerging regional health service needs. Further discussions with ACEM on how this objective can be delivered in an efficient and responsive way will need to be undertaken following this review process.

The Emergency Medicine Education and Training Program
The review indicates that EMET is a valuable program and the department does not propose that changes should be made to its operations. However, it is suggested that ACEM consult with key stakeholders, including service providers and other professional groups, on the future implementation of the program.

4.3 The Emergency Department Private Sector Clinical Supervisor Program

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

It is part of the then Government’s Building emergency department workforce capacity initiative, which aimed to lead to:

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

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

Estimated total funding for the EDPSCS from 2011 to 2016 is about $18.7 million.

The EDPSCS is administered by the department through funding agreements entered into with the participating private hospitals. The criteria for selecting an EDPSCS proposal are that the hospital must:

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

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Findings of the Review of the STP & EMP – Draft Report

- development of effective training networks that support the expansion of private sector training.

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

4.3.2 Proposed reforms to the EDPSCS

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

In its meeting with ACEM the department raised the possibility of the college assuming administration of the EDPSCS, in a similar way to how it manages the ETP and EMET programs. The department believes consideration should be given to this option as:

- it would be in keeping with the department’s general approach of increasing flexibility in the management of the programs that make up the STP and ETP;
- the programs that make up the EMP could be aligned in the one management structure, which, logically, would be operated by ACEM; and
- under ACEM’s management the EDPSCS should become more responsive to the needs of private hospitals and the emergency medicine sector.

As noted above, only eight of the original eleven participating hospitals remain in the EDPSCS program. This suggests that some settings are having difficulties meeting the requirements of the program.

ACEM indicated that it feels it would now be able to handle the management of the EDPSCS, as the larger EMP is now well established. The college believes this would benefit the delivery of the program, as it will be able to assist the private hospitals to recruit and retain specialist supervisors, to meet its accreditation requirements and be responsive to any other needs of the hospitals. It also believes that taking over the management of the program would make it easier for the college to build critical mass in the program. This proposal has been supported by stakeholders.

It should be asked whether the EDPSCS program should be ended and its funding used to train ACEM Fellows in general, rather than support clinical supervisors. The program could be seen as meeting its aim of training more specialists by utilising previously untapped resources in private hospitals. On the other hand, in terms of the broader aims of improving the quality of emergency services and reducing waiting times, it should be noted that the eight hospitals participating in the program are in RA 1 areas.

Nonetheless, it is considered that the proposed change of having ACEM manage the program should proceed with the implementation of other recommended reforms to the EMP, as the department feels it is impractical for this change to take place any earlier. At a later time a targeted evaluation should be made to enable a sound decision on the future of the program to be made. Until that evaluation has occurred no expansion of the program should take place.

The Emergency Department Private Sector Clinical Supervisor Program

The review has found no evidence that supports changes being made to the operations of the
However, the department feels that consideration should be given to having ACEM assume its management. This would bring it into line with the other programs in the EMP and make it more responsive to the needs of the private sector.
# Findings of the Review of the STP & EMP – Draft Report

## ATTACHMENTS

<table>
<thead>
<tr>
<th>Attachment</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Summary of Responses to Specialist Training Program Discussion Papers</td>
</tr>
<tr>
<td>B</td>
<td>Table of Stakeholders sent Discussion Papers</td>
</tr>
<tr>
<td>C</td>
<td>STP FTEs by College, ASGC-RA Category and Public-Private (2015)</td>
</tr>
<tr>
<td>D</td>
<td>STP Posts by College and State and Territory (2015)</td>
</tr>
<tr>
<td>E</td>
<td>Process for the allocation of training posts by college where detailed data is available, including draft spreadsheet of allocation of STP training posts</td>
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<tr>
<td>F</td>
<td>Process for allocating training posts where detailed data is not available</td>
</tr>
<tr>
<td>G</td>
<td>Department’s findings and proposals for changes to the STP and EMP</td>
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</tbody>
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ATTACHMENT A

A: Summary of Responses to Specialist Training Program Discussion Papers

General comments

The department received 35 submissions in response to the discussion papers on the review of the Specialised Training Program (STP) and the Emergency Medicine Program (EMP) sent to stakeholders on 4 September 2015. A list of the submissions received is attached.

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

Almost all stakeholders stated that they feel the STP:

- is meeting its aims and objectives;
- is promoting training in rural and regional areas and expanded settings (such as, private sector settings and community centres) and
- should not be diminished. However, there were a diversity of views from stakeholders on how the main issues raised in the discussion paper should be addressed.

Looking at the submissions broadly:

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

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

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

**Distribution of training posts under the STP**

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

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

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

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

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

**Selection of training posts**

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

- greater local and jurisdictional involvement in the selection process;
- greater involvement from colleges in the process, including the adoption of the model outlined in the Discussion Paper, which is based on the EMP system;³⁵
- the development of training networks or hub models;
- allocating training places based on an audit of rural and regional areas to determine where posts are most needed; and
- encouraging stability and continuity so that settings will support STP posts.

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

Submissions explained the medical academic year commences in February. At present, colleges start to fill training places in April of the previous year and try to complete the process by July. To meet

³⁵ In summary, under this model the department, in consultation with the jurisdictions and the colleges would determine the number of posts to be allocated to each college and the criteria for funding of a post. The settings would apply to the colleges for posts, and the colleges would determine what posts should receive funding, in accordance with that criteria.
this deadline, it was argued, the Government should advertise for applications for training posts in early-January, with applications closing in late-February. While this timeline may seem generous, submissions indicated that in practise it is not, as the number of posts and their locations must be known, trainees have to be recruited by settings and then contracts entered into between the department and each college and between the college and the setting.

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

*Tied funding*

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

Suggestions on how tied funding might be implemented include:

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

Reasons given for not supporting the idea included that it:

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

Some of these comments indicate a misunderstanding of the suggestion put forward in the discussion paper and are not strong reasons for the idea to not be at least tested.

*Mandating the length of rotations in rural/regional posts*

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

While supporting the idea, one submitter believed it would work best for generalist medicine posts; a college supported trainees having two rotations of six months, though not necessarily sequentially; and two other colleges felt the length of the rotation should depend on the specialty.

One of the states argued that for the idea to succeed, trainees best suited to rural/regional training should be selected. Another submission noted that the support of the colleges would be required for this to be implemented.
Findings of the Review of the STP & EMP – Draft Report

On the other hand, some stakeholders argued that mandated, lengthy rotations could make it hard for a trainee to meet all the requirements of the specialist program; would interfere with existing training schedules or would make rural/regional posts less available. One of the states also does not support mandating the length of rotations in rural and regional settings.

A submission argued that one year rotations would not provide clear pathways for trainees; instead the STP should look at establishing rural training networks, where doctors can return to metropolitan centres as needed. A college believes the system already has flexibility to allow the length of the rotation to suit the setting and the trainee’s needs.

**Contribution to salary/Indexation of the salary contribution**

A number of submissions noted the growing difference between the amount of the fixed-contribution ($100,000 per post) and the actual cost of having a trainee, however, there was not support for an increase in the contribution or indexation if it would result in fewer training places being available.³⁶

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

- scaling funding in favour of rural/regional posts or ones that have higher costs;
- allowing both full and partial funding of salaries;
- preferential funding for specialties in short-supply;
- apportioning funding according to the needs of the post, not its location;
- increasing funding for psychiatry positions, as there are disincentives for expanded settings on taking trainees;
- improving supervisor funding, as that is more important to the success of the STP than the size of the salary contribution;
- increasing funding for training in community placements, especially Aboriginal Community Controlled Health Organisations and remote clinics;
- supporting the specific costs that sometimes apply to regional placements but not a general increase in funding per FTE; and
- assessing applications for posts based on whether the setting can afford to make up the difference between the trainee’s salary and the contribution.

A private health care provider argued that the contribution to salary creates a bias towards the public sector, as it does not take into account that private hospitals do not have public sector funding to offset the difference between the salary contribution and actual salary.

A number of stakeholders supported indexation, given the difference between the salary contribution and the actual salary of a registrar. One college feels the salary contribution needs to be indexed at the CPI, at a minimum, but it also does not wish to see a reduction in the number of posts.

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

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³⁶ It should be noted that the STP does not have an indexed funding allocation through the Health Workforce fund.
Regular review of posts

There is strong support for the regular review of training posts to ensure they meet workforce and geographic requirements. Naturally, there are different opinions on when reviews should be conducted:

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

There are also differing views on how the review should be conducted:

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

Rural loading

On the whole stakeholders felt that the loading should be scaled according to the location of the post, or a similar factor. However, submissions generally did not canvass how these increases should be funded. Nor is it clear from submissions whether stakeholders support an increase in the overall level of the rural loading, or if an increase for a post in one location would mean a smaller payment for a post in another location.

Some stakeholders did not agree with the rural loading being raised according to the location of the training post.

There were also suggestions on how the rural loading system could be improved:

- there should be greater oversight of how the loading is used;
- there can be anomalies as some RA-1 sites, such as Gosford, require trainees to move to a new area, so the payment of the loading should be considered on a case by case basis;
- an increase to the loading for rural/regional/remote sites could be funded by reducing the salary funding for RA-1 posts;
- some settings have greater needs based on socio-economic status, not location; and
- the loading should take into account unique geographical issues in some states.

Support projects

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

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

Generalist training

At the outset, it should be noted that different stakeholders appear to have different views on what constitutes a “generalist”. For example, one state health department described a generalist as a specialist, usually a surgeon or physician, with a broad-based practice, dealing with a range of clinical problems. Another submission feels a generalist is a general practitioner with a range of skills, such as training in obstetrics or surgery.

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

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

Some stakeholders oppose the suggestion, arguing that:

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

Training networks

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

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

A state health department noted that creating hub centres “depends on critical mass, availability and range of rotations/ experiences, and good and accessible supervision.” Another feels that training networks would not be appropriate for all specialties.
Findings of the Review of the STP & EMP – Draft Report

*Dedicated funding of trainees*

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

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

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

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

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

*Classification of settings*

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

The ASGC system is by and large supported, with some caveats, though it appears to be generally acknowledged that the MMM system is better at distinguishing between small rural and remote locations, particularly in RA2-3 areas.

One college, for example, argued that it provides for “greater specificity” than the AGSC system, however, the current model is reasonable. One submission argued that neither system is “sufficiently robust to manage the complexities” of a training program.
### B: Table of Stakeholders sent Discussion Papers

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<tr>
<th>Stakeholder</th>
<th>STP Paper</th>
<th>EMET Paper</th>
<th>EDPSCS Paper</th>
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37 The Australian College of Rural and Remote Medicine made separate submissions in relation to the STP and the EMET program.
# Findings of the Review of the STP & EMP – Draft Report

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<tr>
<th>Stakeholder</th>
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## Findings of the Review of the STP & EMP – Draft Report

<table>
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<th>EMET Paper</th>
<th>EDPSCS Paper</th>
<th>Submission made</th>
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### Findings of the Review of the STP & EMP – Draft Report

**ATTACHMENT C**

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

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<th>College</th>
<th>Funding Agreement with Dept.</th>
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## Findings of the Review of the STP & EMP – Draft Report

**ATTACHMENT D**

### D: STP Posts by College and State and Territory (2015)

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<th>College Agreements with Settings</th>
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<th>NT</th>
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<th>SA</th>
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| Percentages | 100.00 | 1.37 | 28.13 | 4.36 | 20.28 | 5.83 | 2.20 | 26.80 | 11.03 |

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---
E: Process for the allocation of training posts by college where detailed data is available

Preliminary calculations:

Before determining the allocation to each college, the department makes a number of separate calculations using data from the Workforce Data Analysis Section, as outlined in the accompanying spreadsheet.

1. The college’s workforce supply for 2014 [Column F].

2. The size of the speciality’s current undersupply, if any [Column G]. This is calculated by multiplying the speciality’s 2014 workforce supply [Column F] by the percentage by which it was considered to be in undersupply [Column E]. That percentage is determined by assigning percentage values to the red, orange and green ratings ascribed to specialties in HW 2025 Volume 3:
   - a specialty with a red rating is considered to have a current shortage of 10 per cent or more;
   - a speciality with an orange rating is considered to have a current shortage of up to 5 per cent; and
   - a speciality with a green rating is considered to currently be in balance.

   Table 2 shows the colours (red, orange and green) assigned to specialties by HW 2025 Volume 3 and each specialty’s 2014 workforce undersupply percentage.

3. The net projected movement in the specialty to 2030. The “net projected movement” is the projected difference between workforce supply and expressed demand as a headcount. For example, the net workforce movement is positive when the workforce supply increases relative to demand [Column H].

4. The forecast workforce supply in 2030 [Column J].

5. The undersupply or oversupply of specialists in 2030.

Determination whether the specialty is in oversupply or undersupply:

The department uses those calculations to make two further, related calculations that will determine whether or not the specialty is in undersupply or oversupply.

6. The adjusted net movement in the workforce position of each specialty [Column I] is calculated by deducting any undersupply in the specialty [Column G] from the net projected movement [Column I]. If the speciality is not in undersupply at 2014, the adjusted net movement is the same as the net projected movement.

7. The adjusted net movement in the workforce position [Column K] is then expressed as a percentage of the 2030 forecast supply. If the adjusted net movement in the workforce position is within plus or minus 10 per cent margin, the workforce is deemed to be in balance. The margin recognises the inherent limitations in the data and in making workforce forecasts out to 2030.

From this point, there are three possible scenarios.
Findings of the Review of the STP & EMP – Draft Report

Scenario 1: The speciality is forecast to be in undersupply by more than 10 per cent

If the undersupply percentage for a specialty is more than 10 per cent, the number of training posts in the next funding agreement will be greater than the number of posts in the current agreement by the amount outside the 10 per cent margin, subject to the adjustment set out below [Column L]. For example, if the forecast supply to 2030 is 200 and the forecast undersupply is 15 per cent, the training post allocation in the current agreement would be provisionally increased by 5 per cent, or 10 posts.

Scenario 2: The speciality is forecast to be in oversupply by more than 10 per cent

If the specialty is forecast to be in oversupply by more than 10 per cent, the number of training posts in the next funding agreement will be fewer than the number of posts in the current agreement by the amount outside the 10 per cent margin, subject to the adjustment set out below [Column L].

For example, if the forecast supply to 2030 is 200 and the forecast oversupply is 20 per cent, the training post allocation in the current funding agreement would be provisionally decreased by 10 per cent, or 20 posts.

Scenario 3: The speciality supply is forecast to be within the margin for error of plus or minus 10 per cent

If the supply percentage is within the margin of plus or minus 10 per cent, there would be no change to the number of trainees allocated to the specialty in the next funding agreement. In other words, the number of posts in the current funding agreement would be the target in the next agreement.

The allocation process ends here if either scenario 2 or scenario 3 apply. However, if scenario 1 applies two more calculations are needed to determine how many additionally posts are allocated to each specialty:

8. The number of training post the STP can fund is limited to 900. Accordingly, the number of additional training posts that can be allocated to those specialties in undersupply is limited by the number of posts deducted from those specialties in oversupply and any other adjustments required to make the total number of STP posts supported to be 900. In the spreadsheet below the total increase for those specialties in undersupply is around 6 per cent [Column M].

9. If the college is forecast to be in undersupply, as in Scenario 1, its training post target [Column M] will be determined by adding the total increase in training posts [Column L], to the college’s funded STP posts, as set out in the department’s funding agreement with the college [Column D], not including period posts.

The below tables show how the allocation process would work for the three scenarios:

- a forecast undersupply in the specialty;
- a forecast oversupply in the specialty; and
- the forecast supply is within the margin of 10 per cent.
Findings of the Review of the STP & EMP – Draft Report

Draft Allocation of STP Training Posts Spreadsheet

### Specialist Training Programme

#### Target Setting

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#### Medical Specialties

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<th>2030 supply</th>
<th>Exits</th>
<th>Increase posts required to balance workforce</th>
<th>New fellows</th>
<th>Increase in STP posts - % of increase applied</th>
<th>Target - based on</th>
<th>Trainee Proportion</th>
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### Special Interest Training Scheme

<table>
<thead>
<tr>
<th>Medical Speciality</th>
<th>College</th>
<th>2030 Existing training posts</th>
<th>2030 supply</th>
<th>Exits</th>
<th>Increase posts required to balance workforce</th>
<th>New fellows</th>
<th>Increase in STP posts - % of increase applied</th>
<th>Target - based on</th>
<th>Trainee Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Clinical genetics</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Clinical pharmacology</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Haematology</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Immunology &amp; allergy</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Respiratory &amp; sleep medicine</td>
<td>RACP</td>
<td>3.00</td>
<td>N/A</td>
<td>9</td>
<td>3.0</td>
<td>3.0</td>
<td>30.00%</td>
<td>3.0</td>
<td>30.00%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Renal medicine</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>RACP</td>
<td>2.00</td>
<td>N/A</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
<td>25.00%</td>
<td>2.0</td>
<td>25.00%</td>
</tr>
</tbody>
</table>

### Total for all specialties

|                          | 870.90 | 889.00 |

**NOTE:** The total of 899 posts results from rounding of allocations. To reach the program limit of 900 training posts the Department has allocated an extra training post to the RACP.

Source: KPMG analysis based on Department of Health data and HWA2025
Findings of the Review of the STP & EMP – Draft Report

Scenario 1: Where there is a forecast undersupply in the specialty

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>STP-funded posts</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>Workforce supply for 2014</td>
<td>1800</td>
</tr>
<tr>
<td>3</td>
<td>Current undersupply in the specialty (HWA orange category: -5%)</td>
<td>90</td>
</tr>
<tr>
<td>4</td>
<td>Net projected movement in the workforce out to 2030</td>
<td>600</td>
</tr>
<tr>
<td>5</td>
<td>Forecast supply to 2030</td>
<td>2300</td>
</tr>
<tr>
<td>6</td>
<td>Adjusted net movement (undersupply in 2014 – Step 3 – deducted from net projected movement – Step 4)</td>
<td>510</td>
</tr>
<tr>
<td>7</td>
<td>Adjusted net movement (Step 6) in the workforce position as a percentage of the 2030 forecast supply of specialists (Step 5)</td>
<td>-22.17%</td>
</tr>
<tr>
<td>8</td>
<td>Provisional increase in training posts (percentage of adjusted net movement percentage under 10 per cent [12.17 per cent] of forecast supply (Step 5) [2300])</td>
<td>279.91</td>
</tr>
<tr>
<td>9</td>
<td>Increase in posts (using 6 per cent)</td>
<td>17</td>
</tr>
<tr>
<td>10</td>
<td>Allocation (STP-funded posts plus revised net movement)</td>
<td>57</td>
</tr>
</tbody>
</table>

Scenario 2: Where there is a forecast oversupply in the specialty

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>STP-funded posts</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Workforce supply for 2014</td>
<td>1050</td>
</tr>
<tr>
<td>3</td>
<td>Current undersupply in the specialty (HWA green category)</td>
<td>Nil</td>
</tr>
<tr>
<td>4</td>
<td>Net projected movement in the workforce out to 2030</td>
<td>200</td>
</tr>
<tr>
<td>5</td>
<td>Forecast supply to 2030</td>
<td>1,450</td>
</tr>
<tr>
<td>6</td>
<td>Adjusted net movement (undersupply in 2014 – Step 3 – deducted from net projected movement – Step 4)</td>
<td>200</td>
</tr>
<tr>
<td>7</td>
<td>Adjusted net movement (Step 6) in the workforce position as a percentage</td>
<td>13.79%</td>
</tr>
</tbody>
</table>
Findings of the Review of the STP & EMP – Draft Report

<table>
<thead>
<tr>
<th>Step</th>
<th>Provisional decrease in training posts (percentage of adjusted net movement percentage over 10 per cent [3.79 per cent] of forecast supply (Step 5) [1,450])</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Provisional decrease is greater than the number of STP posts in Step 1</td>
<td>No posts allocated in 2017</td>
</tr>
</tbody>
</table>

Scenario 3: Where the forecast supply is within the margin for error

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>STP-funded posts</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Workforce supply for 2014</td>
<td>800</td>
</tr>
<tr>
<td>3</td>
<td>Current undersupply in the specialty (HWA green category)</td>
<td>Nil</td>
</tr>
<tr>
<td>4</td>
<td>Net projected movement in the workforce out to 2030</td>
<td>90</td>
</tr>
<tr>
<td>5</td>
<td>Forecast supply to 2030</td>
<td>910</td>
</tr>
<tr>
<td>6</td>
<td>Adjusted net movement (undersupply in 2014 – Step 3 – deducted from net projected movement – Step 4)</td>
<td>90</td>
</tr>
<tr>
<td>7</td>
<td>Adjusted net movement (Step 6) in the workforce position as a percentage of the 2030 forecast supply of specialists (Step 5)</td>
<td>9.89%</td>
</tr>
<tr>
<td>8</td>
<td>Adjusted net movement in the workforce is within the margin for error of 10 per cent</td>
<td>32</td>
</tr>
</tbody>
</table>
F: Process for allocating training posts where detailed data is not available (Non-modelled specialties)

Based on its analysis, the department will:

1. determine the college’s workforce supply for 2014; and
2. estimate the number of exits from the speciality over four years.
3. The department will then calculate the expected increase in the supply of specialists, assuming that the 2014 workforce supply across all specialties will increase by 2.1 per cent per annum over the term of the funding period, recommended to be four years.
4. The number of new training posts per year that will be allocated to balance the workforce over the period of the proposed funding agreement is calculated by subtracting the number of exits (Step 3) from the expected increase in supply (Step 4).
5. The number of new trainees allocated per year will then be adjusted to maintain the STP limit of 900 posts.
6. The department then determines the allocation of additional posts for each speciality by adding the adjusted increase in posts (step 6) to the number of ongoing STP-funded posts, as set out in the department’s agreements with the colleges, not including period posts.

The below table shows how the allocation process would work where detailed data is not available.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>STP-funded posts</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Workforce supply for 2014</td>
<td>450</td>
</tr>
<tr>
<td>3</td>
<td>Increase in workforce supply over four years, at 2.1% per annum</td>
<td>39</td>
</tr>
<tr>
<td>4</td>
<td>Exits from the specialty (9 per annum over four years)</td>
<td>36</td>
</tr>
<tr>
<td>5</td>
<td>The number of new Fellows required per year to balance the workforce over four years (the cumulative increase in workforce supply plus exits, divided by four, rounded down)</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>New training posts adjusted to maintain the STP limit of 900 posts (in this scenario, 6 per cent of the provisional increase in training posts)</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Allocation (STP-funded posts plus adjusted increase in posts)</td>
<td>7</td>
</tr>
</tbody>
</table>
Administration of the Specialist Training Program

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

The department suggests that consideration should be given to greater responsibility being put in the hands of the colleges, as they are the bodies that manage the training of fellows, accredit settings and are in the best position to efficiently fill vacant training posts. The department would still determine the number of training posts allocated to each college over the course of the funding agreement.

The following process for administering the STP outlined above could be considered:

- A determination of how many training posts would be allocated to each college and the targets the college should meet when it fills its posts would be made. Targets would be based on the department’s data analysis and the allocation process outlined in sections 2.4 and 2.5 of this Report.

- The department develops broad guidelines for use by the colleges in selecting the 900 STP-funded training posts.

- To provide an opportunity for new training settings, and to help fill all positions, there would be a call for EOIs from settings that wish to host an STP-funded post about every two years.

- Three or four year funding agreements would be entered into with each participating college for it to deliver the program starting in the next academic year. Agreements would specify the colleges’ allocation of posts, its targets, the funding the college will receive, post review requirements, reporting requirements and ancillary matters.

- Colleges would be required to review all their training posts over the course of the funding agreement to ensure they align with the STP and EMP objectives.

Allocation of training posts to colleges

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

To address this, the department has developed a process, set out in Attachments E and F to this Report, for determining the number of training posts that will be allocated to each college.
Process for setting training post targets

To address the aim of the STP to support training posts in expanded settings, the department suggests consideration should be given to the department setting targets for training posts that the college would be expected to meet within that allocation.

The colleges could be required to meet annual targets for:

- RA2-5 area;
- private setting; and;
- subspecialty.

These proposed targets would be based on the department’s data analysis and the process for determining the number of training posts allocated to each college proposed elsewhere in this report.

Review of training posts

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

Consideration should be given to addressing this finding by requiring colleges to review current training posts over the life of the funding agreements. Colleges would review all their training posts to ensure they are meeting the objectives of the STP, starting with any legacy posts and posts that might not meet the aims and objectives of the STP, applying the following principles when selecting or reviewing training posts:

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

Expressions of interest to host training posts

If the department’s proposal that colleges be given the responsibility for selecting training posts is approved, this could place administrative and financial burdens on settings from having to deal with each college separately.

The department proposes that this could be addressed by it taking expressions of interest from settings that wish to host new STP-funded posts. A template for expressions of interest would be designed by the department in consultation with the colleges.

Colleges and states and territories could be given access to the website to record comments on EOIs, with the jurisdictions looking at workforce needs at a local level.
Rural classification system

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

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

Dedicated Indigenous training posts

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

The department does not believe dedicated Indigenous training posts should be introduced as part of the STP, however, consideration should be given to requiring colleges to report on how many STP-funded training posts have been filled by trainees that have identified as being Indigenous and on what efforts they are undertaking to increase the number of Indigenous Fellows.

The STP support project funding could be used to support Indigenous specialist trainees complete their training.

Specialist International Medical Graduates

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

The department proposes that designated training posts for SIMGs should not be included in training post targets set by the department.

Reporting to the department

The department has found that the present key performance indicators that colleges report against are unclear and inconsistently applied.

The department suggests that consideration be given to streamlining reporting requirements for colleges to make them clearer and more relevant and to assess whether the college is meeting the aims and objectives of the STP and EMP.

The department’s funding agreements with colleges could require them to provide the department with the following reports:

- KPIs linked to the national program outcomes;
- statistical data;
- financial information; and
- risks and emerging issues in program implementation.
Findings of the Review of the STP & EMP – Draft Report

The department suggests that it should also consult with colleges on developing standard definitions for KPIs to make them clearer and on providing enhanced and timelier statistical reports.

Funding of the STP and EMP

The review has proceeded on the basis that there will be no additional funding for the STP and EMP in future years. However, for the reasons set out below, there is strong support for increases to some components of funding, which the department feels should be accommodated, where possible, with offsetting reductions in other components.

Salary support contribution

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

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

Rural loading

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

The department suggests that consideration should be given to:

- the total rural loading pool paid to each college would be increased to $22,500 in 2018 and $25,000 in 2019 and each remaining year of the funding agreement;
- allowing the rural loading payment to any particular trainee to be between a lower limit of $15,000 per FTE per year and an upper limit of $30,000 per FTE per year, at the discretion of the relevant college;
- allowing colleges to vary rural loading payments to trainees according to need but within the set limits, including allowing funds to be used to support a rurally based trainee during a rotation to a metropolitan setting;
- having colleges include clauses in their agreements with settings that require the setting to use the rural loading to meet the aims and objectives of the STP; and
- requiring colleges to identify how the rural loading funding is used in their reports to the department.

Support project funding

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

Accordingly, the department feels consideration should be given to (commencing in the 2018 academic year) reducing funding for STP support projects and dividing it into two funding pools: a “direct funding” pool and a “discretionary funding” pool. The pool system could operate as follows:

- Total funding for STP support projects would be reduced from $5,880,000 per year to $3,380,000 per year.
- Each college would be annually allocated an amount from a direct funding pool of $2,285,000, which would be included in the funding agreement with the college, made up of base funding of $100,000, plus $1,208 per post.
- A discretionary funding pool of $1,030,000 would be held by the department as a common pool of money.
- Colleges could apply for funding for a support project from the discretionary funding pool.
- Applications for funding from the discretionary funding pool could be peer-reviewed and approved by a CPMC sub-committee, in accordance with guidelines developed by the department.
- Guidelines for the allocation of discretionary funding pool moneys would encourage cooperation between the colleges on developing and providing projects to trainees.
- CPMC’s administration fees to review support projects could be subject to negotiation between it and the department, however, it would not be more than $65,000 per year.
- Support project funding proposals could be assessed according to:
  - their capacity to meet the overall aims, objectives and outcomes of the STP;
  - the availability of program funds;
  - 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.

Administrative and governance support funding

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

The department feels that college administration funding support remain at current levels.

Private Infrastructure and Clinical Supervision allowance

The department has found that the PICS program is important to private sector settings but that the purposes for which it can be used should be made clearer.
Consideration could be given to a streamlined model where the infrastructure and clinical supervision elements of funding would be a single payment of $30,000 per year per FTE and the program would be administered by the college responsible for the relevant post, not RACMA. This would be consistent with the principal of devolving greater management of the STP to the colleges. It would also simplify the administration of the program.

Colleges could:

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

The Emergency Medicine Training Program

The department has found little support from stakeholders for the ETP to be integrated with the STP. Equally, it does not believe there is compelling evidence supporting this happening.

However, the department feels that consideration should be given to minor changes to the administration of the ETP to bring it into line with proposed changes to the STP, with the exception that ACEM would not be eligible for support project or PICS funding.

The Emergency Medicine Education and Training Program

The review indicates that EMET is a valuable program and the department does not propose that changes should be made to its operations. However, it is suggested that ACEM consult with key stakeholders, including service providers and other professional groups, on the future implementation of the program.

The Emergency Department Private Sector Clinical Supervisor Program

The review has found no evidence that supports changes being made to the operations of the EDPSCS.

However, the department feels that consideration should be given to having ACEM assume its management. This would bring it into line with the other programs in the EMP and make it more responsive to the needs of the private sector.