The Royal Australasian
College of Physicians

RACP Submission:
Review of the Specialist Training Program

October 2015

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide input to the Commonwealth Department of Health's review of the Specialist Training Program (STP).

The STP is a crucial Commonwealth Government initiative that is delivering significant value; both to improving patient outcomes in the community, and to the capacity of the health system to deliver highly trained medical specialists able to meet Australia's future health needs. The program has been in place since 1997 with support from successive Governments.

Key to the program is that it provides training positions outside the traditional large, metropolitan, public hospital sector. This enables doctors undergoing advanced specialist training to gain a wider breadth of experience and exposure to patients and conditions not always seen in metropolitan hospital settings. This approach to training very effectively prepares doctors for the type of clinical practice they will undertake once they complete their specialist training, and is clearly aligned with the increasing move to delivering specialist care in community-based healthcare settings, as part of an integrated multidisciplinary team.

Importantly, the STP improves access to healthcare in the community and in private organisations, as well as in regional, remote and Aboriginal communities. The RACP administers 356 positions of the total 900 places Australia-wide. The College administers an additional 60 positions with other funding, bringing to a total 416 positions available to RACP trainees through the program. These places benefit over 600 trainees each year.

Over half of the RACP's STP positions include rotations through regional and remote areas, and feedback clearly indicates that these positions have added significantly to trainees' clinical training as well as their knowledge and understanding of specific rural health issues.

Half of all RACP STP posts include rotations in metropolitan areas, capitalising on the depth of experience that trainees can gain within the metropolitan non-hospital and private settings. One-fifth of positions directly work with Aboriginal and Torres Strait Islander communities, in a range of urban, rural and remote settings.

Because the STP is focused on supporting training rotations in a variety of settings, the RACP is aware of many services that have been possible because of an STP position. As just one example, the STP has increased the capacity of a community-based diabetes initiative in Western Sydney, resulting in marked improvements in diabetes outcomes.

> *"Patients are being managed better - an early evaluation of the first 20 patients to go through the Initiative has found that HbA1c levels have dropped 1.5% over the course of the year."*
>
> Prof Glen Maberly, Senior Staff Specialist and STP Supervisor, Blacktown Mt Druitt Hospital

These improved health outcomes, and improved availability of health services in areas of need, must be supported to continue into the future.

In addition to the benefits the STP is delivering today, its design means it is able to help shape the health workforce of tomorrow. In this sense, the STP is operating 'ahead of the curve' in supporting the future of specialist practice. It has, for example, supported an increase in the number of training positions for general medicine specialists. This ability is vital to ensuring Australia has the right blend of generalist and sub-specialists required to meet future patient needs.

The RACP believes the ongoing success of the STP will be ensured by:

1. **Maintaining the program's commitment to providing high quality training in expanded settings that skill specialist trainees to meet Australia's future health needs;**

2. **Supporting training posts in a broad range of expanded settings including community-based settings, Aboriginal Medical Services, private sector, and rural and regional settings;**

3. **Quarantining a funding pool to enable multiple posts/sites to form part of an integrated training network in specialties that address areas of workforce need; and**

4. **Adjusting specific administrative and funding aspects of the program to maximise its efficiency and effectiveness.**

These four requirements underpin the RACP's response to the Department's Discussion Paper, and are set out in more detail below.

1. The aims and objectives of the STP

The RACP believes the aims and objectives of the STP are appropriate. However, consideration could be given to including an additional aim which relates to building capacity for emerging models of care (for example, integrated health care) and a workforce with the experience to deliver care within new innovative models.

The ability to have STP positions in a wide range of expanded settings clearly aligns with overarching Government strategies and priorities that recognise that in the future more health services will need to be delivered in out-of-hospital community-based settings and in a multi-disciplinary, integrated manner. These include the growing demand for patient-centred care, especially in the delivery of chronic disease management services, aged care and palliative care.

Reviews of RACP posts indicate that the STP is performing extremely well in its current form. These findings match the positive conclusions of previous formal reviews of the program, namely the 2013 Review of Australian Government Health Workforce Programmes and the 2014 performance audit report released by the Australian National Audit Office.

Recent RACP surveys and reports show:

- **STP positions represent approximately 10 per cent of all RACP Advanced Training positions**. This is a significant addition to the capacity of the health care sector to train physicians, as well as to the sector's service delivery.

- **Approximately 60 per cent of RACP STP posts are located in non-hospital settings**. The program has been successful in increasing specialist training and workforce capacity in settings such as Aboriginal Community Controlled Health Services, rehabilitation facilities, palliative care facilities, community health centres and aged care facilities.

- **Approximately 47 per cent of RACP STP posts are in private settings**. This large proportion indicates the program is successfully tapping into the contribution that the private sector can make to the training of the future specialist workforce.

- **Approximately 52 per cent of RACP STP posts involve some training in a rural or remote setting**. This provides doctors undergoing specialist training with a deeper understanding of the issues faced by patients living in rural or remote Australia, and better prepares them to effectively treat and manage the rural patients they will see throughout their career. It also highlights that the STP is successfully supplementing the specialist workforce in rural or remote areas. Figures show that in remote and very remote areas, STP increases the number of doctors available by 15.4 and 18.9 per 100,000 population respectively.

- **Approximately one-fifth of RACP STP posts contain a component working in Aboriginal health.** This provides critical training for future specialists working with

Indigenous populations across a wide range of geographical areas, to help them understand health issues unique to Indigenous populations.

- **Seventy-one per cent of recent Fellows who completed a rural STP rotation during their training report that they are either resident in a rural area or are working in a rural area on an outreach basis[1] The corresponding figure for recent Fellows who did not complete a rural STP rotation is 59 per cent.** It therefore appears that STP may lead to more physicians practising in rural areas than might otherwise be the case.

- **Applying the strictest definition of 'generalist', generalist STP positions account for just under 50 per cent of RACP STP positions.** This figure highlights the success of the STP in being able to shape the future health workforce, particularly given that training and career pathways for generalist specialist physicians in some regions are relatively new and emerging.

In 2015, the RACP commissioned a survey of all STP site liaison staff. The results showed overwhelmingly that STP sites perceived great value from the program. Respondents to the survey said that the STP was beneficial to the organisation (100 per cent said at least to a moderate extent) through:

- Increasing the organisation's capacity for service delivery and helping to respond to the needs of the community
- Creating additional training positions and pathways
- Introducing a good learning culture and education
- Expanding skills within the workforce, and
- Improving patient care and outcomes.

Respondents stated that the STP helped build capacity of health services (99 per cent said at least to a moderate extent) by:

- Increasing service delivery and training opportunities for staff
- Enhancing workforce diversity by funding specialty positions that would otherwise not be available
- Increasing trainee exposure to different procedures, treatments, and conditions
- Increasing ability to meet community needs

Ninety-nine percent of respondents said that the RACP's administration of the program was at least moderately effective, with 86 per cent rating it effective to a large or very large extent.

Feedback through College surveys report the following quotes from trainees and supervisors regarding the value of the STP.

Trainees:

- *"The most useful aspect has been assessing the older population in their environment, thus assisting in making a more accurate assessment."*
- *"Exposure to patients in the community and in their own homes. A lot of contacts with General Practitioners including allied health professionals."*
- *"Increase in the breadth of knowledge in community geriatrics, especially within Aboriginal community that otherwise would not have experienced."*
- *"The opportunity to work in alternative health care settings (alternative to hospitals) is eye opening and highly relevant since most of us will end up working in the community rather than the hospital setting."*

[1] Based on survey research commissioned by the RACP in 2015. Although these results are not statistically significant, they are indicative that rural STP placements influence Fellows' propensity to work in rural areas.

- *"Gives a good community perspective and insight on a patient's care and available services and hospital avoidance programs."*
- *"An opportunity to practice holistic paediatric medicine and deliver it to a very vulnerable and deprived sector of the population."*
- *"Exposure to a new and different health care setting poses new challenges and encourages development of the trainee - not only clinically, but in terms of communication, leadership, health advocacy etc. Allows experiences you would not usually encounter in the primary training hospital."*
- *"It truly reflects community rheumatology, and prior to becoming a specialist this is an excellent opportunity to see what challenges are to be faced in day to day practice. The direct supervision of every patient encounter is not available or possible in hospital rotations, and this rotation makes it possible, which is a good learning opportunity."*

Supervisors:

- *"Because it's not traditional there are fewer assumptions, supervision is fresher, challenging and interesting"*
- *"Exposure to more holistic and integrated care for clients with chronic conditions."*
- *"The training in this model is much more one to one and personally supervised. The cases are more complex (community dwelling etc) and more independence is needed by the trainee. It has proven a rewarding experience for both myself and the trainee."*
- *"The relationship between consultants and trainees is much closer than in the public hospital environment as we are working in the same offices and there are no junior resident staff. The opportunity to provide structured education and supervision for outpatient sessions is much better than in the public outpatient setting due to the ability to structure timing of outpatient appointments."*

2. The importance of training in all expanded settings

The College is concerned that some sections of the Discussion Paper specifically focus on rural and regional settings rather than all expanded settings, and that this might reflect an idea of narrowing the scope of the STP going forward.

If this were to happen, doctors being trained as specialists would lose access to the important range and depth of experience that can be gained in metropolitan aged care facilities, private hospitals, rehabilitation facilities, palliative care facilities, community child health centres and Aboriginal medical services.

As can be gauged from the trainee and supervisor quotes listed in the previous section, the value of the STP to the RACP, trainees and the community is that it flexibly targets all expanded settings. This breadth must be maintained in any future iteration of the program to avoid reductions in access to, and the delivery of, critical specialist services. For example, the STP supports specialist paediatric care in the community for children from vulnerable backgrounds; specialist treatment in the community for patients with chronic and complex illnesses through an integrated approach to care; and enables trainees to improve responsiveness to communicable disease outbreaks.

Moreover, College surveys indicate expanded settings outside inner metropolitan teaching hospitals better reflect the environment trainees will practice in when they become Fellows, improving their readiness for specialist practice, particularly those where an integrated multidisciplinary team care approach is important.

Patients and communities would also lose out on the health services that are made available because of the availability of a doctor in an STP training position, and the positive health care outcomes that follow.

The case studies detailed below illustrate the benefits that are being realised in five STP settings - an urban 'diabetes hotspot', a private rehabilitation medicine practice, a rural general medicine environment, a metropolitan community child health setting working with Aboriginal patients, and an inter-regional specialist health service for people with intellectual disability and complex health needs.

These examples are evidence of the positive training and patient outcomes of the STP and the importance of preserving its current remit.

Case Study 1 - Delivering Better Primary Care to Diabetes Patients, Diabetes Prevention and Management Initiative in Western Sydney

Professor Glen Maberly has used STP funding for a doctor training in endocrinology to support the implementation of the Western Sydney Diabetes Prevention and Management Initiative (the initiative). Western Sydney is considered a 'diabetes hotspot', with the risk of developing diabetes twice as high as other areas of Sydney.

The initiative supports coordinated care between specialists, General Practitioners (GPs), allied health practitioners and hospitals, and focuses on improving care for patients with diabetes within and outside of the hospital setting.

Prof Maberly and the STP-funded endocrinology trainee visit General Practices in Western Sydney, where they conduct an outpatient clinic within the General Practice setting, where they:

- Join GPs in their consultations with diabetes patients;
- Discuss case management with GPs and practice nurses; and
- Upskill GPs and practice nurses in diabetes care and management.

Since the beginning of 2014, Prof Maberly and the STP-funded trainee have visited 30 GP clinics and upskilled 50 GPs to manage over 150 patients. This has improved primary health care in the region by increasing the capacity of GPs to manage these patients with diabetes, and by enabling more effective use of hospital-based outpatient clinics. As a result, waiting times for outpatient clinics within the hospital setting have significantly decreased.

Patients are also being managed better, with GPs reporting greater confidence in their management of patients with diabetes. An early evaluation of the first 20 patients to go through the initiative has found that HbA1c levels have dropped 1.5% over the course of the year, a substantial amount.

STP has increased the capacity of the initiative, by effectively doubling the number of GPs that can be upskilled.

The STP-funded trainee has also led a pilot project at Blacktown hospital with the aim of finding undiagnosed diabetes patients. This program has instigated HbA1c levels being measured for all patients having bloods tested within the hospital. Over 50 per cent of patients have returned abnormal HbA1c levels as part of this project. Those with levels greater than 9 are followed up whilst in hospital and again post-discharge to ensure better management in the future. Without this STP position, this program would not have been possible.

Case Study 2 – Tapping into the Capacity for Training within the Private Sector, Rehabilitation Medicine in Queensland

Dr Saul Geffen supervises or co-supervises four STP training positions in Rehabilitation Medicine in south-eastern Queensland. The positions are:

- One based at Dr Geffen's private practice, focussing on the community, an Aboriginal

Medical Service, and outpatient rehabilitation for chronic pain and cancer. This includes a rural outreach service at St Vincent's Toowoomba.
- One based at Canossa Private Hospital, a small private hospital in Brisbane. Canossa has 30 rehabilitation/geriatric beds and presents a mixture of public and private, and interim, transitional care patients and outpatients.
- Two based at the Mater Brisbane Hospital rehabilitation unit. This is one of the largest rehabilitation services in Brisbane, with 50 beds.

Between the four positions, there is a wide spread of private organisation work (all employers are private organisations), community work (including much outpatient work, community rehabilitation and Aboriginal Medical Service work) and rural work (at Toowoomba).

The STP provides approximately one-quarter of rehabilitation medicine training positions in Queensland and is therefore critical to the future of rehabilitation medicine in Queensland.

All three types of settings provide great benefits to specialist trainees, as they are exposed to many situations that they would not encounter in a public teaching hospital.

This is because:
- Trainees in their six-month rotations are exposed to a wide variety of practice locations, including combining tertiary hospitals with smaller hospitals.
- Almost all positions have a component of community work. This allows trainees to treat many patients with chronic illnesses, who are not sick enough to go to a hospital, but who require rehabilitation medicine services in relation to their return to work, integration into the workplace, return to activities of regular life (such as driving), brain injury assessments, management of chronic pain, or sub-acute management of sequelae of cancer. This type of patient is unlikely to be encountered in public teaching hospitals.
- Trainees gain close contact with the consultant (supervisor). They receive more one-on-one structured clinical management of patients.
- They gain more autonomy.
- Private hospitals have a premium on being effective and efficient (as they are profit-driven) and can show trainees good working methods.
- Working arrangements are flexible, for example, to accommodate parents of small children.

The overwhelming advantage for patients in these STP settings is increased access to treatment from a rehabilitation specialist.

Case Study 3 – Broadening Training Experience and Creating a Culture of Education, General Medicine at Albany Regional Hospital

Professor Alasdair Millar supervises two STP training positions at Albany Regional Hospital in rural Western Australia. Albany Hospital manages a broad range of general medical conditions.

Trainees in STP posts spend most of their time working in the hospital, with some time spent in outpatient clinics (particularly in medical oncology and palliative care).

Trainees at Albany Hospital experience a wider variety of patient conditions than in a metropolitan teaching hospital due to the smaller regional setting. This environment lends itself to practitioners treating the whole patient and thinking about how their treatments affect the patient's life, not just as related to a single specialty. As such, trainees working at Albany Hospital look at patient care more holistically and gain more self-reliance, as specialists from different specialties are not necessarily available for consultation.

Prof Millar reports that the STP positions have brought an educational culture to Albany Hospital. The quality of care and treatments for patients have improved as they are based on more recent evidence and trials. Registrars participate in presentations and attend meetings, which also helps transfer their knowledge to other staff.

Case Study 4 – Training Specialists to Deliver Care to Patients in the Community, Community Child Health in Adelaide

Dr Deepa Jeyaseelan supervises a community child health training post at a range of GP Plus clinics and child development/protection clinics in metropolitan Adelaide. Trainees rotate through various community settings, including an Aboriginal family paediatric clinic and early childhood developmental clinics based across GP Plus sites, a child development unit and a child protection service. The post is one of two in South Australia, funded by STP, that offer community paediatrics. All work is done on an outpatient basis.

Trainees work with vulnerable families (often in lower socioeconomic groups) infants, including infants and children in out of home care or those who have experienced trauma and neglect, Aboriginal families, culturally and linguistically diverse families, and children with disabilities (e.g. developmental delays, learning/intellectual difficulties, autism, deafness, physical disability).

Dr Jeyaseelan reports that trainees in the STP post undertake work that is substantially different from that in a teaching hospital and with more responsibility and autonomy. They work directly with patients and their families in performing complex medical, developmental and psychosocial assessments. Rotations through the STP post are for a period of 12 months, longer than the duration of a typical rotation they would have in a hospital setting, which gives them time to get to know the patients' conditions and circumstances intimately and enables them to provide follow-up and continuity of care over a more extended period. Trainees work as an intrinsic part of a multidisciplinary team, including allied health, community agencies, education services, child protection agencies and the police, gaining many skills in working with patients in a setting close to that in which they will work when becoming Fellows.

STP trainees receive a comprehensive immersion into community paediatrics. Patients also benefit from the increased time they are able to spend with the registrar, who is able to more thoroughly understand their situation.

Dr Jeyaseelan states that it is critical to helping produce community paediatricians who understand how to work in a community setting.

Case Study 5 – Training in Intellectual Disability Medicine, Metro-Regional Intellectual Disability Network in South Eastern Sydney

Children, adolescents and adults with intellectual disability have poorer health outcomes and greater difficulty obtaining health services in comparison with the general population and particularly, in regional, rural and remote areas. They experience a high prevalence of significant medical and mental health problems and their health conditions are often unrecognised, misdiagnosed and poorly managed. They require input from a range of sub-specialists and services which must, of necessity be provided in a multidisciplinary and multi-organisational model. There are a limited number of specialists with experience in the field and limited opportunities for trainees to gain experience in standard training posts.

Dr Robert Leitner has funding for four STP posts in Paediatrics, Rehabilitation Medicine, General Medicine and Psychiatry. The aim of these posts is to reduce health inequalities for people with intellectual disability by providing education and training, enhancing the capacity of existing services to meet their health needs, and improving access to quality health services especially in regional settings. These doctors are attached to a specialised multidisciplinary team known as the Metro-Regional Intellectual Disability (MRID) Network. The MRID hub and spoke model utilises the existing and well established services in a metropolitan area (South Eastern Sydney Local Health District) to develop an inter-regional specialist health service for people with intellectual disability and complex health needs in regional, rural and remote areas.

The key outcomes have included:

- A number of STP Registrars in Paediatrics, Rehabilitation and Psychiatry have developed career paths in Intellectual Disability Medicine, an area of workforce need.
- The STP registrars have engaged and connected with clients and families/ carers in their local community settings and developed an interest in practising in regional and rural settings.
- The doctors have provided capacity building and practical support for local clinicians.
- The integration of trainees trained by the program into mainstream health services has further increased access for clients and their families/carers to local services.
- The exposure to a variety of settings in the community such as special schools, day programs and group homes has provided the doctors a better understanding of integrated care.
- The focus on integrated care in expanded community settings has resulted in the prevention of unnecessary and prolonged hospital admissions.
- The MRID has received an international award in 2014 for its integrated model of care.

The transition to National Disability Insurance Scheme (NDIS) requires the development of greater capacity within the mainstream health services to address the needs of people with disabilities. The aims and objectives of the STP posts are in strong alignment with and provide support for the scheme and one of the STP registrar graduates is now a member of the NDIS RACP Working Group.

3. Enabling integrated training networks

The RACP recommends quarantining a funding pool to enable multiple posts/sites to form part of an integrated training network in specialties that address areas of workforce need in rural and metropolitan areas. This would meet an aim of the STP and would be of benefit to many training settings, trainees and Colleges.

This new funding stream under the STP would be used to fund network directors, who are responsible for ensuring trainees are offered positions in a network of organisations.

The network funding pool should include an additional network administration fund set at, for example, $10,000 per site up to a limit of $40,000.

Networks will help reduce the likelihood of vacancies, ensuring trainees are always allocated positions, and facilitating access for general medicine trainees to sought-after subspecialty terms such as respiratory medicine, renal medicine and cardiology. Future general medicine physicians, including those in rural areas, can therefore develop competence in procedures that under current hospital systems are reserved for sub-specialty trainees.

4. STP administration and funding arrangements

This Departmental review presents a useful opportunity to update specific administrative and funding arrangements of the program, which the RACP believes will improve the efficiency and effectiveness of the STP. These include:

- Clarification of terms in the *Operational Framework*
- Increased flexibility in the amount of funding for STP posts, support projects and rural support loading, and the manner in which some payments (e.g. Private Infrastructure and Clinical Supervision funding) are made
- Improving processes for assessment, review and selection of STP posts
- Updating reporting and accountability mechanisms to ensure the program is achieving the aims and objectives intended by the Department.

4.1. The Operational Framework

The RACP believes the *Operational Framework* document is working well overall, and only recommends the following minor changes:

- The framework document would benefit from having a glossary to define and improve understanding of the terms. For example, in the 'Training Settings and Employers' section, it is unclear what is meant by 'backfilling' under private organisation.

- The inclusion of text clarifying the payments that do and do not apply for trainees on leave (e.g. maternity leave and annual leave).

4.2. Funding arrangements

Effectiveness of the Fixed Contribution to Salary Model and Indexation

The RACP considers the 'fixed-contribution to salary model' to be the simplest and most straight-forward way of allocating funds to different posts, and that the costs and complexity of a different model would most likely outweigh the benefits.

While other options could be considered, each of these would add complexity to the decision-making process and hence increase program administration costs. Increased complexity would also cause additional requests for reconsideration from sites and add to the length of the process.

In terms of the amount of funding, College surveys and reports of RACP STP posts have repeatedly reported that funding of $100,000 per annum is no longer viable for the provision of training at many sites. A number of current and prospective STP posts have commented that this amount is so far below the actual costs of training that it makes holding an STP position unviable. The RACP is aware of a few sites that intended to apply for STP funding, but did not because the funded amount was inadequate.

It is noted that the amount of $100,000 per post has not changed in many years. All measures of inflation over that period have recognised significant increases in costs in that time.

The RACP believes that indexation by 1 per cent, or even 2.5 per cent, per annum from 2018, as proposed in the discussion paper, would not make a noticeable difference, as the amount currently funded is too low now and using an indexation percentage very much below the inflation rate would not be effective. With a higher indexation percentage applied, there would probably be no immediate impact on the availability of trainee posts (because the funded amount is currently low).

Although we acknowledge that this may result in the funding of fewer posts, the College recommends that each STP post should be paid a higher amount of $120,000 per FTE per annum, with all posts paid the same amount. This would enable STP posts to operate without so much pressure to find additional sources of funding.

Questions raised in the Discussion Paper regarding registrars billing Medicare through supervisors are difficult to answer given that Medicare billing is a complex area as it relates to the STP. The nature and extent of billing depends on a number of factors, including the proportion of each position that is private (which can change during the year for some posts), specialty-specific items, the nature of the practice and the level of trainee experience. If the STP funding available to sites were to take anticipated Medicare claiming into account, the RACP would be concerned about unintended negative consequences for particular sites. This would also add to the complexity of administration of the program. The RACP does not recommend taking Medicare revenue into account in STP funding for these reasons.

Use of funds from vacant posts

The RACP believes the STP would perform even better than it already is through an improved approach to minimising vacant posts, such as through networking arrangements as described above at Section 3,.

The RACP has recorded an annual 'underspend' of approximately 12 per cent of trainee salary contributions per annum due to posts remaining unfilled for a part of the year. Current arrangements are somewhat inflexible and do not allow the redistribution of funds in the event of vacancies. The College recommends that current arrangements be adjusted to enable any surplus funds to be used for:

- additional STP posts - to date, this has been done through the use of 'period funded' posts; or
- provision of an increase to the salary contribution to existing posts.

Rural Support Loading

Rural Support Loading (RSL) aligns with the aims and objectives of the STP by supporting trainees in rural areas to cover increased training costs associated with being in a rural or remote location.

RACP surveys of ex-rural STP trainees report that training while in STP rural settings is at least as good as, and in some cases better, than training received in metropolitan locations.

The RACP has frequently had surplus RSL funds, indicating that the full amount of RSL is not required by all sites.

Changes recommended to the RSL system are:

- Colleges that administer the STP should discuss how RSL should work at the beginning of the program and achieve consensus on the method. This will be less confusing to STP sites, as each College currently uses different processes and schedules for RSL.
- Guidelines from the Department for appropriate uses of RSL are required, to ensure appropriate use of funding.
- RSL funding should be allocated to Colleges as a pool, along with guidelines for its use. The Colleges would then allocate the funds to individual posts based on criteria set by the College and in keeping with guidelines from the Department.
- To introduce more flexibility to enable Colleges provide more than $20,000 of RSL funding for posts that require a greater amount. RACP reports show that in 2015, 9 out of 223 posts eligible for RSL required more than $20,000, with the costs of accommodation being the main reason.
- The RACP suggests increasing the maximum RSL per post to $25,000. The amount of RSL per post has not changed in many years and has not taken into account rising costs.

In terms of the classification of rural settings, the RACP believes there is no need to change from the Australian Standard Geographical Classification model for the purposes of the STP.

The system of RSL should remain flexible to suit different settings and needs. In regards to whether rural loadings should be scaled so that remote settings receive more funding than less remote settings, analysis by the RACP has shown that the amount of RSL required by STP posts has little relationship to how remote they are (and many at lower RA ratings still require the full $20,000, or even more). Flexibility is required as many other factors come into the equation, including the specialty, the number of other training positions at the same site, and the individual organisation. As such, the College does not recommend that rural loadings are scaled so that remote settings receive more funding than less remote settings.

Support Project Funding

The present system of funding support projects has generally been appropriate to date and has helped in meeting the aims and objectives of the STP. Support project funding has enabled the RACP to develop a wide range of materials for training both supervisors and trainees, as well as develop many other initiatives of benefit to STP and other settings.

The RACP notes that many STP support projects, given their educational nature, also happen to benefit non-expanded settings. The RACP would be greatly concerned if any non-STP benefits of support project funding were viewed as a reason to constrain funding. Significantly fewer projects would be suitable for support project funding if this were to occur.

In terms of support project funding allocated, the RACP recommends that the current amount should be divided into two equal pools:

(i) An amount given to individual Colleges, for College-specific projects, which would be 50 per cent of the amount currently given (based on the number of posts at the College).
(ii) A new pool to be used for collaborative development of support resources suitable for use by more than one College.

Past allocations of support project funding, based on number of posts, allocated large Colleges such as the RACP more support project funding than they required, and at the same time, allocated insufficient funding for even small individual projects to smaller Colleges. A properly governed communal pool of funding would substantially alleviate this problem.

On a separate note related to support projects, the RACP would welcome further guidelines from the Department to clarify the Department's view on allowable uses of support project funding.

Administration Support Payments

The Discussion Paper raises questions regarding Administration Support Payments. The RACP recommends no change to the calculation of administration support payments. To date, the RACP has provided an estimate of the expected administration costs and this has been the amount funded and this has worked well.

Timing of Payments to Specialist Medical Colleges

The College believes that the timing of payments made to date through the STP is working well and that no changes are required.

Private Infrastructure and Clinical Supervision Program

As the RACP has no direct involvement with Private Infrastructure and Clinical Supervision (PICS) funding, the College is unable to comment in detail on this item. However, a key issue, which has been raised with the Department previously, is that PICS is administered by a different organisation from the one administering other STP funding. This frequently confuses and puts STP sites under an administrative burden, as it requires 'triangulation' of discussions between the RACP, the Department and the Royal Australasian College of Medical Administrators (RACMA). RACP STP sites consistently raise this as an issue for them.

Moreover, a number of posts have had an incorrect public/private mix recorded by the Department in the early days of their STP involvement, which has resulted in these posts being paid incorrect amounts of PICS funding. The Department's advice has been that the private mix cannot be changed once it is set (or at least, can only be reduced, not increased). This has adversely affected a number of posts that rely on PICS funding for the viability of their STP arrangements.

4.3. Review, Assessment, Selection and Length of Training Posts

Overall, the RACP believes the current system of post selection promotes the broad aims of the STP by increasing the capacity of the healthcare sector to provide specialist training, while supplementing the workforce in rural locations and developing specialist training arrangements outside inner metropolitan settings.

However, a number of specific design improvements are recommended in relation to the review, assessment and selection of training posts.

Review of STP Posts

The RACP agrees with the proposal in the Discussion Paper of regular reviews of STP posts. Reviews will ensure posts comply with the aims and objectives of the STP and that they represent an optimal use of STP funds. Many of the training posts in the current program have been in place for more than ten years, despite the nature of training positions sometimes changing over time.

There are two distinct ways in which these reviews could occur:

1. Rotating posts through the program for a fixed period (we recommend five years). Any post that is five or more years old would be informed that they will need to reapply for their funding; or
2. Reviewing posts periodically to ensure they are still suitable to be in the program.

Under option 1, the RACP recommends that posts remain in the program for five years. (A shorter time would adversely impact operation of STP posts.) The following method for replacing training posts is recommended:

a. Posts that are more than five years old are discontinued from the program, but are able to apply for funding as part of a competitive application process.
b. The application process is open to any other agencies wishing to apply.
c. The application process is held annually.
d. Criteria to enter the program are reviewed annually and may change slightly from year to year (depending on demand and other issues).

This method will bring fresh training environments into the program and will help reduce occurrence of training posts that no longer offer effective or suitable training.

Under option 2, the RACP recommends that reviews focus on whether the post still meets the aims and objectives of the STP, including meeting priority areas in the program.

The review could also include whether the post has been able to attract trainees over the duration of the post or whether it has been vacant for long periods. Posts that have been vacant for too long a period should have their STP funding discontinued to make way for other posts that are more able to use the funding.

Assessment of STP applications

The RACP can see the benefits of adopting the ‘ACEM’ model, where the College is responsible for the entire assessment of STP applications. Adopting this model would enable the focus of assessments to be placed on the educational merits of training posts.

If, however, applications continue to be assessed by the Department, the RACP requests that the assessment process is made more transparent so that it is clear why certain applications are prioritised above others (particularly in relation to the priority areas of the program).

Selection of posts

In regards to the Department's mention of projections made by the National Medical Training Advisory Network (NMTAN) to improve the responsiveness of the STP to the workforce needs of the broader community, the RACP is unable to comment because it is unaware of any such analysis by the NMTAN.

Tying Funding to Rural and Regional Placements

As described in Sections 1 and 2 of this submission, the RACP strongly recommends against limiting STP to positions with a rural or regional component. This would not align with the program's aims and objectives to provide high quality specialist training opportunities and to develop training arrangements beyond traditional teaching settings.

There are significant issues in regards to the Department's proposal for funding to follow the individual trainee through placements. Delivery of this outcome would require substantial overhaul of the program, which is designed to fund posts and not follow trainees through their complete training. The RACP recommends against modifying the intent of the STP in this manner as it would require wholesale structural change of the program. Similar points are made below in regards to Aboriginal and Torres Strait Islander trainees.

Use of STP funds for identified trainees

In the Department's Discussion Paper, the point is raised as to whether identified posts are required for trainees of an Aboriginal or Torres Strait Islander (ATSI) background. The RACP is working to support the training of ATSI graduates and would support the active placement of ATSI trainees into training posts (whether STP or non-STP).

However, reserving specific positions for ATSI trainees is not considered practical. There are very few trainees who have identified to the College that they are from an ATSI background. Therefore, reserving specific training positions just for these trainees would be impractical. Such positions would need to be suitable for the trainee at a specific stage of their training and be in a suitable location for them. Because of the low volume of these trainees, it would not be possible to reserve a training position purely for this situation.

The RACP tracks the placements and progress of all trainees' programs, regardless of their backgrounds. The RACP keeps statistics on members of an ATSI background. However, it is not compulsory to declare this status and so it is not provided by all members. Because of sensitivities in disclosing the information by some people, a formal requirement for keeping these statistics is not feasible. Any data kept may well be misleading.

The question is also raised in the Discussion Paper as to whether STP funds should be available for a dedicated Aboriginal and Torres Islander (ATSI) traineeship. The RACP believes that introduction of training positions for registrars of Aboriginal or Torres Strait Islander background is an extremely important initiative to address the Indigenous workforce shortage in Australia. However, the RACP holds that this should occur through a program entirely separate from the STP. The STP is focussed on training positions, which run for 12 months at a time, and is not set up to manage complete training of individuals over a six-year (or even three-year) period. Under the STP, there is no body responsible for managing a trainee's complete training pathway.

In regards to Specialist International Medical Graduates (SIMGs), the RACP has had very few SIMGs in STP roles. This may reflect the changing medical workforce profile in response to the doubling of the number of medical graduates in recent years and the consequent increase in demand for specialist training posts.

Length of Rotations in Training Posts

Some STP posts contain no or minimal time in expanded settings. The RACP believe that mandated longer rotations in expanded settings would address this issue.

There are also some posts for which the only time in an expanded setting is in an outer metropolitan public hospital – this does not clearly fall into the priority categories of rural, private or non-hospital settings. It is not clear to the RACP whether outer metropolitan public teaching hospitals meet the intended definition of expanded settings.

The RACP recommends that each STP post contains a minimum of 0.5 FTEs in expanded settings in total (with a minimum of 0.1 FTEs in each individual rotational facility) and a minimum elapsed period of six months that each trainee is in the post.

Trainee time spent in a post should be long enough for the trainee to gain an understanding of the environment. Six months is considered to be long enough in most cases. A maximum of 12 months per post is considered appropriate, although longer than 12 months could be acceptable if the post is part of a networking arrangement where trainees gain different experience after a 12-month period.

4.4 Reporting by Colleges and Settings

The RACP finds most of the Key Performance Indicators (KPIs) against which Colleges report to be clear, reasonable and relevant. However, some require data not captured by the RACP (as advised to the Department on previous occasions). The RACP has therefore been unable to report against them.

To improve reporting, the RACP recommends removing the KPIs against which the RACP is unable to report (these have been clearly identified in all RACP progress reports), and setting target or benchmark values for all or selected KPIs.

It is also not clear about what is done by the Department with the KPIs. While the RACP is able to report against them, there is no definition of ‘targets’ or benchmark values that should be targeted. Greater transparency is recommended in this regard.

5. Supporting Cultural Safety

The Department’s Discussion Paper raises specific issues regarding cultural safety training.

Under the STP, many posts involve trainees working in Indigenous communities, thereby increasing the need for meaningful cultural safety education programs. Other STP posts in expanded settings frequently involve services in communities with a wide range of cultural diversity. The RACP is using STP support project funding to develop cultural safety training for supervisors.

However, the RACP maintains that cultural safety training should be an integrated part of all specialist training and not a compulsory component of STP training. This view aligns with current College activities incorporating cultural safety into various training initiatives outside STP, as well as work being undertaken by the Australian Medical Council in this area.

Participating in an STP post will help trainees embed cultural safety learning covered prior to the STP rotation. This arrangement also avoids the possibility of a trainee who has already been through cultural safety training having to undertake repeat cultural safety training while in an STP post.

Conclusion

The STP ensures access to high-quality and relevant training for new medical specialists. The program's ability to broaden the capacity of the system to provide training based in community and private settings is delivering significant value to the trainees, as evidenced by the case studies and statements highlighted in this submission.

The program improves access to specialist services in rural, remote and Aboriginal and Torres Strait Islander communities, as well as supporting much needed new approaches to chronic disease management in 'hot-spot' areas and expanded settings – many of these programs would not be possible without these advanced training positions.

The RACP believes the ongoing success of the STP will be ensured by:

1. **Maintaining the program's commitment to providing high quality training in expanded settings that skill specialist trainees to meet Australia's future health needs;**

2. **Supporting training posts in a broad range of expanded settings including community-based settings, Aboriginal Medical Services, private sector, and rural and regional settings;**

3. **Quarantining a funding pool to enable multiple posts/sites to form part of an integrated training network in specialties that address areas of workforce need; and**

4. **Adjusting specific administrative and funding aspects of the program to maximise its efficiency and effectiveness.**

The RACP thanks the Department of Health for the opportunity to provide a submission on this critical training program. We look forward to meeting with the Department in the near future to further discuss the design of the STP and how to maintain and build upon the successes of the program to date.