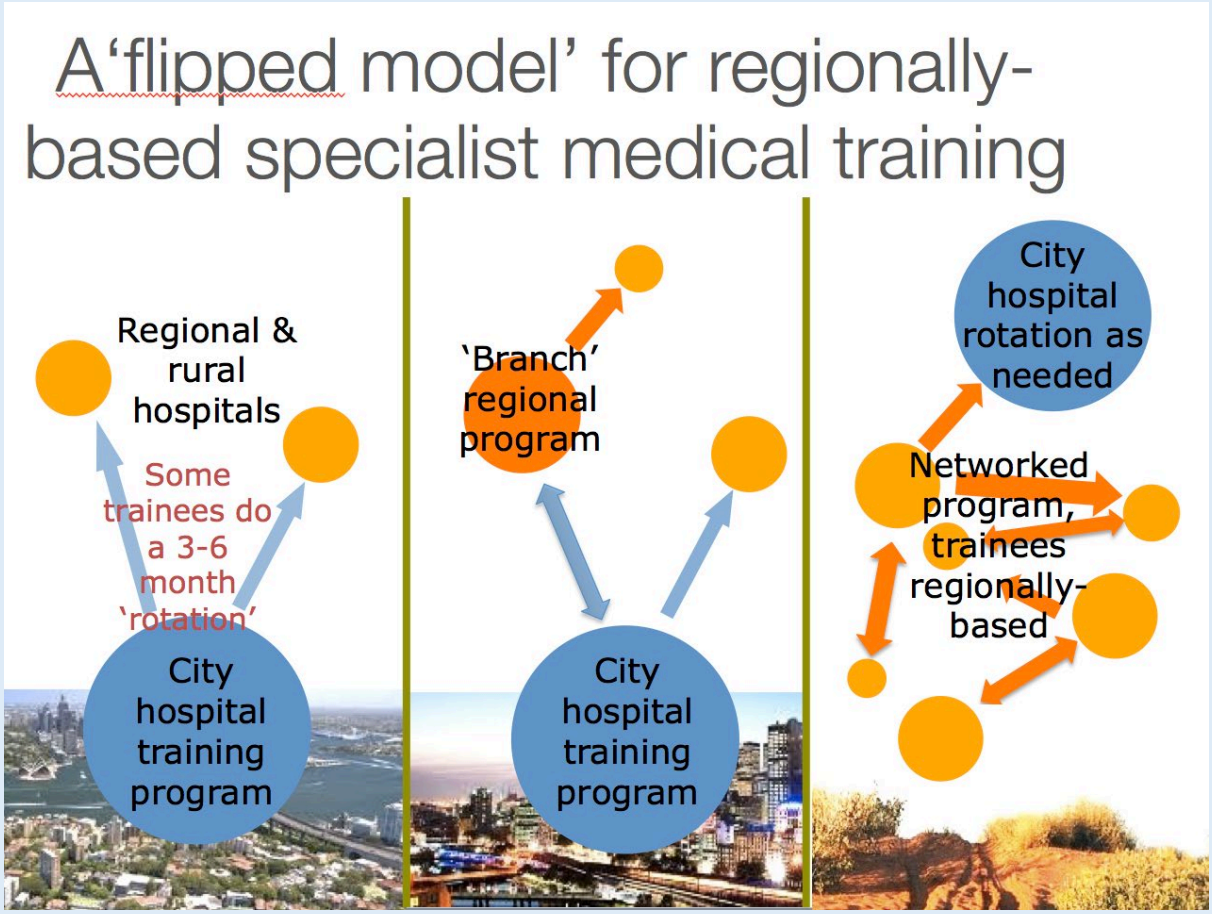
# FORUM REPORT

## Growing our own

## A Regional Training Transformation Forum 2017



# 1. Introduction

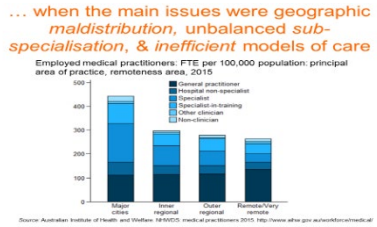
Despite Australia having more than doubled the number of medical graduates over the last two decades with more doctors per capita than most other developed countries, Australians who live in regional and rural locations continue to have poor access to medical practitioners. With a potential oversupply by 7000 medical practitioners by 2030, the total supply of general practitioners and medical specialists is no longer an issue but the distribution of them will be key to effective medical workforce planning for Australia.

This is a report from a forum held on Thursday 31st August convened jointly between the Council of Presidents of Medical Colleges and the Medical Deans of Australia and New Zealand with representation from the Australian Department of Health. The purpose of the forum was to build on work that has already been done, identify champions for change and establish a joint working group that can take forward the development of training programs and workforce models that address regional and rural workforce shortages. In developing the forum a background paper was circulated to participants to assist in preparation for the forum. The paper is at Appendix A and a list of participants is at Appendix B.

# 2. Perspectives on Regionally Based Training

## 2.1 Medical Deans of Australia and New Zealand

Professor Richard Murray presented and indicated that despite having a belief there was a shortage of doctors in Australia, the OECD Data showing the number of practising physicians, for Australia as rising from under 2 per 1000 population in 1980 and now sitting at around 3.5 per 1000 population, compared to around 2.6 for like countries (Canada, New Zealand, UK and US). The growth has occurred markedly since 2010. To address that 'shortage' Australia has been producing (& importing) a lot more doctors with data showing a lot more IMGs granted visas since 2010. As described in the background paper, it is not the shortage of doctors but rather the main issues were geographic maldistribution, unbalanced sub-specialisation, and inefficient models of care.




In this chart shown the distribution clearly depicts more doctors in general practice and specialist medicine in major cities. He suggested there was too much sub-specialisation. In addition, the reliance upon the international medical graduates who have been brought in as a short-term fix for rural shortages are now relocating into major cities, based on data from Medicare statistics.

The sustained investment by the Australian government in rural medical workforce policy initiatives over the past twenty years was acknowledged with reference to the map of new medical schools and rural clinical schools distributed around Australia. However, a rural training pipeline to specialist practice is the unfinished business.

In reference to the World Health Organisation's document on increasing access to health workers in rural areas, a set of recommendations about what works was raised, citing education, regulatory change, and providing financial incentives along with personal and professional support, as part of the package of reforms known to work.

With the WHO reference and evidence from other research the recommendation was for a 'flipped model' for regionally based specialist medical training whereby the city hospital training program where some trainees do a 3-6 month rotation to regional and rural hospitals would be flipped so that trainees would be based in a regional program, rotating to city and also out to remote areas.

The ***'Grow Our Own'*** model for specialist training in regional Australia was then discussed from the perspective of what such a model might look like. It was agreed that picking the right candidates who either came from rural and regional areas, or expressed an interest in working and training was vital. Showcasing what regional specialist careers might look like would also assist. However it was the linking up of regions to enable a critical mass in specialist training which was considered essential to ensure quality training and with a rotate-in to city hospitals for experience in tertiary level care. It was agreed that regionally-based specialist training needed to become a policy priority for governments, Colleges and employers. The model has implications for candidate selection, the design of rotations and the accreditation of posts. It was agreed why such a model was important and for it to occur soon was clear but it was the mechanism for making it happen which needed further development.

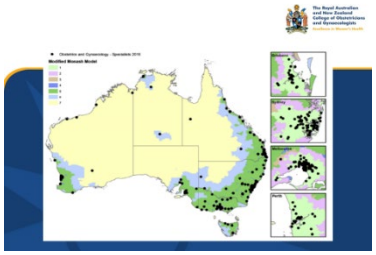
### 2.2 Regional Training from Commonwealth perspective, CMO

Australia's Chief Medical Officer stated that the development of regionally based training programs is very important, and there was a need to reduce the trainee numbers in the metropolitan training sites. The best lever for which government could enable any control over numbers was the STP. Professor Murphy considered it was important for Colleges to look closely at their accreditation processes as another possible element in enabling more regionally based training to occur. By this he meant that Colleges could enable more training posts to be available by accrediting more sites in regional areas. Professor Murphy emphasised the need for the supply of overseas trained doctors to be reduced and this was a challenge considering the direct engagement process by State/Territory jurisdictions and political overtones for health service delivery. He also discussed the implications for city hospitals as the service workforce will be different if there are less trainees available to consultants. He suggested that work needed to be done to develop the buy-in from specialists in the hospitals to 'let go' of trainees to go to rural areas.

## 3. Specialist Medical Colleges: current innovative models

### 3.1 Royal Australia and New Zealand College of Obstetricians and Gynaecologists

Prof Stephen Robson led the presentation on the Colleges work on Integrated Rural Training Pipeline posts and provincial training placements.



| Modified Monash Category | 2015 female population | Specialists and trainees (headcount) | Headcount per 100,000 population | Specialists and trainees (FTE) | FTE per 100,000 population |
|---|---|---|---|---|---|
| 1 | 8,518,707 | 1,841 | 21.6 | 2,151 | 25.2 |
| 2 | 1,101,906 | 204 | 18.5 | 251 | 22.8 |
| 3 | 782,212 | 135 | 17.3 | 166 | 21.2 |
| 4 | 438,711 | 16 | 3.6 | 23 | 5.2 |
| 5 | 871,058 | 6 | 0.7 | 7 | 0.8 |
| 6 | 143,126 | 14 | 9.8 | 17.8 | 12.4 |
| 7 | 95,130 | 0 | 0.0 | 0 | 0.0 |
| Grand Total | 11,950,850 | 2,216 | 18.5 | 2,615.29 | 21.9 |

The current spread of O&G specialists as at 2016 is shown in this map as reflected in the new Modified Monash Model areas and then in terms of the female population, available O&G workforce against those categories. The data shows where training and service provision is needed.

The RANZCOG training program is a six-year post-graduate program involving four years core then two years in advanced training. Trainees are assigned to an *Integrated Training Program* (ITP) which is a group of hospitals through which trainees rotate during their core training.

The *Provincial Integrated Training Program* (PITP) is a model first piloted in Dubbo, NSW in 2015. The broad objectives of the PITPs are to:

- Produce a Fellow with the skills required to work in a provincial setting
- To enable medical practitioners who have demonstrated commitment to rural health to undertake their specialist training and pursue a career in a regional area
- To encourage growth in the rural and regional O&G workforce.

The model sees trainees undertake training via a Provincial Pathway and spend the majority of years 1, 2 and 4 at Provincial site(s), and Year 3 in a major metropolitan teaching hospital. Since then RANZCOG has received funding and has established two IRTP Posts in Mackay and Dubbo.

The following factors were important in selecting locations:

- Accreditation and established rotations
- Support and adequate training opportunities
- Relationship with University Medical Schools
- Other RANZCOG Training Programs

Trainee selection for IRTP posts is via Key Selection Criteria to ascertain a potential trainee's commitment to working in a rural setting. They must have met one of these:

- Lived at least five years in an approved regional/rural location since the start of primary school education;
- Been, or currently are, a rurally bonded undergraduate student;
- Worked a minimum of one year as a GP in a single approved regional /rural location, or
- Undertaken a minimum of 6-12 months of clinical training in an approved regional/rural location either as a medical student, intern, resident or registrar.

Trainees are also advised that transferring from PITP to metro training posts during Core training will not be considered. Their progress is managed through the College's Hospital Accreditation Section and the relevant Regional Training Accreditation Committees with visits monitored by means of submitted Progress Reports from the hospitals.

The training program needs to be well planned to enable the requirements of the curriculum to be met over the four years of Core training. This requires close communication between Training Supervisors at different sites of an IRTP PITP. There needs to be a "local rural champion / hero" the key as hospitals and key staff need to be committed to the rural training program. Hospitals need to be innovative in the ways they enable trainees to access training opportunities. The College needs to ensure selected trainees for the IRTP are genuinely committed to working rurally.

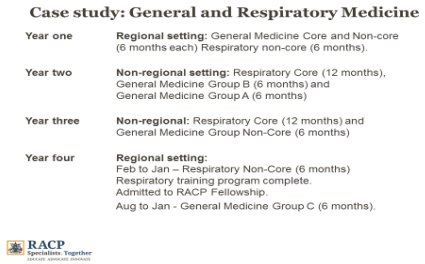
The 2016 Expressions of Interest round identified two potential O&G posts in Bendigo and Mildura, in addition, Gippsland has expressed interest in establishing an IRTP post.

### 3.2 Royal Australasian College of Physicians

Dr Catherine Yelland, President of the RACP presented to the forum and outlined the challenges faced by rural and regional training sites as ranging from how to best make available a depth and breadth of learning experiences through to avoiding a geographical maldistribution of trainees. She emphasised that trainee preference to optimise training and progress to Fellowship needs to be matched with rural and regional communities' access to care. The RACP had observed that the centralisation of training at teaching hospitals places pressure on rural and regional settings to find positions for all trainees, which can reduce the diversity of training experiences and result in challenges attracting and retaining trainees. The RACP has sought – and seeks - to address these challenges in a number of ways, as follows:

- A Dual Training pilot, developed and delivered in partnership with NSW Health to allow trainees to train in regional and metropolitan settings;
- The administration of over 400 Specialist Training Program places, which includes rural and remote hospitals and community health settings. This also includes the Integrated Rural Training Pipeline; and
- Plans within the RACP Education Renewal Program, which will include opportunities to align training to rural workforce needs and increase regionally based specialist training opportunities.

**The Dual Training Pilot & Case Study**


There were two models within the Dual Training Pilot for NSW: General Medicine and Respiratory Medicine at Dubbo / Royal North Shore, Sydney, and General Medicine and Endocrinology at Orange / Prince of Wales, Sydney. There were two Advanced Trainees recruited for the pilot, both of whom started in 2014. The trainees spent time in both regional and metropolitan settings. This allowed them to complete two specialty training programs concurrently and allowed them to complete their training in reduced time (when compared to completing the programs in sequence). The trainee's journey in General Medicine and Respiratory Medicine is shown in the slide above. In the final year of training, the trainee returned to the regional setting to complete six months of Respiratory Medicine – at which point they were admitted to RACP Fellowship – followed by a final six months of General Medicine training. The importance of generalist training especially in rural settings was noted.

**Training Pathways:** The RACP administers forty two training pathways. Sites must be committed not just the local champion e.g. Alice Springs. The most popular is general medicine and one other specialty. There have been several positive outcomes from the pilot. This includes another dual training program, which was implemented in Victoria in 2015 following general Medicine and Gastroenterology model (Bendigo / Austin Health, Melbourne). The success of these pilots has garnered additional support from RACP Committees – including the Advanced Training Committee in General & Acute Care Medicine – keen to offer more opportunities like these. The RACP also hopes to support sites to help them develop dual pathways, as needed.

**Specialist Training Program** is a Federal Government initiative to increase training posts for specialists outside traditional public teaching hospitals, providing an annual trainee salary contribution of $100,000 per post. The RACP administers more than 400 Specialist Training Program (STP) posts, which includes rural and remote settings.

- 39.7% of STP training takes place in rural settings. This includes 'period funded' posts which are short term and is based on rotational facilities, rather than actual trainees in place.
- There is also an additional loading for rural and remote settings available.

The **Integrated Rural Training Pipeline** has been designed specifically to focus specialist training within rural and regional settings. In 2017, the RACP allocated six training posts. The application process for this is through Expressions of Interest, which are managed by the Department of Health, and reviewed in partnership with the RACP and jurisdictions.

Following the first round of IRTP funding the successful models of training have incorporated a 'networked' approach to enable the trainee to complete the majority of their training within a rural setting (with 66% being the minimum requirement). Dr Yelland indicated that in order to deliver this training, a number of rural healthcare settings have joined together to deliver the entire training program. In doing so, the training pathway is clearly mapped and the trainee commits to moving between the settings identified. This thinking also anticipates the formation of the Regional Training Hubs.


This slide outlines two examples of successful applications from the last round of Expressions of Interest, through the Integrated Rural Training Pipeline (IRTP). The first is an Advanced Training position in Nephrology, with the trainee located at Alice Springs Hospital and Central Australian Renal Services.

The model for this position is built around community outreach clinics, telehealth services and remote provision of dialysis services. The second is an Advanced Training position in Sexual Health Medicine, with the trainee located in three Tasmanian Sexual Health Service clinic locations, in Hobart, Launceston and Devonport.

## 3.3 Royal Australasian College of Surgeons

Mr John Batten FRACS, President, Royal Australasian College of Surgeons presented to the forum. According to 2016 Activity Report & 2016 RACS Census the surgical workforce in Australia shows:

- 14.44% of RACS Fellows work and live in rural and remote areas of Australia.
- Majority are general surgeons, followed by orthopaedic and otolaryngology (ENT) surgeons.
- 34% report they practice in both metro and rural or regional locations.
- 2.3% of RACS Fellows are locums and nearly half are Younger Fellows under the age of 40 years.

Mr Batten discussed generalism and sub-specialisation with reference to the **Surgical Education Training (SET)** programs, which produces generalists in nine specialties (Cardiothoracic, General, Neurosurgery, Orthopaedic, Otolaryngology – Head & Neck, Paediatric, Plastic and Reconstructive, Urology, and Vascular.

There is a trend to sub-specialty practice and in particular, metropolitan sub-specialist practice seen as the norm or the only viable future practice mode. Graduates of the SET program often desire additional experience to build their confidence & competence. There is increasing recognition that rural centres require generalist specialists but there is a shortage of appropriate post fellowship training opportunities for rural and regional surgeons.

Mr Batten referred members of the forum to the RACS Generalism Position Paper link to be found at:
https://www.surgeons.org/media/21600030/2015-03-27_pos_fes-fel-061_generalists_generalism_and_extended_scope_of_practice.pdf

Within General Surgery in Australia, the SET program is administered by a number of hospital networks in each state. All these hospital networks have been metropolitan based, even though there are many training positions in rural hospitals. It is likely that there is little scope to expand rural training positions in General Surgery, however it would be possible to set up rurally based training networks.

**Surgical Training & Support Models** In moving towards a **sustainable rural surgery workforce**, the ideal arrangement for a rural community is for a surgeon to be resident but is not always practical.

There is a shortage of surgeons in rural Australia and New Zealand. Some centres are too small to support a resident surgeon and some of the surgical specialties require equipment which can only be located in large centres. Another option is the regular rotation of surgeons from a larger centre. This allows elective and emergency services to continue, and provides some continuity of care. These models have been proven to work in several towns in South Australia.

**RACS Rural Coach Program - established in 2011**

- Supports Trainees and IMGs interested in a career in rural surgery or in contributing to the rural workforce in locum or outreach work.
- Not a training program. Provides mentoring & collegiate support.
- Rural Coaches are experienced rural surgeons who provide 1-1 support through career guidance & advocacy.
- Provides annual grants to assist attendance at the Provincial Surgeons of Australia (PSA) Conference (funded by General Surgery Australia).
- No funding (pro-bono).

Support for SET Trainees who indicate an interest in rural surgery has been intermittent. For many years the Commonwealth has supported rural training by funding the Rural Surgical Training Program. Should additional funding for a rural training model become available through an avenue such as the Specialist Training Program (STP), this should be pursued because at least anecdotally (based on surgeons trained in previous rural surgical training programs) those surgeons trained in a rural environment are likely to seek long term employment in a similar environment. There is also good evidence in a broader forum that those medical practitioners educated in a rural environment are more likely to seek employment in a rural or regional setting. The process and transparency of STP funding, however, needs to be addressed. Reasonable deadlines also need to be in place. Funding needs to be indexed annually as shortfalls can make a post financially unworkable for a hospital and can lead to additional cost shifting.

**Rural Coach Program Outcomes:**

- 29 participants in 2017:
  - SET 6 (4) SET 5 (10) SET 4 (6)
  - SET 3 (5) SET 2 (4) SET 1 (0)
- 49 participants have obtained their Fellowship & 9 have remained in rural areas.
- 55 PSA grants awarded

**Rural Training Hubs established in 2013**

- Uses pre-existing surgical training positions
- Focus on General Surgery & its sub specialties
- Provides exposure to other specialties and has links with the Alfred Hospital for trauma
- Trainees spend time in each of the Hub hospitals and spend their final rotation in a peripheral hospital
- Integrated Rural Training Pipeline (IRTP)
- 100 STP targeted in 2017-2018

**The SW Victorian Regional Training Hub involves the Geelong, Ballart, Colac, Warrnambool & Hamilton hospitals**


The Hub is tailored for regional needs. A career plan is drawn up for each Trainee so they know where they are going to be over the 5 year period. Trainees interested in a rural career could be appointed to a rural network and the majority of their

training could occur in rural areas. They would also require rotations in metropolitan hospitals for exposure to a range of tertiary surgical services. In considering the regional training hubs, Dr Batten pointed out that there is no shortage of Medical students, and

- All the surgeons in the regional hub need to be supportive if the program is to work
- Resistance from some metropolitan hospitals because they could lose rotations
- To prepare someone for rural practice they need good general training
- Desirable to recruit Trainees from rural areas
- Rural hubs appear best suited for Victoria, Tasmania and NSW

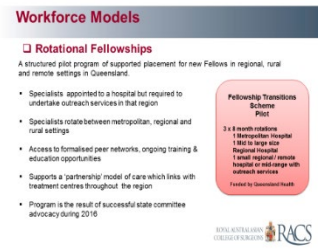

## Surgical Workforce Models

In formalising the rural metro interface project, the College commenced a project in 2017. The model seeks to ensure that rural and remote patients have access to high quality and standards of surgical care while also reducing the reliance on IMGs & locum surgeons to fill rural shortages in the long term.

**Project Objectives**

- Establish rural workforce needs in each jurisdiction.
- Recommend the short, medium and long-term strategies to advocate for better deployment of the surgical workforce.
- Support rural surgeons and Younger Fellows
- Advocate with jurisdictions to move towards joint rural-metro appointments
- Develop model(s) for formalising links between metropolitan and rural hospitals

**Rotational Fellowships Project**




The pilot provides for 2 rotational fellowships each for a 2 year period, fully funded by Queensland Health so no impact on budget of individual hospitals. Expected to commence in 2018. It involves restructure of surgical specialist posts to meet the individual's need.


**Anticipated benefits**

- Coordinated pathways & training networks
- Better management of vocational training
- Improvements in recruitment & retention rates
- Reduced dependence on IMGs and locums in the long-term

**Extended General Practitioner Proceduralist (Surgery) Training Pathways**

- Engaging with ACRRM, RDAA & RACGP to define scope of practice and standards for training, supervision & credentialing
- General Practitioner Proceduralists Position Paper drafted.

## 4. OPEN FORUM DISCUSSION

Forum participants discussed the presentations. It was agreed that the entire "infrastructure" was the key to the success, and that people want to live and work there so build the nest. In relation to the impact on tertiary metropolitan hospital services it noted the more supervision of junior doctors rotating would likely be required. To address isolation issues, an idea was for a group of trainees (from more than one College) to go a certain location together. A possible future action may be in the formation of a rural professional network or encouraging them to build early in a trainee career. It was agreed that one of the barriers that needed to change was the selection criteria, noting STP is only 7% of all training budget outside of General Practice. Consideration needed to be given to the importance of the partner as a factor for retaining workforce in rural / remote settings. The influence Colleges have in identifying potential local champions was noted in the context of change and engaging the consultants in supporting rotations. The importance of tele-supervision as a benefit in helping with accreditation, supporting distributed supervision and reducing isolation.

## 5. RECOMMENDED NEXT STEPS

CPMC and the Medical Deans valued the opportunity to partner in a forum on the important topic of how we can grow regional training in Australia and with the support of the Australian Government.

A new CPMC subcommittee will be considered by the CPMC Board comprising lead Colleges to work on models for change and to talk with training committees, with the initial representation from RACS, RACP, RANZCP and ACEM, co-opting the Chair of the Medical Deans. Initial areas of focus for the subcommittee would include:

-trainee selection processes

-identifying key contacts within Colleges who understand the importance of regionally based training programmes and can be a "go to" person to assist with accreditation issues

-regional "change champions" to support sharing resources and infrastructure and opportunities for collaboration