PROXIMITY

Specialist Training Program Evaluation and Targeted Stakeholder Engagement Final Report

Department of Health, Disability and Ageing

February 2025

We acknowledge the Traditional Custodians of the land on which we live and work.

We pay our respects to them, their cultures and their Elders past and present.

We recognise their deep and enduring connection to land, sea and community, and the ongoing cultural and spiritual significance it holds.

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PROXIMITY

Glossary

Acronym	Definition
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal and Torres Strait Islander community-controlled health organisation
ACD	Australian College of Dermatologists
ACEM	Australian College of Emergency Medicine
ACSEP	Australian College of Sport and Exercise Physicians
AHPRA	Australian Health Practitioner Regulation Agency
AIDA	Australian Indigenous Doctors Association
AIDA STSP	Australian Indigenous Doctors' Association Specialist Trainee Support Program
AMC	Australian Medical College
ANAO	Australian National Audit Office
ANZCA	Australian and New Zealand College of Anaesthetists
ATSIHS	Aboriginal and Torres Strait Islander Health Service
CCHS	Community-controlled health services
CGH	Australian Government Community Grants Hub
CICM	College of Intensive Care Medicine
CSGA	Commonwealth Standard Grant Agreement
Department, the	Australian Government Department of Health and Aged Care
EMET	Emergency Medicine Education and Training Program, including EMET Training Hubs
FATES	Flexible Approach to Training in Expanded Settings
FTE	Full time equivalent staffing costs. Full time equivalent is a unit of measurement used to determine how many total full-time employees are required based on the standard ordinary work hours or week.
HWD	Health Workforce Data
IRTP	Integrated Rural Training Pipeline
KEQ	Key evaluation questions
LHN	Local Health Networks
MBS	Medicare Benefits Schedule

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Acronym	Definition
MABeL	Medicine in Australia: Balancing Enjoyment and Life
MMM	Modified Monash Model location codes
MWAC	Medical Workforce Advisory Collaboration
Multidisciplinary teams	A group of healthcare professionals from different specialties working together collaboratively.
NMWS	National Medical Workforce Strategy 2021-2031
OTD	Overseas-trained doctors
Post	A training position or placement funded through the program
PICS	Private Infrastructure and Clinical Supervision
RAP	Reconciliation Action Plan
RACDS	Royal Australian College of Dental Surgeons
RACMA	Royal Australian College of Medical Administrators
RACP	Royal Australian College of Physicians
RACS	Royal Australian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RCPA	Royal College of Pathologists of Australasia
RSL	Rural Support Loading
ST&F Survey	Specialist Trainees and Fellows survey
STP	Australian Government Specialist Training Program
STPS	Specialist Training Placements and Support
Tasmanian Project	Training More Specialist Doctors in Tasmania

Executive Summary

Executive Summary

The Department of Health and Aged Care (the Department) commissioned Proximity Advisory Services (Proximity) to conduct an independent evaluation of the Specialist Training Program (STP), complemented by targeted stakeholder consultation on the findings of the evaluation, with the findings and consultation to inform future direction for the program. The evaluation was to include an assessment of the appropriateness, effectiveness, implementation and efficiency of the STP to date and consider how the program could be improved (sustainability).

This evaluation, conducted by Proximity between March and November 2024, explored available data and literature, undertook primary data collection in the form of survey responses from key stakeholders, and engaged extensively with colleges, state and territory government officials, the community-controlled sector, peaks and other health bodies to explore the current program settings and opportunities to improve its sustainability over the long term.

This report is complemented by a Consultation Outcomes Report at **Appendix 1**, which summarises the key stakeholders engaged, the process for validation, and the key thoughts, discussions and findings.

This Evaluation Report, along with the Consultation Outcomes Report, provide the first step in a significant consultation and change journey for the STP as the Department responds to the findings and recommendations, and key national strategy outcomes relating to the specialist workforce are implemented.

Program context

The health and wellbeing of Australians living in regional, remote and very remote Australia is a priority for the Australian Government.

Non-GP speciality training is a "shared space" across Commonwealth, states and non-GP specialist medical colleges (the colleges). Inequality of access to health services remains a key issue for Australian communities, with the medical (including specialist) workforce needing to be geographically well distributed. Since the early 2000's the issue of training specialists in expanded settings has been a matter of interest for the Commonwealth, leading to the establishment of a number of programs, including the STP.[1] Currently the optimal distribution and service mix is not consistently achieved across Australia, resulting in service gaps and inefficiencies, and potentially impacting on the quality of patient care and the working life of Australia's doctors. The Australian Government funds approximately 7 per cent of specialist training places, largely in regional, rural, remote and private facilities.[2]

Ensuring timely access to trained medical specialists is another key component of a highly effective health system, and the supply of specialists from across specialties is integral to this. Wait times, a useful proxy for access to specialist healthcare, have increased over recent years, meaning access to specialists for elective surgery in Australian public hospitals has reduced. At the same time, the number of specialists in training across specialties is changing, and in recent years has been improving in its alignment to some, but not all, of the areas of undersupply in the trained workforce. [3]

As the composition of the specialist medical workforce changes over time, alongside that of the general population, Commonwealth, state and territory governments and the colleges play an important role in monitoring these changes and in directing funding to respond to changing workforce need.

The STP, which commenced on 1 January 2010, aims to improve the quality of the future specialist workforce by providing registrars with exposure to a broader range of healthcare settings by extending vocational training for specialist registrars (trainees) into settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private facilities. The program is administered by 13 colleges, providing salary contribution funding for trainees and supervisors, along with financial support to training settings where training placements take place. The overall investment in the STP by the Australian Government over the current grant agreement is approximately $708.6 million, with current funding agreement activity ending on 28 February 2026.

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[1] 2017 Review of the STP
[2] National Medical Workforce Strategy – Secretary's foreword
[3] Medical Deans Australia and New Zealand, 2024. 'National Data Report 2024', *Medical Schools Outcomes Database*, <medicaldeans.org.au/md/2024/05/MSOD-National-Data-Report-2024.pdf

The program has evolved over time in response to government priorities, and currently has the following aims:

- To **broaden experience** of vocational training for trainees into settings outside traditional metropolitan teaching hospitals, including **regional, rural, remote and private** facilities;
- To contribute to improving specialist medical workforce supply and distribution by **enhancing the availability of the specialist workforce in areas of unmet community need**, including rural and remote locations; and
- To enhance **Indigenous health outcomes** through increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists.

The National Medical Workforce Strategy 2021-2031 (NMWS) is highly relevant to the STP, setting priorities for Commonwealth funding across the medical workforce. The NMWS aims to provide the Australian community with a high quality and well distributed medical workforce able to provide the health services communities need. The NMWS also aims to clarify how the work of the Commonwealth, State and Territory Government, health services, medical colleges, universities, regulators and other local planning bodies can deliver the optimal medical workforce for Australia. A series of actions will be taken forward as part of the NMWS under five priority areas:

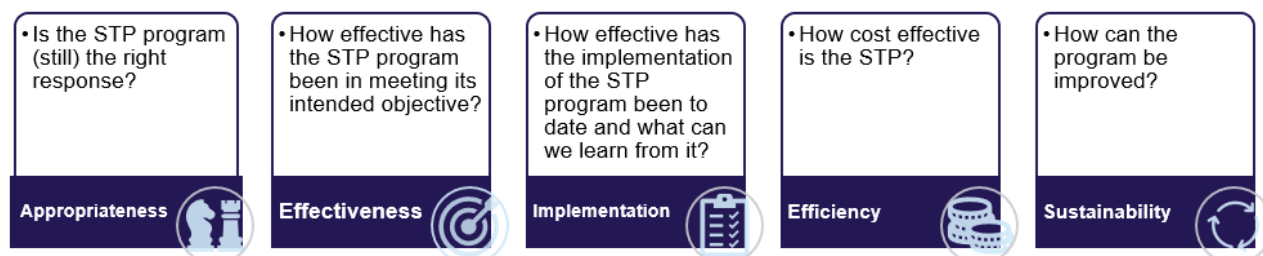| Collaborate on planning and design	Rebalance supply and distribution	Reform the training pathway	Strengthen the generalist capability of the workforce	Support for medical practitioners to train and work flexibly

This evaluation used the NMWS, along with the National Health Reform Agreement (NHRA) as the key guiding policy documents with which the program will need to be aligned in the future to deliver the specialist trainee outcomes the Australian population requires.

Evaluation methodology

Evaluating the STP in 2024, approximately 15 years after its inception, provides an opportunity for the Commonwealth to take stock of current administrative settings, drawing on the insights and perspectives of key stakeholders, including the colleges and the states and territories, to build coherence around medical workforce planning and investment.

This evaluation is focused on five domains:

• Is the STP program (still) the right response?	• How effective has the STP program been in meeting its intended objective?	• How effective has the implementation of the STP program been to date and what can we learn from it?	• How cost effective is the STP?	• How can the program be improved?
Appropriateness	**Effectiveness**	**Implementation**	**Efficiency**	**Sustainability**

The domains summarise the key evaluation questions (KEQs) of interest to the Department in commissioning this evaluation. These KEQs, and the conclusions drawn against each from this evaluation, are provided at **Appendix 2.** This mixed-methods program evaluation draws on an extensive stakeholder engagement process in order to provide insights into the appropriateness and effectiveness of the STP, including whether the programs are on track to meet intended objectives.

Summary of Key Evaluation Findings

Table 1 – Findings and observations across domains of interest

	Findings and observations
Appropriateness	**Appropriateness of the design of the STP** Overall finding: **Adequate** Strength of Evidence: **Sufficient Evidence** Overall, while the program is unique as a contribution to funding non-GP specialists outside of public metropolitan settings, in its current form the STP does not respond to the changes in the evolving national non-GP specialist medical workforce. The STP targets generally remain static over time, based on historic funding levels and largely determined by colleges, and the program does not draw on data and modelling around workforce. While to date a reliable source of insight into workforce demand and supply has not been available to the Commonwealth, recent investment has focused on maturing the workforce modelling in this area. Introducing mechanisms to target the program towards changing workforce need would greatly enhance the STP in its ability to contribute to a specialist workforce that is well distributed and aligned to need.
Effectiveness	**Program effectiveness in funding posts in private settings** Overall finding: **Good** Strength of Evidence: **Sufficient Evidence** Evidence available to this evaluation indicates that the program is supporting trainees to gain experience in private settings, by enabling colleges to drive post selections to serve the training needs required for specialty and sub-specialty fellowship. Fill rates for private settings are high, indicating that the program is successfully meeting targets for funding this type of expanded setting. At the same time, a proportion of funded full time equivalent (FTE) staffing costs is targeted at specialties which may not require training in private settings. While this training is beneficial, this funding could be better focused on the other aims and objectives of the program. An enhanced governance mechanism, such as the tripartite forum identified in the program Appropriateness chapter, could support better targeting of funding to long term need rather than maintaining historical funding levels across the program. **Program effectiveness in enhancing the rural and remote specialist workforce** Overall finding: **Adequate** Strength of Evidence: **Sufficient Evidence** Evidence available to this evaluation indicates that overall, maldistribution of the specialist medical workforce is a key feature of the current Australian health system, and the STP is one of the few funding sources available to help ameliorate it. Fill rates for the STP indicate the program meets targets for funding posts in regional, rural and remote settings. At the same time, however, the need for different specialists is likely to vary with relative remoteness, and a national, Commonwealth funded program like the STP should target investment in MM2-7 carefully and consider prioritising generalist specialties in areas where multidisciplinary teams and substantial infrastructure are not available. A rudimentary calculation of the STP funding for posts in Colleges which provide generalist specialisations indicates the program does not currently align to specialisations needed in each location, with around half of funding in the program going to MM1 settings. The current minimum placement length in the program is three months and there are no explicit incentives for longer-term placements. This does not support the long-term aim of the program to encourage specialists to relocate away from metropolitan areas and support a correction of the workforce maldistribution across Australia. A range of factors influence trainee registrar decisions to live and work in regional, rural and remote areas, and the timing of training in those areas is within scope of the STP. While some program elements support longer term placements, the STP as a program is not actively pursuing this aspect of the aim. **Program effectiveness in increasing the number of First Nations medical specialists** Overall finding: **Poor**

	Findings and observations

Strength of Evidence: **Sufficient Evidence**

Overall, evidence available to this evaluation suggests the STP does little to support Aim 3 of the program. It rarely funds posts in the community-controlled sector and does not collect data regarding the populations served by settings where posts are based. Placing non-Indigenous trainees in these settings is the STP's most powerful lever to affect change in both Indigenous health outcomes but also in reducing systemic racism and increasing the quantum of Aboriginal and Torres Strait Islander medical specialists.

While Colleges have worked hard over recent years to improve their cultural competency, the sector overall remains immature in its engagement with Indigenous ways of knowing and being. In line with the priorities, principles and suggested actions set out in Closing the Gap and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, STP could be improved through more:

- Active engagement and collaboration with Indigenous community leaders to ensure the program is fit for purpose and Indigenous led.
- Investment across the sector in cultural safety and cultural awareness.
- Investment in the training experiences of First Nations trainees through professional and peer networks, alongside workplace flexibility and supervisor support.
- Prioritisation of STP posts in community-controlled settings and settings with high Aboriginal and/or Torres Strait Islander populations served. This experience supports non-Indigenous medical officers to build a deep understanding of Indigenous health, to help them to identify and eradicate their own unconscious bias about First Nations people, and to champion cultural safety in other settings where they go on to work.

Program effectiveness in building the sector's capacity to support non-GP specialist trainees

Overall finding: **Good – Adequate**

Strength of Evidence: **Some Evidence**

Overall, the Support Projects and Flexible Approach to Training in Expanded Settings (FATES) program have injected a combined monetary value of almost $60 million over the current agreement period, to support the STP's objectives. The focus and outputs of these projects are in line with the intent of the STP, particularly in the case of FATES projects, these are regularly evaluated to determine their short-term success at a project level. While these are positive aspects of the two components of the overall STP, there is little evidence to suggest that this funding would not be more effective if it were spent as originally intended, in funding of posts in expanded settings. Extensive stakeholder consultation undertaken with the sector for this evaluation strongly suggests that there is unmet demand for posts in priority areas for the program, indicating that current administrative settings require adaptation to reduce underspend and enable posts to be filled.

Instead of redistributing unspent funds to ad-hoc, time limited projects run by colleges, opportunities to prevent underspend within the STP should be considered. The administration activity required to manage additional Support Projects and FATES could then be redirected to the additional effort required of the Commonwealth to more frequently acquit expenditure across the program. Over time, with improved data collection enabling more rigorous evaluation, the impact of each program component could be better understood and funding could be targeted towards elements which are most effective in supporting the capacity of the sector to train non-GP specialists.

	Findings and observations
Implementation	**Effectiveness of the implementation of the STP** Overall finding: **Good** Strength of Evidence: **Sufficient Evidence** Overall, while the design of the program is not entirely aligned to its intended aims, the activities undertaken across the program are largely in line with the program guidelines. The program is generally well run by colleges, bringing expertise and unique visibility of the specialist workforce to the prioritisation of funding for the STP. More transparency from colleges in their approach to managing the program would allay concerns from stakeholders in the wider sector. Additional investment in the overall collaboration and coordination of the STP to include stakeholders from state and territory governments would strengthen implementation of the program and align with expectations in the program guidelines. Including stakeholder collaboration with the community-controlled sector and incorporating Indigenous collaboration into the design and implementation of the program would strengthen its contribution to outcomes, however the current guidelines do not require this. The guidelines themselves could be strengthened in other ways as well, by providing more guidance and clarity around targets and post distribution, and by specifying a range of data and intelligence sharing that would support better management for outcomes by the Commonwealth.
Efficiency	**Efficiency of the STP** Overall finding: **Adequate** Strength of Evidence: **Some Evidence** To understand the efficiency of the STP, the costs and value of the program to the Commonwealth must be considered. On the cost side, the Commonwealth provided $8.5 million in administration funding to colleges across the STP in 2023, with the aim of achieving a range of qualitative benefits associated with the program. While the total administrative cost of the program is within the general bounds of comparable government programs, the program has only partially achieved its intended aims and so does not represent strong value for money. At the same time, the program achieves value through positive unintended outcomes. The main value achieved by the program is the provision of support for settings to meet the day-to-day health needs of their local community through funding access to trainee registrars. This is of value to settings and local health networks and the community more broadly; however, it is by no means the primary intent of the program, and other available funding streams from Commonwealth and state governments are intended to fund these healthcare costs. While the program provides a unique opportunity for the Commonwealth to directly influence the supply and distribution of the overall medical specialist workforce in Australia, the current administrative settings do not enable it to do so. Without increasing the costs of administration, the Commonwealth could take a more active role in the supply and distribution of the medical workforce through the STP, providing long term value beyond meeting the day-to-day health needs of the community
Sustainability	**Sustainability of the STP** Overall finding: **Adequate** Strength of Evidence: **Sufficient Evidence** The sustainability of the STP could be improved through the introduction of mechanisms within the program to enable ongoing monitoring of the STP's contribution to its aims, and to enable STP funding to be redirected to better meet its aims and objectives. Additional program governance, along with a return to a simplified funding design, would greatly enhance the overall sustainability of the program and alignment to the intended outcomes of the NMWS.

Recommendations

The overall findings against the evaluation domains indicate that the program could be strengthened while it is valued in its contribution to providing training opportunities to the non-GP specialist workforce, the focus and responsiveness of the program could be improved. The following recommendations would improve outcomes in the short-term, with a longer-term lens required to determine the merit of continuing the program as is, versus a broader program re-design in line with other national strategies, outcomes of actions under the NMWS, and engagement with the NHRA.

Table 2 - Suggested recommendations

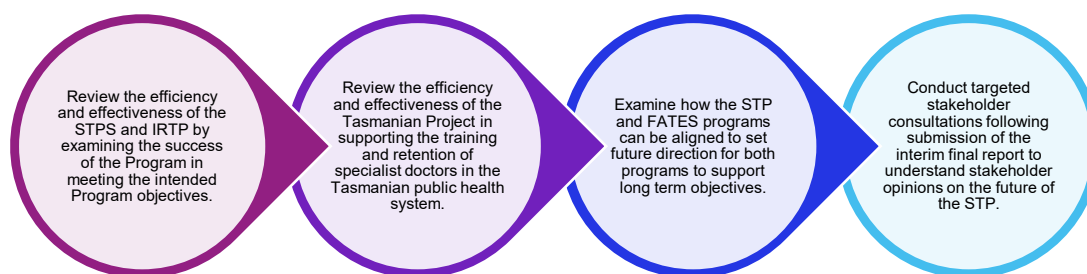| Recommendation	Detail
Utilise and link funding to national medical specialist workforce data and modelling	During and since the development of the NMWS, the Commonwealth has increased investment in medical workforce demand and supply modelling. Introducing a mechanism to link this analysis to the direction of specialist training in the long term would enable the targeting of Commonwealth funding towards geographical areas, specialties, sub-specialties and trainee demographics which would best support Australia's changing medical workforce needs.
Establish a tripartite specialist training governance group	To ensure future funding through the STP is responsive to Australia's specialist workforce needs, and not solely reliant on data received, target setting for the STP should be undertaken by a tripartite specialist training governance group, comprising the Commonwealth, state and territory health bodies and the Colleges, taking a national, coordinated lens to specialist training needs.
Return to a simplified, streamlined program design in accordance with the Commonwealth Grant Rules and Principles 2024	A simplified model of the STP would remove separate rules and funding streams for the Tasmanian Project and the Integrated Rural Training Pipeline (IRTP), retaining only the elements of the Specialist Training Placements and Support (STPS) funding. This funding could be targeted through enhanced governance mechanisms to private posts, First Nations posts, and regional, rural and remote areas, without additional funding rules and administration required. This change would not necessarily lead to the loss of funding to sites with IRTP or Tasmanian Project funding, as this could be accommodated within targeting processes where these are found to be appropriate. As part of a simplified program design, more frequent acquittals and reallocations of underspends would enable a return to the original intended volume of Support Projects. With these changes, complexity across the program operational guidelines would be removed, and existing Commonwealth and Colleges forums could be used to ensure consistent interpretation of funding rules are applied across Colleges. In this way, many of the pressure points currently identified by settings, supervisors and trainees would be removed, and the complexity of administering the program reduced for all stakeholders. In addition, value for money for Commonwealth investment would also be realised.
Introduce a STP Strategic Framework and Outcomes Hierarchy	Introducing a STP Strategic Framework and Outcomes Hierarchy would enable the articulation and measurement of the program's strategic objectives in a systematic and rigorous manner. The program currently operates with a range of similar but slightly varying aims, objectives and outcomes, set out across documentation such as the Operational Framework, Support Project Guidelines, Reserve List Guidelines and FATES grant guidance. The aims of each of the various elements of the program all broadly align, however a clearer mapping of outcomes, activities and performance measures would support efficient and effective program management, including in helping determine the best use of funding and in assessing the performance of the program over time.
Invest in improved program data and reporting	Investing in improved STP data and reporting, particularly if linked to a Strategic Framework and Outcomes Hierarchy, would become a key enabler of a strong and sustainable program response to the training needs of the non-GP specialist workforce. Several key data areas are currently missing from the administration of the STP. Data scoping should be undertaken with Colleges and healthcare settings, with a view to building on the Minimum Dataset which is currently also under development for the national medical specialist workforce.
Publish activities, outputs and outcomes data for the STP	In future iterations of the STP, data collected across the program should be made publicly available through the sharing of key performance indicators on a regular basis. This could be through quarterly publication showing performance against targets on College websites, and could also include publishing of College reserve lists, and movements of posts on and off these lists. The publication of this data would promote greater transparency across the program and provide insights to support the ongoing management of funding. If combined with reallocation of funding where necessary, data transparency could also support reduction of the level of unspent, uncommitted STP funding.
Draw on Indigenous governance committees in each College	Over recent years the Colleges have been working with the Australian Indigenous Doctors Association (AIDA) to establish Indigenous governance committees to support them in their work as stewards of the medical specialties they represent. These committees could be used to great effect in future iterations of the STP, to help direct funding towards settings with high First Nations populations served, towards community-controlled settings for relevant specialties, and to guide efforts to support the cultural safety of trainees, clients and the health sector more broadly.

Methodology and Program Background

Evaluation methodology

Evaluation objectives and scope

The aim of this evaluation as determined by the Department is to assess to what extent the STP - including FATES, the IRTP and the Tasmanian Project - has influenced specialist medical workforce distribution, including in regional, rural and remote and private facilities in Australia. The Department anticipates the evaluation findings to provide advice on how best to consolidate and contemporise the program including to better align with the NMWS.
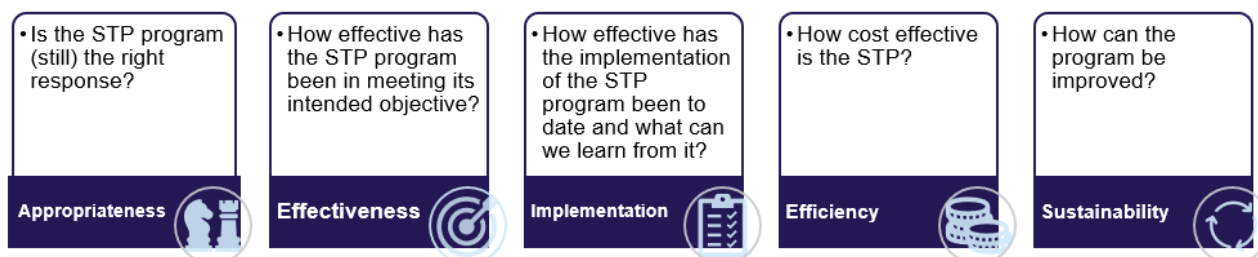
Regular fortnightly project management sessions were held between Proximity and the Workforce Training Branch under the Health Resourcing Group at the Department, to review and plan next steps in the evaluation. At key intervals, senior executives from the Department were engaged.

The objectives and scope of the evaluation were to:

Review the efficiency and effectiveness of the STPS and IRTP by examining the success of the Program in meeting the intended Program objectives.	Review the efficiency and effectiveness of the Tasmanian Project in supporting the training and retention of specialist doctors in the Tasmanian public health system.	Examine how the STP and FATES programs can be aligned to set future direction for both programs to support long term objectives.	Conduct targeted stakeholder consultations following submission of the interim final report to understand stakeholder opinions on the future of the STP.

Evaluative approach

The key evaluation questions are focused across five domains for this evaluation:

Appropriateness	Effectiveness	Implementation	Efficiency	Sustainability
• Is the STP program (still) the right response?	• How effective has the STP program been in meeting its intended objective?	• How effective has the implementation of the STP program been to date and what can we learn from it?	• How cost effective is the STP?	• How can the program be improved?

This convergent mixed methods program evaluation draws together findings from across various data sources related to the STP and the overall context in which it operates.[4] Individual results have been obtained from each data source against each KEQ, and these have then been synthesised, with consideration for recurring themes, how results complemented and extended each other, and whether there were areas where they contradicted each other.

To draw conclusions across the five domains of inquiry, a set of evaluative rubrics were then applied to determine the most appropriate interpretation of the data collected, and to explicitly demonstrate how this is weighted. These evaluative rubrics were designed by Proximity in consultation with the Department to ensure relevance to the overarching inquiry domains.

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[4] Creswell, J. & Plano Clark, V. (2017). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: Sage.

Table 3 – Strength of evidence rubric

Strength of evidence	Description
Sufficient evidence	Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.
Some evidence	Where the evidence suggests the observation is true but there are data limitations, such that the find is qualified and further and/or different data (which may have been unavailable to this evaluation) would need to be sourced to be more confident in the conclusion reached.
Weak evidence	Where the evidence is indicative of a finding but there are major shortcomings in the data such that limited confidence can be placed on the conclusion.
No evidence	Where no data exists upon which to make any finding.

Alongside a strength of evidence rubric, a rubric is used to explicitly state the merit determination made against each evaluation criterion. This rubric is used to support clear evaluative judgement against each domain of enquiry applied to the STP, across the KEQs, set out in **Table 4**, below. For this report, observations from the data available to the evaluation have been synthesised to provide merit ratings across the five domains of inquiry for the evaluation.

Table 4 - Merit determination rubric

Merit Rating	Standard observed
Excellent	Performance was clearly very strong in relation to the overarching question of the evaluation domain. No significant gaps or weaknesses were identified.
Very Good	Performance was generally strong in relation to the overarching question of the evaluation domain. Some minor gaps or weaknesses were identified.
Good	Performance was generally strong in some areas relating to the overarching question of the evaluation domain. Some gaps or weaknesses were evident.
Adequate	Performance demonstrated some weaknesses in relation to the overarching question of the evaluation domain, however minimum expectations or requirements were met.
Poor	Performance was weak in relation to the overarching question of the evaluation domain. Minimum expectations or requirements were not met.

The Bellberry Human Research Ethics Committee reviewed and approved this evaluation in accordance with the National Statement on Ethical Conduct in Human Research.

Data collection and analytical framework

Appendix 2 provides the KEQs against each domain of enquiry, and the relevant data sources available to the evaluation.

Data collection and analysis activities across the project focussed on the following key data sources:

- Two surveys distributed in collaboration with the Colleges, one for medical officers and one for healthcare settings where STP posts are funded
- Program documentation and reporting
- National datasets and College data regarding workforce distribution
- Semi-structured stakeholder consultations

Surveys

Reflections from current medical students, specialist trainees, fellows and supervisors of specialist trainees were sought through a survey focused on the attitudes and decision-making process of early career medical specialists in deciding their career path and the location for their practice. The survey took approximately 10 minutes to complete. It asked for information about the participant's personal history, and then presented questions asking for their views about the drivers underpinning medical practitioners' choice of specialty and geographic location.

A further survey sought input from training settings where STP posts have been hosted. This gave settings the opportunity to provide input into the administrative arrangements of the STP. The survey took approximately 10 minutes to complete.

At the end of both surveys, participants were invited to provide their name and contact email address if they would like to be interviewed as part of the project. Interviews with small groups of survey respondents were then conducted to discuss respondents' views, and themes from these sessions have informed this report.

Program documentation and reporting

Data mapping was conducted in the first phase of the project in consultation with Colleges and the Department. Program data includes grant reporting from Colleges and STP related data about the number of STP participants and their locations, post fill rates, program costs and financial management. In some cases, College reporting also includes important qualitative information, like decisions about what to do with unused program funds and Department or College views about the appropriateness of the STP funding arrangement. Additional data was sought directly from Colleges to explore changes over time in STP posts and to help inform the evaluation regarding the broader funding context within which the STP operates.

There are important limitations in the data available to this evaluation through program documentation and reporting. Colleges have provided a range of different data relating to different time periods, across all relevant categories of information, meaning the dataset is incomplete and comparison across Colleges may be unreliable. Strong STP related data is collected and stored by the Commonwealth on FTE, settings and locations of posts. This is in a format that is accessible and able to be analysed reliably.

Other data from the Commonwealth needs to be extracted from College grant agreement reporting, and is not collected, held or used in a format that allows ease of analysis. Data regarding funding, targets and support projects was extracted from individual College grant agreements and performance reports to generate a new dataset created for the purpose of this evaluation.

Neither the Commonwealth nor Colleges collect data regarding trainees, their demographic characteristics, salary levels, training location, training duration or the locations in which they live and work over time. Data regarding the overall numbers, characteristics and locations of Fellows and trainees is not consistently collected, however some Colleges, state health departments, sub-specialty societies and peak bodies collect data regarding workforce distribution.

The use of target, funded and filled data

Throughout this report FTE and posts are referred to as target, funded or filled. These terms have the following meaning:

Target: The number of posts (STP, IRTP and Tasmanian Projects) or funding supplements (Rural Support Loading (RSL) and Private Infrastructure and Clinical Supervision (PICS)) made available by the Commonwealth to a College under the STP grant agreement.

Funded: The number of FTE/posts for which Colleges have entered into agreements with health settings. This number is equal to or lower than the target. Lower numbers result where Colleges are unable to enter into agreements with health settings to fill target posts. There can be a variety of reasons for this, such as a lack of supervisors, an inability of a setting to cover the salary gap or setting perceptions of low probability of recruiting trainees into the post.

Filled: Actual FTE filled in a health setting. The number of filled posts is often lower than the number of funded posts, both of which are lower than the number of target posts. This is because a setting may have difficulty recruiting to a post, a trainee may change practices or go on leave. The filled number provides an indicator of the actual impact the STP has on the number of trainees and in the delivery of health care.

National data regarding workforce distribution

Longitudinal data sets were accessed to provide insight into the overall medical specialist employment landscape in which the STP operates. The Health Workforce Data Tool was used to inform an assessment of the overall contribution of the STP to the Australian medical specialist workforce and the relationship between STP funded posts and areas of Australia with lower access to medical specialists. This health workforce data is collected during the registration process of health professionals, by the Australian Health Practitioner Regulation Agency (Ahpra) on behalf of the Commonwealth.[5]

Semi-structured stakeholder consultations

Semi-structured interviews provided the opportunity to explore issues in moderate detail, in a conversation, while retaining reasonably high levels of objectivity and providing comparable results across groups.

Thirteen Colleges, eight state and territory jurisdictions (jurisdictions), Indigenous health stakeholders and other organisations with direct involvement in the STP were engaged through consultations.. The interview questions were based on the evaluation domains (appropriateness, effectiveness, implementation, efficiency and sustainability) and all stakeholders were provided with the consultation themes in advance.

At the beginning of each session, stakeholders were informed their participation was voluntary and there would be no negative outcomes associated with non-participation. Stakeholder participation in semi-structured interviews was enthusiastic and led to rich data collection. In many cases, stakeholders sought to extend the length of consultation sessions because of the amount of feedback they had about the STP and, in some cases, FATES.

Stakeholder input was documented, analysed and sorted into key themes. These key themes, together with quantitative analysis of program data, formed the basis for this report.

Appendix 1 sets out the stakeholder list in further detail, as part of the Consultation Report summarising key themes arising throughout the project. In total 64 stakeholder consultation sessions were held to inform this evaluation, with over 200 individual stakeholders.

Data analysis techniques

To gain insight from the variety of datasets available, the following data analysis techniques were used:

- Descriptive techniques for quantitative datasets, such as mean, median and variance.
- Thematic analysis for qualitative data, identifying patterns across stakeholder groups to understand key themes and tensions. This analysis required collating and coding written and verbal data to gauge the frequency of experiences or opinions.
- Narrative analysis, gathering stories shared by participants in the STP, focusing on the individual experience. This analysis, which is qualitative, provides a view of the practical operation or perceptions of the STP.

Validation sessions

In the context of an independent evaluation, a validation workshop or session refers to a meeting that brings the evaluators and stakeholders together to review the evaluation findings. The purpose of these validation sessions was to ensure consistency between the evaluation findings and key stakeholder views and to test the proposed report recommendations.

In consultation with the Department, stakeholders were formed into seven groups for the validation sessions. The stakeholder groups were Colleges (across two sessions based on availability), healthcare settings, medical officers, university deans, and Indigenous health and rural health peak bodies.

Stakeholders were grouped into like-streams. Like-streams were used because they allow the focus to be on the most relevant components of the evaluation for the stakeholder group and to allow stakeholders the space to interact and elaborate on the experience of their group. It also allowed for bespoke presentation material to be developed, specifically suited to the stakeholder group.

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[5] Department of Health and Aged Care, 2022. 'National Health Workforce Dataset', <hwd.health.gov.au/resources/information/nhwds.html>

The validation sessions brought together stakeholders in a group atmosphere for the first time in the evaluation. This format displayed the strength and, at times, the diversity, of opinion across parties. Given the time constraints and the high level of engagement in the sessions, participants were encouraged to provide written feedback through the meeting chat function and to contact the evaluators following the session if they had further input.

Limitations of the evaluation

As with any evaluation, there are key limitations that should be noted when considering findings and recommendations from this project. While strength of evidence rubrics are provided throughout to highlight where specific findings may be based on limited evidence, there are two overarching limitations with this evaluation overall. These are:

- The potential for data collected through interviews and workshops to reflect personal bias or self-interest. To manage this risk, the full range of stakeholders of relevance to the program were consulted and their contrasting views were obtained and presented regarding the strengths and limitations of the STP.

- Data available to this evaluation did not allow outcome evaluation, and findings of effectiveness are largely confined to consideration of whether outputs are achieved. Data regarding the number and characteristics of trainees funded under the program, along with the duration of posts and where trainees go on to practice, is not captured, limiting the extent to which the program's impact on the distribution of the medical workforce can be observed. In the absence of outcome related data, survey methods were used to build a counterfactual exploring the impact of rural placements compared with other factors, such as trainees being of rural origin.

The Specialist Training Program context

The Specialist Training Program context

STP aims in the context of other funding

Established in 2010, the STP has three intended aims:[6]

AIM 1:	To broaden experience of vocational training for trainees into settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private facilities.
AIM 2:	To contribute to improving specialist medical workforce supply and distribution by enhancing the availability of the specialist workforce in areas of unmet community need, including rural and remote locations.
AIM 3:	To enhance Indigenous health outcomes through increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists.

The STP is the Commonwealth's key investment in specialist medical training. Unlike state and territory government funding for non-GP specialist training, which is primarily targeted to traditional metropolitan teaching hospitals, the STP is focused on funding training posts in 'expanded settings', including in regional, rural, remote and private settings. Many of these settings would not otherwise offer training places for non-GP specialist trainees.

The overall investment by the Commonwealth in the STP over 2022 to 2025 is approximately $708.6 million, providing funding for approximately 1,080 (FTE) non-GP specialist trainees per year. The program has evolved since its introduction in 2010 to currently include several funding streams and associated components, which are targeted in various ways. Thirteen Colleges are funded to administer the program.

Funding streams

Specialist Training Placements and Support (STPS)

In 2023, STPS provided $107,268 per annum (pro rata, per FTE) in salary support for around 920 trainee placements each year.[7] At least half of each placement must be spent in an expanded setting. Placements must be for a minimum of 3 months.[8] STPS funding includes, where applicable:

- **The Rural Support Loading** (RSL) allowance of $25,000 per annum per post, pro rata per FTE, paid to eligible rural training settings. Eligible costs are reimbursed when incurred by the trainee, such as relocation expenses, or by facilities, such as training room renovations or videoconferencing facilities.[9]
- **Private Infrastructure and Clinical Supervision** (PICS) allowance of $30,000, pro rata per FTE, paid to eligible private training settings to support infrastructure, such as training room outfitting, and supervision of trainees, such as programs which enhance a supervisor's leadership and management skills.[10]

Integrated Rural Training Pipeline (IRTP)

IRTP was introduced in 2017. In 2023, it provided $153,240 per annum (pro rata, per FTE) in salary support for up to 99 FTE. IRTP trainees must complete at least 66 per cent of their specialty training outside of metropolitan areas, with only limited time spent in metropolitan rotations to meet accreditation requirements. It is possible for IRTP funding to 'follow the trainee' as they rotate through settings, rather than be tied to a particular post. The RSL can also be applied to IRTP posts. Colleges may also retain 5 per cent of the IRTP funding to assist in administering the program, subject to Departmental approval.

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[6] Department of Health and Aged Care, Health Workforce Division, Supplementary Budget Estimates, February 2024.

[7] In 2023, the STP base salary was $107,268 per FTE. Salaries will increase at a rate of 1.55 per annum in 2024 and 2025. IRTP salaries will also increase by 1.55 per cent. Tasmanian Project salaries will increase at 1.35 per cent (2024) and 1.30 per cent (2025).

[8] Department of Health and Aged Care, 2021. 'Specialist Training Program (STP) Operational Framework 2022-2025', <www.health.gov.au/sites/default/files/2023-03/specialist-training-program-operational-framework_1.pdf>

[9] Department of Health and Aged Care, 2021. Rural Support Loading (RSL) Guidelines

[10] Department of Health and Aged Care, 2021. Private Infrastructure and Clinical Supervision (PICS) Guidelines

Training More Specialist Doctors in Tasmania (Tasmanian Project)

Introduced in 2014 in response to distinctive ageing population health challenges for Tasmania, this funding aims to support approved specialty training in Tasmania and the training and retention of specialist doctors in the Tasmanian health system. This funding largely supports the employment of supervisors and trainees in the Tasmanian public health system in 65 (FTE) posts each year. All posts in Tasmania meet the definition of rural, regional or remote and are therefore in 'expanded settings'.

Support Projects

Each College is allocated $100,000 per annum, plus $1,210 per post pro rata FTE, in support project funding each year. Support Projects support the success and sustainability of delivering training in expanded healthcare settings, of relevance and benefit to STP training posts and trainees. Priority must be given to those which support rural and private posts, Aboriginal and Torres Strait Islander trainees, and cultural safety training in Indigenous healthcare delivery.[11] The development and implementation of Support Projects may cover more than one year, but all activity must be completed by the end of the activity period specified in the Grant Agreement.

Administration funding

Administration funding is provided to Colleges based on estimates of forward budget requirements and previous year expenditure reports. There is no formula to determine the administrative funds for each College.

Flexible Approach to Training in Expanded Settings (FATES)

A competitive grant program available to the Colleges, FATES is designed to complement other elements of the STP, providing time limited funding for projects which aim to enhance specialist training in expanded settings through innovative training models. FATES began in 2021, through the allocation of $29.5 million in unspent STP funds to successful grants in four annual funding rounds. FATES funding is available over four years. To date, 30 projects have been funded across 12 Colleges, totalling $19.2 million.

Program delivery and governance

STP funding agreements are in place between the Commonwealth and the Colleges. Colleges have subsequently implemented funding and administration agreements with over 2,000 training settings nationwide. State and territory funding bodies also provide some input into the administration of the program.

Program guidelines

The STP Operational Framework provides guidance from the Commonwealth to the Colleges in their roles implementing the STP and undertaking collaboration and consultation with stakeholders across the program.[12] In the current administrative arrangements for the STP, the Commonwealth has commissioned Colleges to manage stakeholder relationships as well as the flow of funding to support training in expanded settings

The Commonwealth

The Commonwealth, through the Department, provides oversight of the STP, oversees delivery of the program by Colleges, reports to government on the program's performance, and manages the funds through a shared-services agreement with the Community Grants Hub in the Department of Social Services.

The Colleges

All non-GP medical specialty focused Colleges in Australia are funded to deliver the STP, except the Royal Australian College of Dental Surgeons (RACDS), which has to date not been invited to tender for the opportunity to deliver the STP. There is no known reason for the RACDS not to be included in future closed, non-competitive grant opportunities for the STP. The Colleges contracted to deliver the STP are diverse in terms of the number of specialties and subspecialties they administer, the geographical distribution of their

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[11] Department of Health and Aged Care, 2021. STP Support Project Guidelines
[12] Department of Health and Aged Care, 2021. 'Specialist Training Program (STP) Operational Framework 2022-2025', <www.health.gov.au/sites/default/files/2023-03/specialist-training-program-operational-framework_1.pdf>

specialists, the number of fully qualified specialists they serve, and the number of STP posts they are funded to deliver:

Table 5 - STP College snapshot

College	Specialties/ sub-specialties	Specialists	Trainees	Proportion of specialists based in MM1	Proportion of trainees based in MM1	STP FTE filled in 2023
Australian College of Dermatologists (ACD)*	1	652	129	NA	90.5%	29.0
Australian College of Emergency Medicine (ACEM)	1	3,242	2,271	76.5%	82.0%	75.1
Australian College of Sport and Exercise Physicians (ACSEP)*	1	162	52	95.9%	90.5%	7.0
Australian and New Zealand College of Anaesthetists (ANZCA)	2	6,275	1,615	84.8%	85.4%	55.0
College of Intensive Care Medicine (CICM)	2	1,159	1,035	84.5%	86.6%	18.1
Royal Australian College of Medical Administrators (RACMA)	1	351	208	NA	NA	23.2
Royal Australian College of Physicians (RACP)	33	18,781	8,471	86.2%	91.0%	342.3
Royal Australian College of Surgeons (RACS)*	8	6,447	1,046	97.1%	84.2%	65.9
Royal Australian and New Zealand College of Ophthalmologists (RANZCO)*	1	1,082	151	86.0%	86.4%	15.3
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)*	5	2,070	597	83.1%	88.9%	42.6
Royal Australian and New Zealand College of Psychiatrists (RANZCP)*	1	4,505	1,943	85.8%	NA	182.8
Royal Australian and New Zealand College of Radiologists (RANZCR)	2	3,483	834	86.2%	86.2%	55.9
Royal Australian College of Pathologists of Australasia (RCPA)*	8	2,347	600	92.8%	92.5%	93.6

* predominantly practicing in private practice or requiring private practice training

Sources: Data provided by Colleges to this review. Figures are a mixture of 2024 and 2023, depending on College data holdings. Where College data was not available, data was sourced from Ahpra, Medical Board of Australia Registrant data, March 2024. Numbers are approximate and subject to frequent change as specialists and trainees move practice locations, complete training and exit or enter the industry.

Healthcare settings

STP funding can be used to support accredited non-GP specialist training places in any setting, in line with accreditation requirements set by the Australian Medical College. These requirements ensure that an appropriately qualified supervisor is available to support the trainee, and that the scope of practice undertaken by the trainee in the post contributes to the required training to attain Fellowship in that specialty. Training settings funded under the STP include healthcare facilities in the public, private and Aboriginal community-controlled sectors, public and private hospitals, laboratories, private consulting rooms and community health settings. While STP funding is for posts in 'expanded settings', posts are also funded in metropolitan teaching hospitals provided half or more of the post is undertaken in a rural or regional location, through rural pathway training programs.

State and territory health bodies

State and territory health bodies are consulted as part of approval processes for posts. They are asked to indicate their support, or lack of support, for the funding of STP posts. Reasons cited for supporting posts are generally focused on meeting the service needs of particular regions, or in meeting identified workforce need. STP posts in public settings are also co-funded by state and territory health bodies, as the STP provides only a contribution to the salary and training costs of trainees and their supervisors. Best estimates of the proportion of trainee salary covered by the STP are that it may cover only around 77.4 per cent of a typical level 3 registrar salary in a public hospital, without factoring in overtime.[13]

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[13] Proximity analysis provided within Interim Evaluation Report, September 2024.

Evaluation Detailed Findingss

Evaluation Detailed Findings

This section provides an overview of the key evaluation findings against key evaluation questions. The findings are presented under broad evaluation domains and further categorised according to the themes arising from the evaluation.

Appropriateness - is the STP (still) the right response?

Key evaluation questions relevant to this section

KEQ1: To what extent does the STP demonstrate alignment between the identified need, the program response (activities and outputs) and the intended outcomes?

KEQ2: Is the STP an appropriate way to address inequities in the quality and distribution of Australia's rural, regional and remote specialist workforce?

KEQ3: Should the STP and/or the FATES program continue to be administered by the Commonwealth and, if not, how should it be administered and through what mechanism?

KEQ13: Are there changes required to the funding of the STP such as integration of the STP Support Project funding being moved into the FATES program and/or consolidation of existing successful FATES pilot projects into ongoing programs via a College consortia arrangement?

To assess the extent to which the design of the STP is appropriate, the following criteria are of relevance:

- To what extent are program elements supportive of the program aims.

- To what extent are program elements aligned with drivers of trainee decision making.

- To what extent the design of the program supports its responsiveness to ongoing medical workforce needs in Australia.

The STP is a program response intended to correct areas of unmet need and maldistribution of the non-GP specialist medical workforce in Australia. Analysis for this evaluation domain focuses on the program logic of the STP and the extent to which the design of the program is appropriate to create its long term intended impact.

Overall, while the program is unique as a contribution to funding non-GP specialists outside of public metropolitan settings, in its current form the STP does not respond to the changes in the evolving national non-GP specialist medical workforce. STP targets generally remain static over time, based on historic funding levels and largely determined by Colleges, and the program does not draw on data and modelling around workforce.

While to date a reliable source of insight into workforce demand and supply has not been available to the Commonwealth, recent investment has focused on maturing the workforce modelling in this area. Introducing mechanisms to target the program towards changing workforce need would greatly enhance the STP in its ability to contribute to a specialist workforce that is well distributed and aligned to need.

Merit determination: Adequate Strength of Evidence: Sufficient evidence

The STP in the broader strategic context

The STP, comprising the Commonwealth's key contribution to non-GP specialist training in Australia, was designed to focus on funding training in settings which would not otherwise be funded to deliver training through state and territory funding mechanisms. State and territory health budgets fund the bulk of non-GP specialist training nationally. In 2021, the NMWS estimated that states and territories fund 93 per cent of non-GP specialist training places, which are largely in public settings in metropolitan areas.

Through the STP, the Commonwealth has the opportunity to invest in the long-term pipeline of non-GP specialists and build the workforce to respond to anticipated future need. Without the STP, non-GP specialty training would be solely funded by state and territory health bodies. States and territories tend to be focused on meeting current service need for the community, particularly in metropolitan areas, where the service need is greatest.

Responding to maldistribution and sub-optimal supply

Analysis of key indicators shows that the specialist medical workforce in Australia is maldistributed, with a skew to metropolitan areas and characterised by sub-optimal supply of some specialist areas. Ensuring timely access to trained medical specialists is a key component of a highly effective health system, and the supply of specialists from across specialties is integral to this. In Australia, the overall number of medical specialists has increased over recent years, however the distribution of these reflects oversupply of some specialties and undersupply of others.[14] Wait times, a useful proxy for access to specialist healthcare, have increased over recent years, meaning access to specialists for elective surgery in Australian public hospitals has reduced.[15],[16] At the same time, the number of specialists in training across specialties is changing, and of recent years has been improving in its alignment to some, but not all, of the areas of undersupply in the trained workforce.[17]

As the composition of the specialist medical workforce changes over time, alongside that of the general population, Commonwealth, state and territory governments and medical colleges play an important role in monitoring these changes and in directing funding to respond to changing workforce need.

The STP is unique in its intention to directly address the maldistribution of the non-GP specialist medical workforce, and to build a stable and high quality rural, regional and remote health workforce. The STP also provides funding for private settings to provide training posts, which are not funded through the states and territories. The STP also aims to correct the undersupply of Aboriginal and/or Torres Strait Islander medical specialists and, in so doing, to support improved First Nations health outcomes.

Target setting for funding through the STP has historically relied on Colleges to identify the proportion of STP funding which should be directed to private or rural, regional and remote settings. To date, a reliable source of national medical workforce data has not been available to the Commonwealth to inform STP funding agreements. While Colleges and jurisdictional health portfolios collect and analyse health workforce data, the timeframes, purpose and focus of these data sets vary widely.

The STP Program Logic

The STP Program Logic set out in **Figure 1** is based on the current program settings and sets out the arrangements in place to administer the STP. The program logic also articulates the short, medium and long term intended outcomes of the program in improving the alignment of the geographical and professional distribution of specialists to Australia's health needs.

A range of assumptions and external factors which are key to the program, contributing to its intended outcomes but which operate outside the STP itself, are included in the program logic. Some of these may be influenced by government policy and practices, while others are outside the administration of the STP.

Program activities, outputs and outcomes

The STP Program Logic details the inputs, activities and outputs associated with achieving the intended outcomes of the program. There are key roles and responsibilities for several stakeholder groups within the STP, both in the design and targeting of the program, as well as in its day-to-day delivery. The various activities across the program focus on collaboration, knowledge sharing and program administration.

In this program logic, these activities, when undertaken consistently by the Commonwealth, Colleges, state and territory health bodies and health settings, combine to produce four outputs for the STP, so that:

- Training pathways are established and coordinated in line with set targets and priorities.
- Specialist trainees are funded to undertake training in settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private settings.
- Regular forums take place to inform STP targets and priorities, and to draw on and inform national medical workforce demand and supply data and modelling.

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[14] Department of Health, 2021. 'National Medical Workforce Strategy', <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

[15] Australian Institute of Health and Welfare, 2023. 'Elective Surgery', <www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery>

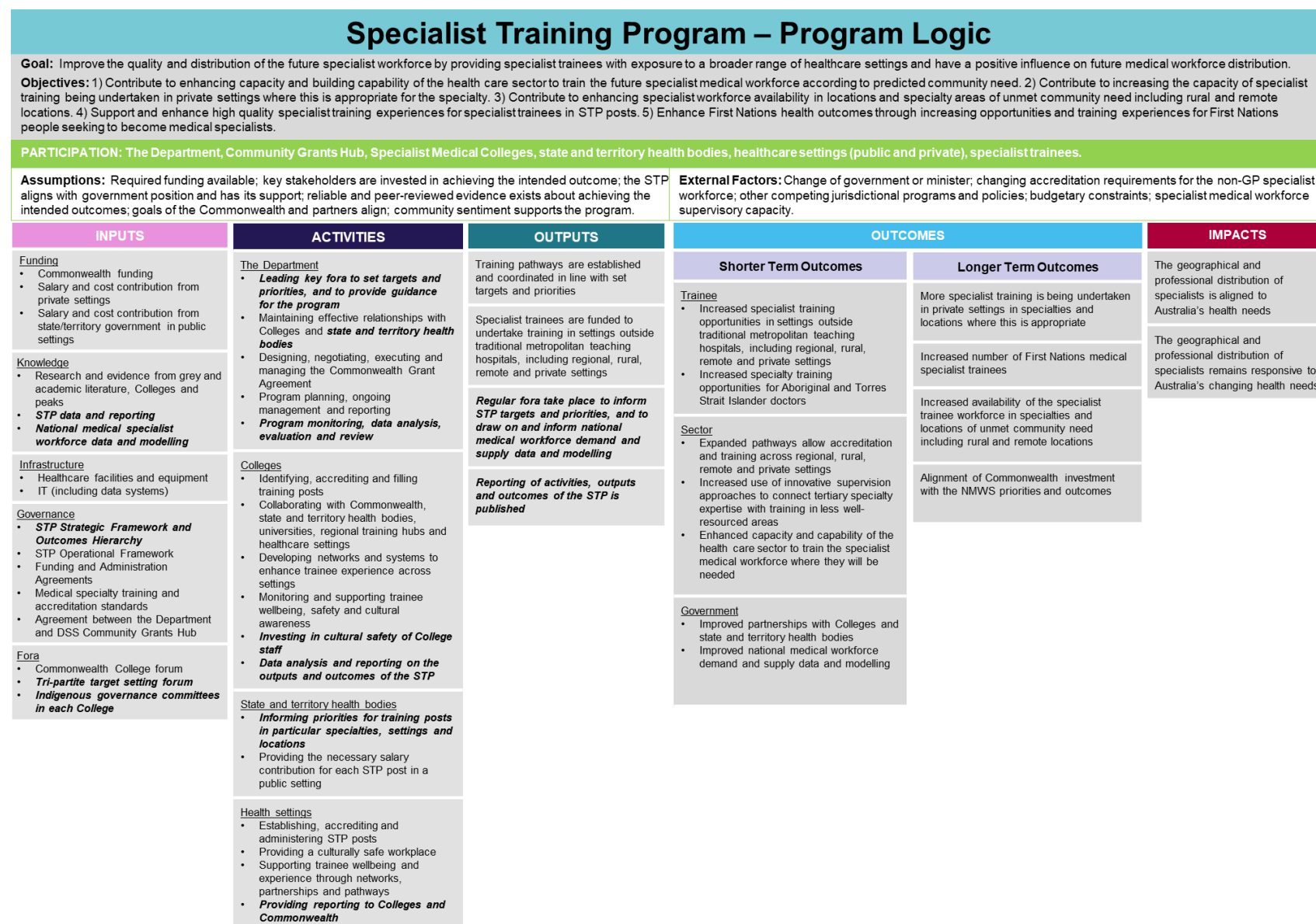[16] Australian Medical Association, 2022. 'Shining a Light on Elective Surgery 'Hidden' Waiting List', <www.ama.com.au/elective-surgery-hidden-waiting-list>

[17] Medical Deans Australia and New Zealand, 2024. 'National Data Report 2024', *Medical Schools Outcomes Database*, <medicaldeans.org.au/md/2024/05/MSOD-National-Data-Report-2024.pdf>

- Reporting of activities, outputs and outcomes of the STP is published.

In theory, these four outputs will lead to the outcomes of the STP and its ultimate intended impact, that the geographical and professional distribution of specialists is aligned, and remains responsive, to Australia's health needs.

Figure 1 – Program Logic for the STP

Specialist Training Program – Program Logic

Goal: Improve the quality and distribution of the future specialist workforce by providing specialist trainees with exposure to a broader range of healthcare settings and have a positive influence on future medical workforce distribution.

Objectives: 1) Contribute to enhancing capacity and building capability of the health care sector to train the future specialist medical workforce according to predicted community need. 2) Contribute to increasing the capacity of specialist training being undertaken in private settings where this is appropriate for the specialty. 3) Contribute to enhancing specialist workforce availability in locations and specialty areas of unmet community need including rural and remote locations. 4) Support and enhance high quality specialist training experiences for specialist trainees in STP posts. 5) Enhance First Nations health outcomes through increasing opportunities and training experiences for First Nations people seeking to become medical specialists.

PARTICIPATION: The Department, Community Grants Hub, Specialist Medical Colleges, state and territory health bodies, healthcare settings (public and private), specialist trainees.

Assumptions: Required funding available; key stakeholders are invested in achieving the intended outcome; the STP aligns with government position and has its support; reliable and peer-reviewed evidence exists about achieving the intended outcomes; goals of the Commonwealth and partners align; community sentiment supports the program.

External Factors: Change of government or minister; changing accreditation requirements for the non-GP specialist workforce; other competing jurisdictional programs and policies; budgetary constraints; specialist medical workforce supervisory capacity.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		IMPACTS

INPUTS

Funding
- Commonwealth funding
- Salary and cost contribution from private settings
- Salary and cost contribution from state/territory government in public settings

Knowledge
- Research and evidence from grey and academic literature, Colleges and peaks
- *STP data and reporting*
- *National medical specialist workforce data and modelling*

Infrastructure
- Healthcare facilities and equipment
- IT (including data systems)

Governance
- *STP Strategic Framework and Outcomes Hierarchy*
- STP Operational Framework
- Funding and Administration Agreements
- Medical specialty training and accreditation standards
- Agreement between the Department and DSS Community Grants Hub

Fora
- Commonwealth College forum
- *Tri-partite target setting forum*
- *Indigenous governance committees in each College*

ACTIVITIES

The Department
- ***Leading key fora to set targets and priorities, and to provide guidance for the program***
- Maintaining effective relationships with Colleges and ***state and territory health bodies***
- Designing, negotiating, executing and managing the Commonwealth Grant Agreement
- Program planning, ongoing management and reporting
- ***Program monitoring, data analysis, evaluation and review***

Colleges
- Identifying, accrediting and filling training posts
- Collaborating with Commonwealth, state and territory health bodies, universities, regional training hubs and healthcare settings
- Developing networks and systems to enhance trainee experience across settings
- Monitoring and supporting trainee wellbeing, safety and cultural awareness
- ***Investing in cultural safety of College staff***
- ***Data analysis and reporting on the outputs and outcomes of the STP***

State and territory health bodies
- ***Informing priorities for training posts in particular specialties, settings and locations***
- Providing the necessary salary contribution for each STP post in a public setting

Health settings
- Establishing, accrediting and administering STP posts
- Providing a culturally safe workplace
- Supporting trainee wellbeing and experience through networks, partnerships and pathways
- ***Providing reporting to Colleges and Commonwealth***

OUTPUTS

Training pathways are established and coordinated in line with set targets and priorities

Specialist trainees are funded to undertake training in settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private settings

Regular fora take place to inform STP targets and priorities, and to draw on and inform national medical workforce demand and supply data and modelling

Reporting of activities, outputs and outcomes of the STP is published

OUTCOMES

Shorter Term Outcomes

Trainee
- Increased specialist training opportunities in settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private settings
- Increased specialty training opportunities for Aboriginal and Torres Strait Islander doctors

Sector
- Expanded pathways allow accreditation and training across regional, rural, remote and private settings
- Increased use of innovative supervision approaches to connect tertiary specialty expertise with training in less well-resourced areas
- Enhanced capacity and capability of the health care sector to train the specialist medical workforce where they will be needed

Government
- Improved partnerships with Colleges and state and territory health bodies
- Improved national medical workforce demand and supply data and modelling

Longer Term Outcomes

More specialist training is being undertaken in private settings in specialties and locations where this is appropriate

Increased number of First Nations medical specialist trainees

Increased availability of the specialist trainee workforce in specialties and locations of unmet community need including rural and remote locations

Alignment of Commonwealth investment with the NMWS priorities and outcomes

IMPACTS

The geographical and professional distribution of specialists is aligned to Australia's health needs

The geographical and professional distribution of specialists remains responsive to Australia's changing health needs

Improved monitoring and responding to the changing specialist medical workforce

Responsiveness, data management and use are emerging areas of work for the STP and the Commonwealth more broadly, including through the 2021-2031 NMWS. Currently, the STP does not include appropriate governance or data and reporting mechanisms to guide the program. For example, there is no STP forum that brings together the Commonwealth, state and territory health bodies and Colleges to discuss need, which in turn could drive the process of setting STP post targets based on workforce demand and supply modelling. There is also no data collected about STP trainee retention in expanded settings, nor is data collected which would inform the program's impact on Aboriginal and Torres Strait Islander trainees. Without these, the program has a substantially reduced opportunity to respond to changing specialist workforce needs. It therefore relies heavily on the knowledge and informal networks maintained at the College level of the specialist pipeline and the workforce intentions of existing specialists. The risk here is the insular focus on individual specialties, rather than taking a national, whole of system view.

The key drivers targeting funding for non-GP specialist training are state and territory service need, largely focused on metropolitan teaching hospitals, and College level workforce planning to manage the pipeline of specialists in various specialties and sub-specialties. Neither of these lenses draw on a holistic, national understanding of current and future medical workforce.

The current STP funding agreements, covering the period 2022-25, were established prior to the release of workforce data modelling conducted for the NMWS, which provides a point in time view of the need for different specialties across Australia. As part of the development of the NMWS, multi-lateral working groups were established to explore Australia's medical workforce needs, including representatives from government health portfolios in all jurisdictions. Ongoing work to establish data systems to monitor workforce requirements is underway and standing committees in place to contribute to these.

To support target setting for funding specialist training in the future, the Commonwealth would benefit from insight into the changing need for non-GP medical specialties, and the location of the non-GP specialist workforce. While Colleges have insight into this from knowledge about their specialties and sub-specialties, the ability to draw on regional level analysis from jurisdictions, and to build a national picture of the changing non-GP specialist workforce would strengthen the program and help target Commonwealth investment in line with the NMWS.

The STP may benefit from leveraging the data and governance arrangements supporting the ongoing body of work associated with the NMWS, to inform future targeting of STP funding.

Strengthening the STP

The program logic for the STP reflects the current administrative arrangements as set out in program documentation, along with some key inputs, activities and outputs which could be added or strengthened in the program. Through discussions with stakeholders across the STP, these additional areas were identified as having strong potential to strengthen the program's design and delivery. These are presented in **bold italics** in **Figure 1**, and primarily focus on how the program can be more responsive to available non-GP specialist workforce demand and supply data. They will be discussed in further detail in the Sustainability chapter.

The specific inputs which could be used to improve the STP are as follows:

- An STP Strategic Framework and Outcomes Hierarchy
- Improved STP data and reporting
- National medical specialist workforce data and modelling
- Tripartite target setting forum
- Indigenous governance committees in each College

With these in place, along with appropriate associated activities, additional outputs would be created to support the program's outcomes.

Responsiveness to ongoing medical workforce needs in Australia

The current design of the STP does not enable ongoing engagement with workforce data or targeting of funding towards specialties or locations of highest need. While the program guidelines do not preclude posts moving between settings or across locations, in practice Colleges and settings are reluctant to move an STP post to a new location. For Colleges, moving a post represents a relationship risk and an administrative burden. Settings

are naturally loss-averse and will generally not support a post being re-prioritised to a new location if that entails their losing a trainee. This tendency helps settings to plan and maintain a stable workforce, however this has the consequence of fixing funding in place, rather than supporting adaptation of the program over time to respond to areas of emerging workforce need.

At the same time, the distribution of funding between Colleges is set across multi-year grant agreements. The allocation of funding is a negotiated process, whereby national workforce needs are only one consideration. In practice, Colleges are the primary voice advocating for particular funding outcomes. Colleges tend to focus on their own specialties, rather than overall national health needs. Across several grant agreement cycles over the program lifetime, the allocation of funding between Colleges has been relatively stable, suggesting the STP has not adjusted to changing demand for medical specialists over time. Colleges responsible for multiple specialties have broad discretion in selecting which specialties from within their College receive an STP post. This limits the Department's ability to influence which specialties are funded at a sub-College level.

Priority One of the NMWS sets out key steps to building a collaborative, cross sector network of data and decision makers, and as this evolves opportunities to incorporate this into the operational guidelines supporting the STP should be considered.[18]

Appropriateness of the design of the STP	
Overall finding: *Adequate*	Strength of Evidence: *Sufficient Evidence*
Performance demonstrated some weaknesses in relation to the overarching question of the evaluation domain, however minimum expectations or requirements were met.	Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.

Summary

Overall, while the program is unique as a contribution to funding non-GP specialists outside of public metropolitan settings, in its current form the STP does not respond to the changes in the evolving national non-GP specialist medical workforce. STP targets generally remain static over time, based on historic funding levels and largely determined by Colleges, rather than drawing on national workforce data and modelling.

While to date a reliable source of insight into workforce demand and supply has not been available to the Commonwealth, recent investment has focused on maturing the workforce modelling in this area. Introducing mechanisms to target the program towards changing workforce need would greatly enhance the STP in its ability to contribute to a specialist workforce that is well distributed and aligned to need.

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[18] Department of Health, 2021. 'National Medical Workforce Strategy', <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

Key evaluation questions relevant to this section

KEQ4: To what extent is the program effective in increasing specialist training numbers?

KEQ6: Is there early evidence to show FATES is contributing to achievement of STP policy intents and vice versa?

KEQ7: How effective has the program been in influencing trainees' choices or actions, particularly around Fellows choosing to continue their careers in expanded settings due to the program?

KEQ8: What is the likelihood of the program contributing to the desired long-term outcomes (rectifying the maldistribution of specialists maintaining medical specialists to rural and remote locations)?

KEQ11: Is there a minimum length of rural rotation required for cost-effective delivery of the STP and/or to improve the chances of trainees returning to work in rural areas following a Fellowship?

KEQ14: Is there a risk in reducing the focus on the STP to rural and remote locations only?

While the program design could be strengthened to enable it to become more responsive to changing health workforce supply and demand, a key focus of this evaluation is to examine how effective the STP has been in achieving its aims. These are:

1. To broaden experience of vocational training for specialist registrars (trainees) into settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private facilities.

2. To contribute to improving specialist medical workforce supply and distribution by enhancing the availability of the specialist workforce in areas of unmet community need, including rural and remote locations.

3. To enhance Indigenous health outcomes through increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists.

The following chapter provides observations and analysis of how well the program has achieved these aims. Drawing on program data and documentation, along with extensive consultation feedback, each of the three aims of the program are examined separately. There is some overlap between aims 1 and 2, and this evaluation has separated these into two distinct concepts: the extent to which the STP has been effective in funding training placements in private settings, and the extent to which it has been effective in enhancing the rural and remote non-GP specialist workforce.

The extent to which the program is effective in enhancing the sector's capacity to support non-GP specialist trainees, supporting the overall intent of the STP, is also examined. The elements of the STP which focus on this objective are the Support Projects and the FATES grant program. Data, documentation and consultation feedback are analysed to evaluate how well these components operate to effectively meet this intent of the STP.

Overall, evidence available to this evaluation suggests that improved targeting of funding could strengthen the STP's contribution to its three aims, and that the intent of Support Projects and the FATES program could be met with reduced funding in these areas.

Effectiveness in funding posts in private settings

AIM 1: To broaden experience of vocational training for specialist registrars (trainees) into settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private facilities.

To assess the effectiveness of the STP in achieving the aim of supporting training places in private settings, the following criteria are of relevance:

- How well the STP meets targets for funding private settings.
- To what extent STP funding for private posts is aligned to specialisations which need private training.
- To what extent STP funds posts that would not otherwise be funded.

STP targets are generally well met for posts in private settings

The STP grant agreement for each College sets out a target for the number of STP posts to be funded in private settings and in non-metropolitan locations. A review of the grant reporting provided by Colleges shows that in 2023 the Commonwealth provided PICS for 461.6 FTE in private settings (the private settings target).[19] Contracts were entered into with Colleges to fund 447.3 FTE in private settings (funded posts), of which 422.9 were filled.[20] At 91.6 per cent, this represented the highest target-to-filled rate in the three years for which data is available (2021-2023). On an individual College basis, most Colleges had a target/filled ratio of greater than 80 per cent. RANZCOG was the main outlier, with funded FTE provided for only 52.2 per cent of the private setting target.[21]

Settings for different specialties differ

When considering the effectiveness of the STP in funding posts in private settings, it is also important to reflect on the need for private training for some specialties. There is wide variation across specialties in training setting and supervisory requirements, and not all specialties benefit from exposure to private settings in the same way.

The scope of practice possible in different settings

There is a degree of variation across specialties and sub-specialties in terms of the training settings which enable the experience required to obtain fellowship. Specialties represented across all 13 Colleges funded through STP are considered to be able to exercise their full scope of practice in major metropolitan face to face settings. At the same time, almost all specialties are considered able to also do this in regional hospitals, and many can also exercise their full scope of practice in private rooms. [22]

Through stakeholder consultation conducted during the evaluation, a common argument was made that the accreditation of specialists is based on an outdated model where training must occur in large tertiary teaching hospitals in metropolitan settings. While the clinical acuity seen in public metropolitan hospital settings is recognised as valuable to many specialties, the current view from many stakeholders to this evaluation is that the value of obtaining training in other settings is also very high but may be underutilised in some specialties.

Other drivers attracting trainees to 'non-expanded' settings

In discussions with medical officers, registrars and healthcare settings, the value of different settings for trainees was explored, and a potential hidden factor surfaced – being the need for registrars in many specialties to obtain referees from highly regarded fellows in their specialty of interest in order to successfully obtain fellowship. The competitive nature of obtaining fellowship through some specialties drives registrars to seek posts in metropolitan, publicly funded tertiary settings (i.e. settings which do not meet the definition of 'expanded' for STP) where relationships with well-respected or influential mentors and colleagues can be nurtured.

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[19] While referred to as a 'target' in internal documents, the Department views these as 'targets' as the maximum amount of PICS funding a College can receive, rather than a reflection of the number of private placements the Commonwealth is deliberately seeking to enable.
[20] PICS funding is from STP Grant Agreements, Funded and filled figures are from Department of Health and Aged Care, STP Post Data. The 5 IRTP FTE in private settings have been excluded because IRTP does not have a private setting target.
[21] The Grant Agreement between the Commonwealth and RANZCOG includes a target of 11.5 PICS positions. It appears RANZCOG was only able to enter into agreements with private health settings for 6 FTE (the funded amount). All 6 funded FTE were filled.
[22] Department of Health, 2021. 'National Medical Workforce Strategy', Appendix D, <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

This aspect of the specialist pathway is unregulated and may be seen to provide perverse incentives which in some ways work against the objectives of STP to expand trainee experience across settings. At the same time, it provides local health networks (LHNs) with a supply of unaccredited trainees in many relevant specialties, and assists in meeting the patient caseload in tertiary settings.[23] The concern from trainees and others expressed that moving to expanded settings, be they private rooms or regional areas, will not be recognised as high value by College selection committees, further reinforcing the barriers to the STP's aim to broaden the experience of trainees into expanded settings.

Specialties where these reflections may be particularly relevant are surgery, physician sub-specialties, obstetrics and gynaecology and paediatrics.

The value of training experience in expanded settings

Specialties across the 13 Colleges gain value from training experience in expanded settings. Where metropolitan tertiary settings provide a high level of clinical acuity for many specialties, this is also the case in regional centres outside of metropolitan areas. Stakeholders consulted argued that regional and remote settings are also characterised by a high level of variety in cases, where often trainees are providing care for the community across a wide range of patient needs as part of a small team of skilled generalists. At the same time, private rooms provide experience and exposure to another healthcare setting, enabling trainees to gauge their interest in pursuing a practice in this setting, which plays an important role in the Australian healthcare system in relieving the caseload of public hospitals and waiting lists. For specialties that are out-patient practices, such as dermatology and ophthalmology, training and healthcare provision must take place in private settings as most public hospitals do not have positions on staff for these specialties.

There may be limited funding available for teaching and training in expanded settings

When considering the role of STP in supporting trainees to experience expanded settings, it is also important to consider the broader funding picture for these posts. As discussed above, while most specialties can exercise their full scope of practice in tertiary metropolitan settings, funding for these settings as determined by LHNs and state and territory budgets do not necessarily support the full range of specialties which the Australian healthcare system must provide for the community.

Of the specialties currently funded through STP, consultations suggest that there are some specialties that receive little or no public funding, or which particularly benefit from training opportunities in private settings. These are:

- Sports exercise physicians (ACSEP)
- Dermatologists (ACD)
- Surgery (RACS)
- Ophthalmology (RANZCO)
- Obstetrics and gynaecology (RANZCOG)
- Psychiatrists (RANZCP)
- Pathologists (RCPA).

The funding available to private settings for trainees is limited to STP, philanthropic donations and business decisions to redirect earnings into training posts. The latter two do not represent reliable ongoing sources of funding and are subject to change with little notice where costs or other competing demands arise. STP represents a crucial form of funding for the specialties which require access to training in expanded settings.

The STP provides support for trainees to gain experience in private settings across all College specialties

STP funding is directed to posts in a mix of public and private settings in all 13 STP-funded Colleges. **Figure 2** shows four of the specialties identified above as particularly benefiting from or relying on private setting funding are those that have the highest proportion of private posts targeted relative to total STPS post: Exercise Physicians, with 100 per cent of their STPS posts in private settings, (4 posts of their total of 4); Pathologists, with 80 per cent of their STP posts being private (72 out of 90 posts); Dermatologists, with 75.9 per cent of their

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[23] NSW Ministry of Health, 2020. Review of Trainees in Unaccredited Positions,
<www.health.nsw.gov.au/workforce/culture/Publications/review-trainees-unaccredited.pdf>

STP posts being private (22 out of 29 posts); and Ophthalmologists, with 70 per cent of their STP posts private (11 out of 15 posts).[24]

Figure 2 - Target STPS trainee FTE by College, by setting type, 2023

Target STPS trainee FTE by College and setting type
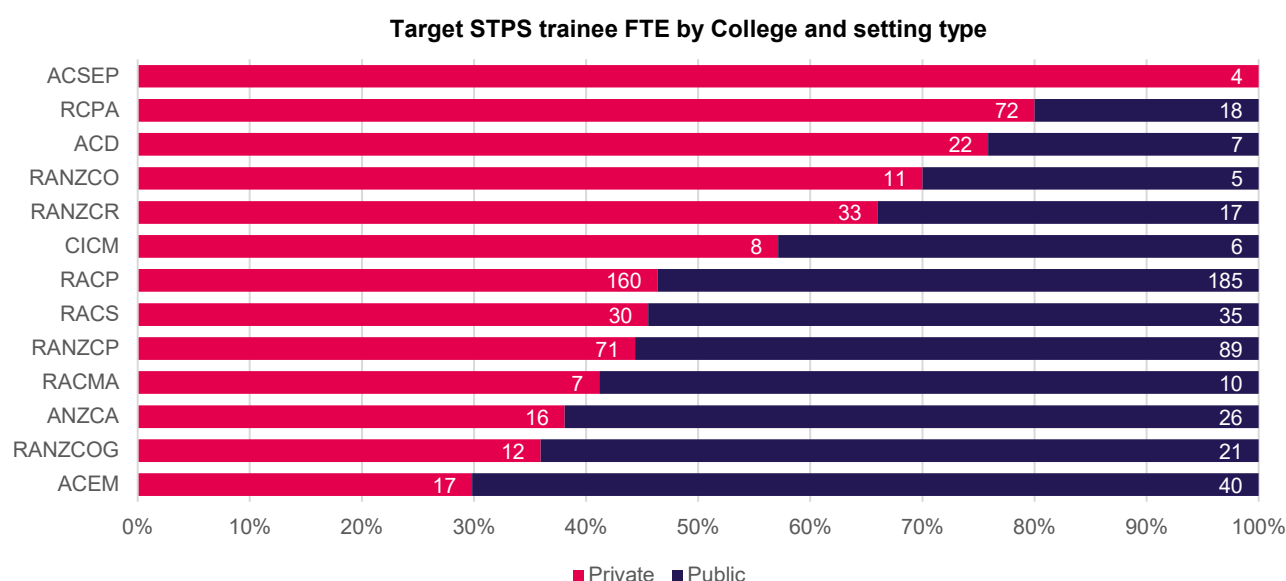
The numbers within the bars denote trainee target FTE per College, e.g. RCPA had 72 target FTE in private settings and 18 target FTE in public settings. These figures exclude IRTP and the Tasmanian Project as these sub-streams do not have a within stream 'private settings' target.
Source: Department of Health and Aged Care, STP Grant Agreements.

The Colleges with the next highest proportion of private posts funded are those who do not rely on private settings, Radiologists, Intensive Care Medicine specialists, and Physicians (although this is such a diverse group of sub-specialists it is unclear whether this is driven by training requirements for trainees across the various sub-specialties). Surprisingly, obstetrics and gynaecology are the specialty with the smallest proportion of private posts, contrary to the suggestion heard in consultations that private training is an important opportunity for these trainees.

It is interesting to consider the need for Commonwealth funding of trainee posts in private settings. A prima facie analysis of posts against the suggested need of specialties and sub-specialties for private training suggests that target FTE allocated to private practice posts in radiology (33 FTE), intensive care medicine (8 FTE), emergency medicine (17 FTE), medical administration (7 FTE) and anaesthesia (16 FTE), could be redistributed. This combines to around 81 FTE currently targeted at private settings for specialisations which do not appear to require private setting exposure. This may represent up to $8.5 million in STP trainee salaries which could be better focused on the other aims and objectives of the program. Where these are in regional, rural and remote areas, or occupied by First Nations trainees, this would serve other aims of the STP, but where this isn't the case, moving funding to these priority areas may strengthen the program overall.

When this suggestion was tested in validation discussions with Colleges and other stakeholders, the value of having access to stable, long-term STP funding was raised, along with the benefit of exposure to private settings. However, state and territory government stakeholders argued that a reduction of funding for private posts would have a flow-on beneficial impact on the public health system, based on the challenge for public settings in competing for specialists who can attract far higher salaries in private practice. The overall conclusion from the validation sessions was that it was not possible for this evaluation project to identify a definitive list of specialties or sub-specialties who require training in private settings, however the benefit of improved targeting of the program was broadly recognised.

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[24] 'Target' is the number of FTE included in the grant agreements between the Commonwealth and Colleges. 'Target' is the appropriate measure because this section is related to the Commonwealth's adherence to the program objective of broadening experience in private settings. The ratio in this section compares the total private posts targeted and the total number of STPS FTE targeted. IRTP and Tasmania Program Posts are not included because these streams do not have a within stream 'private settings' target.

A mechanism to draw through knowledge and information from Colleges, state and territory health bodies and from areas across the Department would serve an important purpose for the STP, assisting in more meaningful targets for non-GP specialists training places in private settings.

Program effectiveness in funding posts in private settings	
Overall finding: **Good**	Strength of Evidence: **Sufficient Evidence**
Performance was generally strong in some areas relating to the overarching question of the evaluation domain. Some gaps or weaknesses were evident.	Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.

Overall finding

Evidence available to this evaluation indicates overall the program is supporting trainees to gain experience in private settings, by enabling Colleges to drive post selections to serve the training needs required for specialty and sub-specialty fellowship. Fill rates for private settings are high, indicating the program is successfully meeting targets for funding this type of expanded setting. At the same time, a proportion of funded FTE is targeted at specialties which may not require training in private settings. While this training is beneficial, this funding could be better focused on the other aims and objectives of the program. An enhanced mechanism, such as the tripartite forum identified in the program appropriateness chapter above, could support better targeting of funding to long term need rather than maintaining historical funding levels across the program.

Effectiveness in enhancing the rural and remote specialist workforce

AIM 2: To contribute to improving specialist medical workforce supply and distribution by enhancing the availability of the specialist workforce in areas of unmet community need, including rural and remote locations.

To assess the effectiveness of the STP in achieving the aim of supporting a correction of the maldistribution of the medical workforce, the following criteria are of relevance:

- How well the STP meets targets for funding posts in regional, rural and remote settings.
- To what extent STP funding for posts is aligned to specialisations needed in each location.
- To what extent STP is associated with trainees moving to live and work in regional, rural and remote areas over the longer term.

There is a maldistribution of specialists across Australia with the vast majority in metropolitan areas

There is evidence to suggest that Australia has enough doctors to address its needs, however the medical workforce is maldistributed and focused in metropolitan areas.[25] In 2022, major Australian cities had 160 FTE specialist clinical medical professionals per 100,000 people, compared with 53 in remote and very remote areas.[26] This creates inequalities in the health of Australians. For example, the cancer survival rate in non-metropolitan areas is 18-32 per cent poorer.[27] The rate of disease burden is 1.4 times higher in remote and very remote areas, in comparison to major cities.[28] Australia relies heavily on overseas-trained doctors (OTD) to help correct workforce maldistribution, however without support and training it is extremely difficult for OTDs to adapt to rural and remote areas.[29]

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[25] Gorman, D, 2015. 'Developing Health Care Workforces for Uncertain Futures', *Academic Medicine*, vol. 90(4), pp. 400-403
[26] AIHW, 2024. 'Health Workforce', <www.aihw.gov.au/reports/workforce/health-workforce>
[27] Fox, P and Boyce, A, 2014. 'Cancer Health Inequality Persists in Regional and Remote Australia', *Medical Journal of Australia*, vol. 201(8), pp. 445-446
[28] AIHW, 2021. 'Australian Burden of Disease Study 2018', <www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-disease-burden/contents/remoteness-areas>
[29] O'Sullivan, B, Russell, DJ, McGrail, MR and Scott, A, 2019. 'Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency', *Human Resources for Health*, vol. 17(8)

Appropriate geographic distribution of the medical workforce is one of the most critical components of providing equitable and effective healthcare to all Australians. It is also one of the most challenging. Appropriate distribution is affected by a range of factors such as population density, demographics and disease burden of each region and its proximity to other service hubs. The STP uses the Modified Monash Model (MMM) of population distribution as a guide to 'rurality'. There are seven 'MM' categories, with MM1 classified as 'Major Cities' and MM7 as 'Very Remote Communities'. These classifications are calculated based on population and remoteness (quantified by road access to services).[30]

Currently, approximately 71.3 per cent of Australians live in an MM1 region.[31] Nationally, MM1 regions are specialist dense. Between 86.8 and 84.8 per cent of medical specialists primarily practice in MM1 regions.[32] With the exception of Emergency Medicine specialists (76.5 per cent), over 80 per cent of specialists from all 13 STP-funded Colleges practice in an MM1 region.

On a per-1,000 resident basis, the availability of specialists declines between MM1 and MM5, before rising again in MM6 and MM7 locations. The jump in MM6 and MM7 regions is primarily related to the way places are classified, with MM4 regions defined as 'medium rural towns with a population between 5,000 and 15,000' and MM5 regions labelled as 'small rural towns'. Areas that are MM6 are more remote but can have substantial populations. For example, Alice Springs has an MM6 rating and a population of approximately 26,000. Alice Springs functions as a hub for a large surrounding MM7 region and is better equipped to provide medical services than many less remote, lower population MM4 and MM5 regions.

Figure 3 - Specialist FTE per 10,000 Australian residents

Specialist FTE per 10,000 resdients
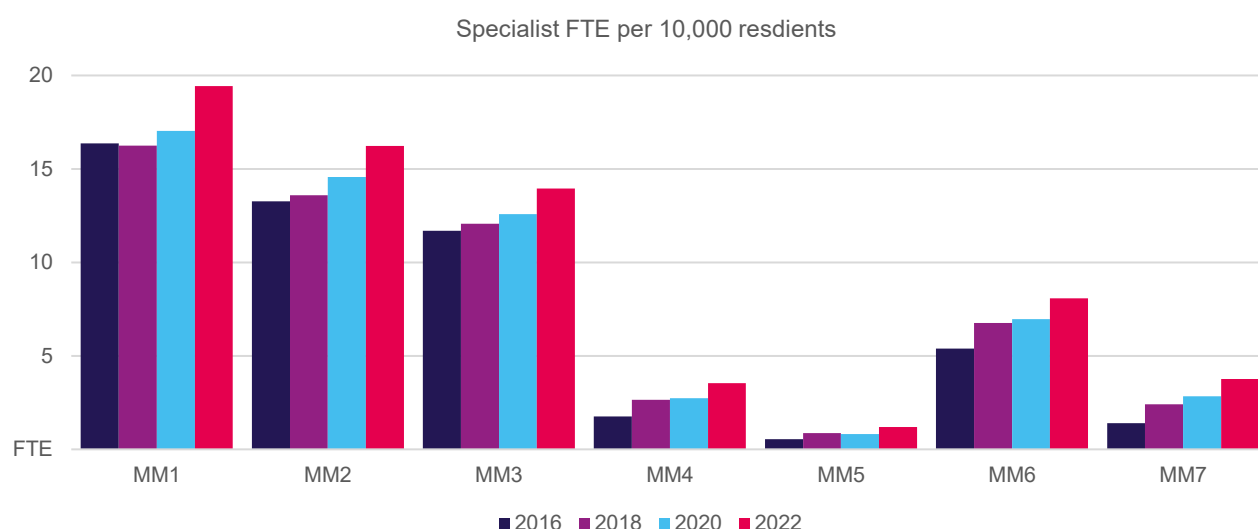
Sources: Department of Health and Aged Care, Health Workforce Data (HWD): Specialists (note, HWD does not include Dermatologists, Sports and Exercise Physicians and Medical Administrators). Share of population in MM regions - Versace et al, 2021.

Availability of medical specialists varies in Australia by region

Survey results from the Australian Bureau of Statistics (ABS) indicate patient experiences of medical specialty availability are slightly worse outside of MM1 regions. In 2022-23, people in MM2-MM7 zones were more likely to report that they "needed to see a medical specialist but didn't". In the 'outer regional, remote and very remote Australia' group, 30.9 per cent of respondents reported that they "waited longer than they felt was acceptable to get an appointment with a medical specialist".[33]

Taken together, medical specialist distribution data and ABS surveys of patient responses indicate the specialist workforce in Australia is skewed towards metropolitan regions and patient perceptions of access to services are

[30] Department of Health and Aged Care, 2023. 'Modified Monash Model', <www.health.gov.au/topics/rural-health-workforce/classifications/mmm>
[31] Versace, VL, Skinner, TC, Bourke, L, Harvey, P and Barnett, T, 2021. 'National analysis of the Modified Monash Model, population distribution and a socio-economic index to inform rural health workforce planning', *The Australian Journal of Rural Health*, vol. 29, no. 5, pp. 801-810
[32] Health Workforce Data (HWD) set. Of the specialties relevant to this review, the HWD does not include Dermatologists, Sports and Exercise Physicians or Medical Administrators
[33] ABS, 2023. 'Patient Experiences', <www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>

worse outside of MM1 regions. However, despite these sources, the overall and specialty level scale of maldistribution is not clear. Similarly, while it is clear which regions have more, or less, access to specialists, the optimal number of specialists for each region cannot be ascertained from currently available data. This is a major barrier for the efficient allocation of STP funding by the Commonwealth to Colleges, and by Colleges in deciding which settings are most in need of more specialist trainees.

The trainee specialist workforce is somewhat more evenly distributed

The trainee workforce is more evenly distributed than fully qualified specialists.[34] In 2022, 77.4 per cent of trainees practiced in an MM1 region (compared to 84.8 per cent of qualified specialists). In 2022, the number of trainees per 10,000 residents was higher in MM2 regions than MM1s and the discrepancy between MM1s and MM3-7 was lower than for fully qualified specialists.

Despite this relatively more even distribution, during consultations and in response to the Settings Survey, challenges recruiting trainees in MM2-MM7 regions was one of the most common concerns for health settings. Sixty-three per cent of health training settings in MM2-4 that responded to the Settings Survey reported having difficulty securing specialist trainees.[35] This result was common across both public and private settings, many of which reported being 'out-competed' by metropolitan based facilities. Specialist trainee recruitment was reported as a challenge by MM1 settings, however at a substantially lower rate (33.7 per cent).[36]

The balance of non-GP specialist generalism and sub-specialties

Specialist medical college fellows are recognised as specialists by the Medical Board of Australia. Generalist non-GP specialists practice across the entire range of their specialty. For instance, generalist cardiologists treat all heart conditions, while subspecialist electrophysiologists focus on rhythm disorders. Similarly, generalist obstetricians and gynaecologists manage pregnancy, assist with deliveries, and provide gynaecological services like colposcopy and prolapse management. In contrast, gynae-oncologists specialise in treating gynaecological cancers.[37]

An effective and efficient medical workforce needs a balance of doctors with both broad and narrow scopes of practice across all levels of care. Over time, specialty training and specialist practice tends to lead to greater subspecialisation. Priority four of the NMWS aims to rebalance this trend by promoting generalists, especially for doctors in specialties that can serve regional, rural, and remote areas. Funding models should provide better compensation for practitioners in rural and remote areas and actively promote generalist non-GP specialist medical careers. Additionally, junior doctors should be encouraged to develop a wide range of generalist skills before choosing a specialty. The ideal balance between generalism and subspecialisation is not clearly defined and will vary based on geography, demographics, available resources, and other epidemiological and systemic factors.[38]

Generalist non-GP specialists who can practice across the full scope of practice within their specialty are crucial for delivering high-quality care locally, particularly in rural and remote areas. However, as the workforce becomes more subspecialised, it loses flexibility. This can result in patient care being divided among multiple subspecialists, which may reduce efficiency and increase the risk of adverse events. Promoting generalist non-GP specialist medical capability, including through digital support, will facilitate the adaptation of locally developed care models to meet community needs.

The need for different specialists varies with relative remoteness

There is a discourse in the literature around whether Australia should increase its focus on generalism and flexibility between specialties to address workforce gaps. Given that Australia's population is ageing, the number of co- or multi-morbidity cases are increasing, it is suggested generalist roles are best placed to address this. Further, it is argued generalist medical practitioners may be of more use in non-metropolitan areas where the

[34] Department of Health and Aged Care, 2023. Health Workforce Data Tool
[35] Proximity 2024, Health Training Settings survey
[36] Proximity 2024, Health Training Settings survey
[37] Department of Health, 2021. 'National Medical Workforce Strategy', <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>
[38] Department of Health, 2021. 'National Medical Workforce Strategy', <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

extent of medical care is limited.[39,40] This idea arose frequently in stakeholder consultations, and a list of specialties where there may be value in prioritising generalist non-GP specialists has emerged. This is shown in **Table 6.**

At the same time, the need for specialist medical officers for many in-patient focused sub-specialties may be largely confined to metropolitan and regional centres, due to requirements for substantial infrastructure and for access to teams of multidisciplinary specialists in the provision of care. While specific infrastructure requirements vary across specialisations and treatment modalities these can include highly specialised and costly machinery, equipment, medical computerised technology, and real-time data sharing amongst specialists. With multi-million-dollar funding required to maintain facilities with such infrastructure, investment is generally targeted to metropolitan locations where patient demand is high and the workforce required for specialised multidisciplinary care is available. This means in practice, efforts to correct maldistribution of in-patient focused specialties may best be focused on MM2 locations, and some MM6 locations, like Alice Springs, discussed above.

For other specialties a focus on maldistribution is less salient. Regional areas in MM2-7 locations also need access to emergency medicine specialists and intensive care specialists. For pathologists, for example, infrastructure requirements and the relative ease with which samples can be transferred from region to centre mean that pathology is likely to remain a metropolitan focused specialty, and stakeholders argued that recent advances in diagnostic and communications technology mean this has minimal impact on health outcomes for clients outside of metropolitan centres.

To the extent that a generalist specialist workforce is more likely to meet the needs of areas outside MM1 and MM2, it is useful to reflect on where trainee posts are currently funded and the extent to which this aligns with providing a more generalist specialist workforce in these regions. As shown in **Table 6**, there are five Colleges supporting training in relevant generalist specialties, RACP, RACS, RANZCO, RANZCOG and RANZCP. Unfortunately, RACP (physicians) and RANZCP (psychiatry) were unable to provide data to this evaluation on the MMM distribution of their trainees. For ophthalmology, obstetrics and gynaecology, and surgery, over 80 per cent of trainees are in metropolitan areas.

Table 6 - Stakeholder views of which Generalist non-GP Specialists may be needed in rural and remote areas

Physicians (RACP)	Surgeons (RACS)	Ophthalmologists (RANZCO)	Obstetricians and Gynaecologists (RANZCOG)	Psychiatry (RANZCP)
Advanced Training General and acute care medicine Geriatric medicine General paediatrics	General/Acute care surgery Paediatric surgery Orthopaedic surgery	Ophthalmology	Obstetrics and Gynaecology	General psychiatrist

Alignment of program elements with drivers of trainee decision making

Consultation and literature indicate some key factors of high relevance to trainee decision making, in terms of where they wish to eventually practice. One key factor raised by stakeholders is the length of time of positive exposure to rural posts. The current minimum placement length in the program is three months and there are no explicit incentives for longer-term placements. This does not support the long-term aim of the program to encourage specialists to relocate away from metropolitan areas and support a correction of the workforce maldistribution across Australia.

Furthermore, trainees with regional and rural backgrounds are substantially more likely to report intending to practice outside of major cities once they complete their training.[41,42] The STP does not target or prescribe the recruitment of rural origin trainees, instead leaving this to Colleges and settings to determine.

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[39] Hudson, JN, Weston, KM and Farmer, EA, 2017. 'Changes in Medical Education to Help Physicians Meet Future Health Care Needs', *Medical Journal of Australia*, vol. 206(9), pp. 378-379
[40] NRHA, 2019. 'Medical Practitioners in Rural, Regional and Remote Australia', <www.ruralhealth.org.au/sites/default/files/publications/fact-sheet-medical-practitioners.pdf>
[41] MSOD-National-Data-Report-2024.pdf (medicaldeans.org.au)
[42] Proximity 2024, Specialist trainee and Fellows survey

The final factor emphasised by stakeholders as driving the likelihood of trainees remaining in or returning to rural posts is the timing of the STP placement in their journey to specialisation. Anecdotally it appears early in a trainee pathway, trainees are more likely to be able to transfer from metropolitan to regional or rural areas. Once trainees have partnered or had families, relocation becomes much more difficult and, anecdotally, less likely to succeed.

There is a lack of data regarding duration of placements, and of trainee movements over time. There is also no data collected through STP on the experience level of STP trainees to help understand where they are on their training pathway. This data would provide insight into salary contributions required by settings, as well as enabling a testing of the suggested link between training timing and likelihood to remain in rural locations.

Overall, the program does not align to known factors driving trainee attraction to non-metropolitan areas, and does not collect data to better test and explore the importance of these factors for STP trainee decision making over time.

Factors that attract specialists into metropolitan versus rural practice

When considering factors which attract medical professionals to live and work long term in regional, rural and remote areas, exposure earlier, and longer-term exposure to non-metropolitan training are key. The need for a strong network of training providers, settings and a collaborative approach with Colleges is also vital, while for some specialties, working against out-dated bias which privileges metropolitan teaching hospitals is crucial.

Regional attributes of trainees

The key factor determining whether a medical officer lives and works in a non-metropolitan area is their own background. [43] Multiple studies have found those who grow up in regional, rural or remote areas are twice as likely to wish to settle outside the city.[44] Respondents to the Specialist Trainee and Fellows Survey (ST&F survey) undertaken as part of this review supported this research. Most trainees with a rural background intended to practice outside metropolitan areas (66.2 per cent) in the future, whereas trainees with a metropolitan upbringing have considerably more interest in a career in a major city (75.8 per cent).[45]

Figure 4 - Trainee place of upbringing and intended future practice location

Specialist trainee place of upbringing and intended practice location
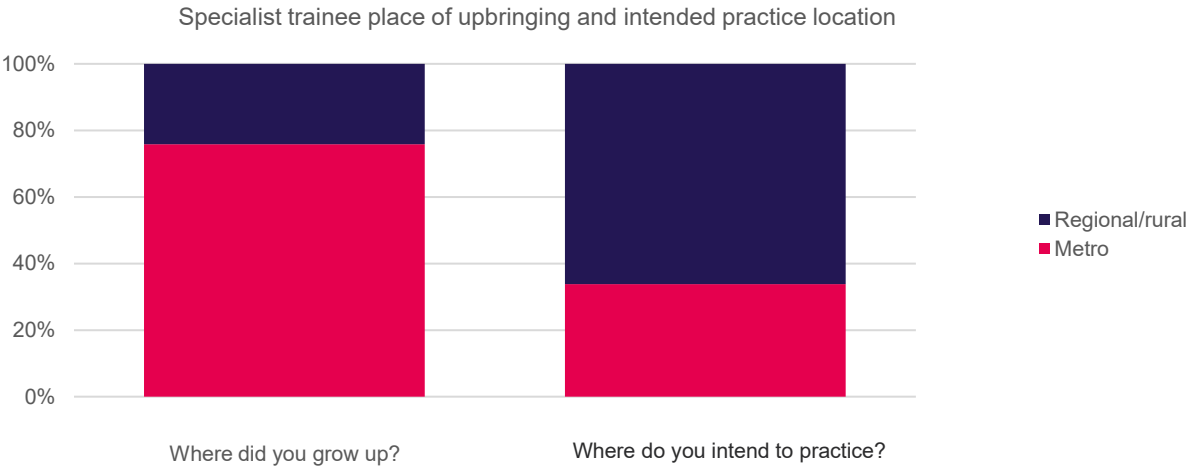
n= 191 (Metro background = 120, regional/rural background = 71)
Source: ST&F survey

Many stakeholders to this evaluation noted the importance of attracting students from regional, rural and remote areas into medicine to build the long-term pipeline of rural practitioners. Having funding for STP posts to then support the preferences of those who wish to live and work outside of metropolitan centres is necessary but not sufficient to help correct the maldistribution of specialist medical officers in Australia. Clear pathways to achieve this are also required.

[43] Kondalsamy-Chennakesavan, S, Ranmuthugala, G and Darshan, D 2015, 'Determinants of rural practice: positive interaction between rural background and rural undergraduate training', *Medical Journal of Australia*, vol. 202, pp. 41-45.
[44] Department of Health, 2021. 'National Medical Workforce Strategy', <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>
[45] Proximity 2024, Specialist trainee and Fellows survey

At the same time, empirical studies indicate there are insufficient numbers of rural-origin medical students to address medical workforce maldistribution in Australia.[46] Young people from regional and remote areas are also increasingly likely to move to the city for university, and these students are less likely to return.[47] General practitioners (GPs) with over 6 years of rural background were found to be significantly more likely to practice rurally than those with a rural background of 5 years or less. With specialists, only those with at least 11 years rural background are significantly more likely to practice rurally.[48] For specialists, other factors relevant to the career path for their specialisation may be working against their own preferences to live and work in region, rural or remote areas.

The importance of non-work factors

When asked what factors most influenced their choice of future practice location, trainee respondents to the ST&F survey overwhelming cited factors outside of work (71.4%) as most important. Non-work factors included responses related to family (28.8 per cent), such as proximity to parents and the ability of spouse to find work, lifestyle (10.2 per cent) and an existing connection to the location (8 per cent). Work factors such as professional development (13.3 per cent), job availability (10.6 per cent) were important, however made up a minority of overall responses. Only one trainee nominated 'salary' as an important factor.

The predominance of non-work responses provides support for previous research that has emphasised the importance of social connection in attracting and retaining trainees to work in rural areas.[49] For the STP, this result underscores the importance of providing assistance and support for trainees to become embedded in the community during their rotation and, wherever possible, assisting the families of trainees to find work, appropriate schooling and care.

Figure 5 - Trainee responses about the factors most influencing their intended future practice location, work and non-work related factors

Trainee responses about the factors most influencing their intended future practice location
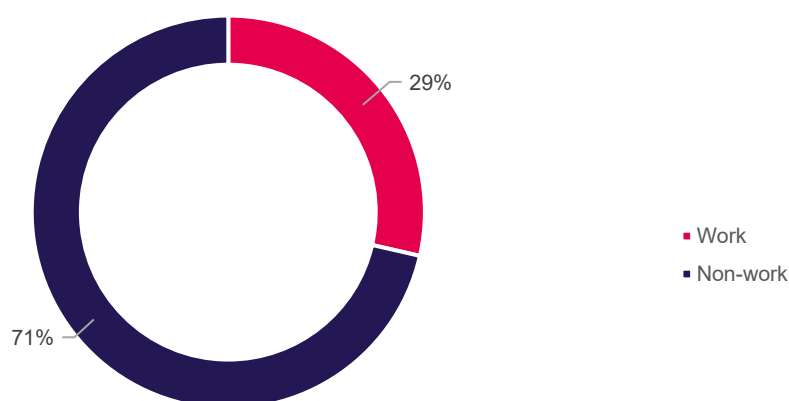
n = 175 (work = 50, non-work = 125)
Source: ST&F survey

Evidence also suggests the appeal of rural work may be decreasing, as domestic medical graduates are less likely to work in rural communities than their counterparts of four to five decades ago.[50] Furthermore, they are increasingly choosing specialties other than general practice, which reduces the chances of them practicing

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[46] Hay, M, Mercer, AM, Lichtwark, I, Tran, S, Hodgson, WC, Aretz, HT, Armstrong, EG and Gorman, D, 2016. 'Selecting for a Sustainable Workforce to Meet the Future Healthcare Needs of Rural Communities in Australia', *Advances in Health Sciences Education*, vol. 22, pp. 533-551

[47] Mackey, W, 2019. 'More Regional Australians are Moving to the City to Study. Few Return when they've Finished', *Grattan Institute*, <grattan.edu.au/news/more-regional-australians-are-moving-to-the-city-to-study-few-return-when-theyve-finished/>

[48] McGrail, MR, Humphreys, JS and Joyce, CM, 2011. 'Nature of Association Between Rural Background and Practice Location', *BMC Health Services Research*, vol. 11(63)

[49] Cosgrave, C, Malatzky, C and Gillespie, J, 2019. 'Social Determinants of Rural Health Workforce Retention: A Scoping Review', *International Journal of Environmental Research and Public Health*, vol 16(3).

[50] O'Sullivan, B, Russell, DJ, McGrail, MR and Scott, A, 2019. 'Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency', *Human Resources for Health*, vol. 17(8)

rurally.[51] This appears to be being driven by several factors, including bias against regional and rural work, professional isolation that may occur, the lack of lifestyle and family support, networking opportunities and emotional support.[52] Stakeholders to this evaluation also discussed a move away from GP pathways towards specialist pathways as a response to inadequacy of Medicare Benefits Schedule (MBS) funding, long hours and churn through patients that is required for GPs in Australia to meet their costs of living.

Timing factors influence whether trainees are likely to move permanently to regional or rural areas

Many stakeholders argued that early in a student's training journey was a more appropriate time for them to train outside metropolitan areas, and that STP training may occur too late in their pathway to effectively influence their intentions. While there is some variation across specialties and individual trainees, HWD analysis shows that the average age of new Fellows is 38 years.[53] Anecdotally, feedback from stakeholders indicates that in many cases, by the time medical officers commence STP training they are likely to have partnered, had children, or largely settled into the area where they have undertaken the majority of their training to date. The suggestion that STP placements at the end of the training program, where registrars are looking for a permanent role after they complete their specialty training, may be the best timing for rural placements.

Face to face consultations and the ST&F survey also suggested rotation duration influences the likelihood a trainee will remain in a non-metropolitan area long term. Of the 75 trainee respondents that had undertaken a regional/rural placement of more than a year, 51 (68 per cent) intended to practice outside of an MM1 region. Trainees that undertook rotation/s of less than 12 months were more likely to intend to practice outside of MM1s in the future than trainees who had not undertaken a placement outside of MM1. However, they were much less likely to intend to practice regionally than trainees who had undertaken longer placements.

Figure 6 Relationship between length of regional/rural placement and intended location of future practice

Length of longest rural placement and intended location of future practice
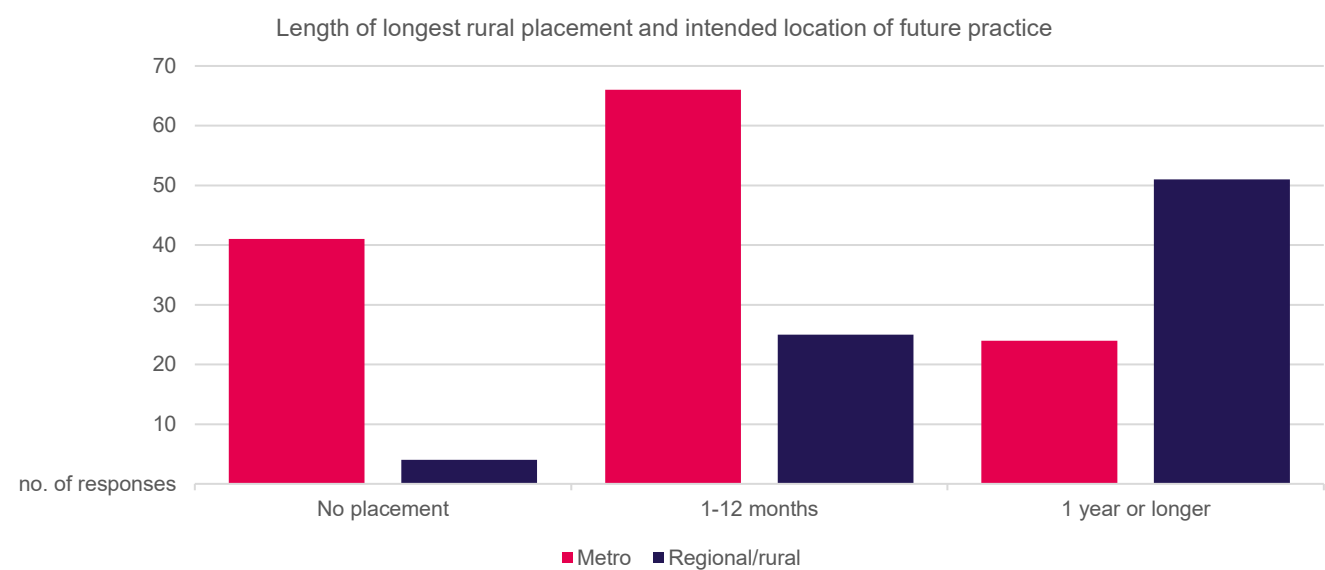
n=211 (none=45, 1-12 months=91, 1 year or longer-75)
Source: ST&F survey

In the context of the STP, a short, 3-month placement is likely to have a limited, short-term effect on the maldistribution of specialists. An STP placement provides access to a registrar and assists the healthcare setting in meeting the health needs of its local area. In the longer term, however, rotating registrar trainees through short term placements in a post is of less benefit to that local community than if the registrar moves there permanently, providing experience and expertise in the longer term.

While the IRTP stream of the STP supports longer term placements, and STPS can be used for half or more of a placement in a non-metropolitan setting, data collected across the program does not include placement duration. It is not possible to map the length of time trainees spend in regional, rural or remote locations, and

[51] O'Sullivan, B, Russell, DJ, McGrail, MR and Scott, A, 2019. 'Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency', *Human Resources for Health*, vol. 17(8)
[52] NRHA, 2023. 'Evidence Base for Additional Investment in Rural Health in Australia', pg. 31,
<www.ruralhealth.org.au/sites/default/files/publications/evidence-base-additional-investment-rural-health-australia-june-2023.pdf>
[53] Department of Health, 2020. 'National Health Workforce Dataset *Medical* Practitioners 2019', < hwd.health.gov.au>

therefore the extent to which the program is contributing to meeting the longer-term medical workforce needs of non-metropolitan areas is unclear. At the same time, the lack of monitoring and focus on this as a key lever within the program to support trainees establishing themselves to live and work in non-metropolitan areas is a sign that the STP is not highly effective in this aspect of its aim.

Infrastructure and pathways are needed to support non-metropolitan practice

To support long term movement to non-metropolitan locations, regional medical schools were cited as very influential, with a recognition that successful training and placements require a range of key stakeholders to be engaged and invested in the trainee's experience throughout their training pathway. Supervision, training settings and Colleges all need to be onboard, and active engagement is required to ensure frequent reliance on locums and other workforce shortages in non-metropolitan areas do not undermine efforts to build the workforce in the long term.

A wide variety of stakeholders consulted in this evaluation also described a bias towards metropolitan training hospitals, with trainees attracted to these settings for prestige, salaries and connections to influential practitioners in their fields of interest. Rural and regional training settings frequently described being 'outcompeted' by metropolitan hospitals for a limited pool of trainees.[54] This does not apply to all specialties equally, however. As discussed above, some specialties particularly benefit from training opportunities in private settings. Those where metropolitan training hospitals are most attractive are those which are in-patient focused (such as surgery (RACS); obstetrics and gynaecology (RANZCOG) and some sub-specialties of physicians (RACP)), and commentary from relevant literature as well as direct consultation with medical officers indicate there is a widely held belief that trainees will lose their skills and in other ways be disadvantaged by training in regional areas as part of their training journey to eventual fellowship. At the same time, stakeholders indicated where Colleges demonstrate a strong value for regional training in their selection processes this concern from trainees was ameliorated.

In 2019, results from the Medicine in Australia: Balancing Enjoyment and Life (MABEL) study suggested that a mix of policy approaches are required to tackle maldistribution of the medical practitioner workforce in Australia.[55] Focus areas suggested include selecting rural-origin medical students, increasing the numbers of generalist doctors in non-metropolitan areas, creating more opportunities to extend rural training or return, and improving working conditions. These focus areas were all raised in various forms, by multiple stakeholders, across the consultations conducted as part of this evaluation.

The STP is generally meeting its targets for regional, rural and remote posts

The STP elements which are directly targeted at correcting maldistribution of the medical workforce are the IRTP and the Tasmanian Project. This funding is exclusively provided to regional, rural and remote settings. STPS funding is also available to MM2-7 posts, along with the RSL to support trainees and settings with the costs associated with the post.

Across 2022 and 2023, the target to fill rates and funded to fill rate for the IRTP, Tasmanian Project and STPS RSL supported posts were consistent with the STP as a whole.[56] The modest exception was IRTP, which had a lower target to filled ratio of 87.5 per cent, predominately due a low target to filled rate for RANZCO. The IRTP also had the lowest funded to fill rate (92.2 per cent).

Over the same period, the Commonwealth provided Colleges with an RSL for 858 FTE (429 per year). Colleges entered into contracted arrangements with health settings for 837 FTE in MM2-7 locations, or which 782 were actually filled by trainees. There was wide variability in the target to filled ratio across Colleges, including a ratio of less than 90 per cent for eight Colleges and more than 100 per cent for RACS and RANZCOG. Results of greater than 100 per cent indicates that some FTE worked in MM2-7 however did not receive the RSL.

Colleges were provided with funding for 130 FTE in the Tasmanian Project (65 per year). Colleges entered into agreements with health settings for 127 FTE, of which 119 were filled. The overall target to filled ratio for the

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[54] Proximity 2024, Health Training Settings survey
[55] O'Sullivan, B, Russell, DJ, McGrail, MR and Scott, A, 2019. 'Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency', *Human Resources for Health*, vol. 17(8)
[56] While referred to as a 'target' in internal documents, the Department views these as 'targets' in a narrow sense, i.e as the maximum amount of RSL funding a College can receive, rather than a reflection of the number of rural placements the Commonwealth is deliberately seeking to enable.

Tasmanian Project was 91 per cent. Like the IRTP, the relatively small number of FTE in the Tasmanian Project means that variations of 1-2 FTE have a notable impact on the target to funded ratio.

Table 7 - Target to filled and funded to filled ratios for STP components and STP total, 2022 and 2023

	FTE/Post Target	Funded	Filled	Target/filled ratio	Funded/filled ratio
RSL[1]	858	837	782	91.1%	93.4%
IRTP	199	189	174	87.5%	92.2%
TAS	130	127	119	91.0%	93.3%
STP (all streams)[2]	2,169	2,144	1,983	91.4%	93.8%

[1] Rural specific component of STPS
Source: Targets – Department of Health and Aged Care STP Grant agreements allocation of STP, PICS, RSL and TAS FTE and IRTP posts. Funded and filled FTE – Department of Health and Aged Care STP Post Dataset

STP trainees are more likely to practice in an MM2-7 location than the general specialist trainee population

In 2023, 77.4 per cent of total filled STP FTE was in an MM2-7 location across all streams. This is substantially higher than the national proportion of 54.6 per cent of trainees in MM2-7.[57] It is also substantially higher than the 11.44 per cent MM2-7 practice rate reported for total specialist trainee cohort by STP participating Colleges.[58]

If STP trainees practiced in MM2-7 locations at the same rate as the total trainees from STP participating Colleges, there would be 433.8 less trainees practicing in MM2-7 regions. If realised, this would reduce the number of trainees in MM2-7 by approximately 8 per cent.[59] The relatively high proportion of STP trainees located in MM2-7 speaks to the effectiveness of these components of the program.

The program is also funding places which are not in expanded settings

While the STP is making a clear contribution to the MM2-7 workforce, in 2023, 10-11 per cent of total STP posts (111.9 funded FTE/108.2 filled FTE)[60] are in metropolitan public hospitals. The salary cost to the Commonwealth of these posts is $11.4 million. The majority of MM1 public posts were comprised of Psychiatry (39.1 funded FTE/36.8 filled FTE), followed by Obstetrics and Gynaecology (7.0 funded and filled FTE). At an STP level, Anaesthesia trainees specialising in Pain Medicine were most likely to work in a public MM1 setting (45.7 per cent of all filled Anaesthesia - Pain Medicine STP trainees).

When discussed during validation sessions, it was widely agreed that STP posts which are funded in metropolitan teaching hospitals can effectively connect trainees to opportunities to train in rural and regional areas, provided the post is attached to rural training pathways. While the program allows for up to half of training to occur in a metropolitan teaching hospital, it is unclear from the program data what proportion of posts which are partially based in these non-expanded settings are attached to rural and regional training pathways.

As raised in the discussion above about the program logic for STP, improved program data, along with a strengthened mechanism to set targets to meet long term workforce needs in Australia, could improve the effectiveness of the program in this regard, ensuring that all funding is flowing to an area of unmet need (i.e. not funded by state and territory health bodies) and in a way which is directly beneficial to the aim of enhancing the rural, regional and remote medical workforce. Where no direct link is found between funding of an MM1 public post and rural pathways, this funding should be redirected to placements in expanded settings which would better support the program objectives than providing funding and personnel to metropolitan public settings.

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[57] Department of Health and Aged Care, 2023. Health Workforce Data Tool
[58] Source: Medical College reporting for this review.
[59] This number is derived by assuming that filled FTE from all programs was located in an MM2-7 at the same ratio as the general specialist population reported by Colleges to this review, rather than the current STP rate of 54.6 per cent.
[60] There is no 'target' for MM1 public FTE in Grant Agreements

Figure 7 – Filled FTE and share of speciality FTE in public MM1 hospitals

Filled FTE and share of speciality FTE in public MM1 hospitals

Legend: Filled MM1 — Share of specialty STP trainees in public MM1 (right axis)
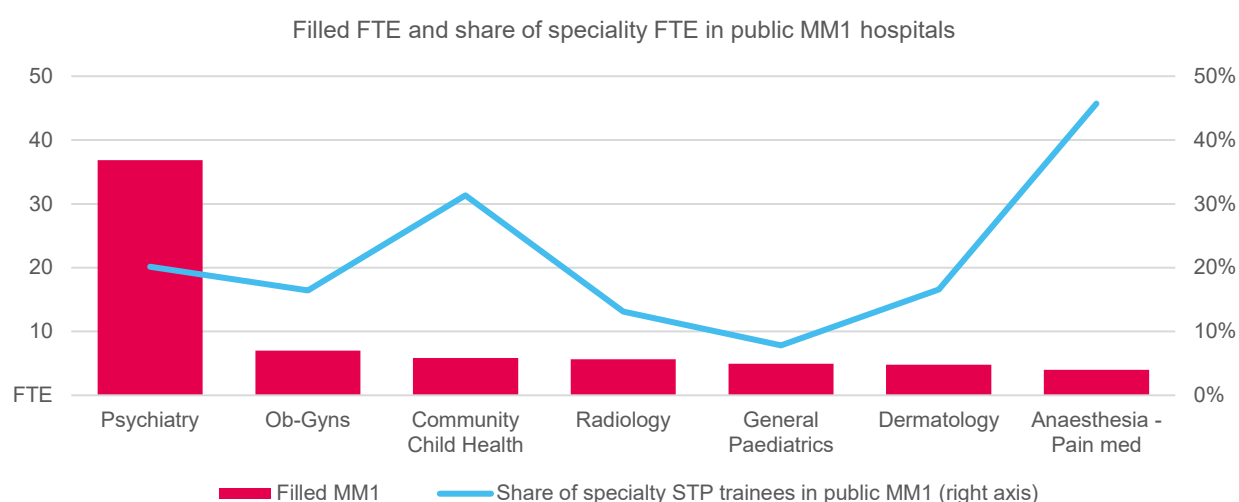
Source: Department of Health and Aged Care, STP Post Dataset

Overall, while STP funding targets are generally well met, and the STP trainee distribution is more skewed to rural and regional areas than the general population of trainees, the targeting of STP towards MM2-7 could be improved. Targets for Colleges across the program tend to remain relatively static, and the lack of responsive target setting mechanisms, as discussed above, constrains the program's ability to meet its aim to enhance the rural and remote specialist workforce. This mechanism could support ongoing redistribution of STP funding into areas of unmet need, including into generalist specialties where appropriate. It could also support an amplification of features of the program which support long term transfers of registrars into rural and regional areas, by specifying targets for longer, rural based posts such as currently delivered in IRTP posts.

Program effectiveness in enhancing the rural and remote specialist workforce

Overall finding: **Adequate**

Performance demonstrated some weaknesses in relation to the overarching question of the evaluation domain, however minimum expectations or requirements were met.

Strength of Evidence: **Sufficient Evidence**

Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.

Overall finding

Evidence available to this evaluation indicates that overall, maldistribution of the specialist medical workforce is a key feature of the current Australian health system, and the STP is one of the few funding sources available to help ameliorate it. Fill rates for the STP indicate the program meets targets for funding posts in regional, rural and remote settings. At the same time, however, the need for different specialists is likely to vary with relative remoteness, and a national, Commonwealth funded program like the STP should target investment in MM2-7 carefully and consider prioritising generalist specialties in areas where multidisciplinary teams and substantial infrastructure are not available. A rudimentary calculation of the STP funding for posts in Colleges which provide generalist specialisations indicates the program does not currently align to specialisations needed in each location, with around half of funding in the program going to MM1 settings. The current minimum placement length in the program is three months and there are no explicit incentives for longer-term placements. This does not support the long-term aim of the program to encourage specialists to relocate away from metropolitan areas and support a correction of the workforce maldistribution across Australia. A range of factors influence trainee registrar decisions to live and work in regional, rural and remote areas, and the timing of training in those areas is within scope of the STP. While some program elements support longer term placements, the STP as a program is not actively pursuing this aspect of the aim.

Effectiveness in increasing the number of First Nations medical specialists

AIM 3: To enhance Indigenous health outcomes through increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists.

To assess the effectiveness of the STP in achieving the aim of enhancing Indigenous health outcomes, the following criteria are of relevance:

- To what extent the STP funds posts in settings with a high First Nations population served
- To what extent STP funding is supporting systemic change in the health sector to improve cultural safety
- To what extent STP is informed by genuine two-way knowledge sharing and collaboration with Indigenous leadership in the health sector.

Supporting First Nations health outcomes

Health outcomes for First Nations people lag behind those of non-Indigenous Australians, driving recognition across governments of a need for increased numbers of First Nations doctors, who are better placed to understand the health needs of First Nations people, and to attract First Nations patients to receive the care they need.[61],[62] However there are several barriers faced by First Nations medical students, specialists in training and practitioners during their training. It is also by no means the sole responsibility of First Nations people to enhance Indigenous health outcomes in Australia or to shoulder the burden of reforming the systemic barriers facing Aboriginal and Torres Strait Islander people across the health sector.

To progress Aim 3 of STP requires commitment from Colleges, health settings and supervisors to ensure First Nations trainees experience supportive and beneficial training placements. It requires an active, ongoing commitment to build cultural awareness and cultural safety in health settings and into College selection processes. Actions to enhance Indigenous health outcomes and increasing the number of Aboriginal and Torres Strait Islander medical specialists should be place based and designed through genuine collaboration and partnership with Indigenous community leaders in each location. Stakeholders to this evaluation argued that one of the most powerful methods of reducing lingering racism in the sector is to maximise the health workforce's experience in Indigenous health. STP placements in community-controlled health services is a key mechanism through which it can support this outcome, along with exposure to healthcare settings which serve a high volume of Indigenous clients.

Commonwealth policy settings aimed at Closing the Gap

The Australian Government's commitment to improving outcomes for First Nations people is set out in the Closing the Gap National Agreement, a Commonwealth Government initiative bringing together Australian governments, the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and Indigenous peoples from across Australia. The Agreement aims to address and overcome systemic inequality faced by Aboriginal and Torres Strait Islanders in Australia.[63] The Agreement outlines four Priority Reform Areas for Joint National Action, and under Priority Reform Area 2, *Building the community-controlled sector,* the Health Sector is identified as an initial sector for partnership action, and strengthening the community-controlled sector has subsequently been highlighted as a priority.

Informed by the Closing the Gap National Agreement, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan sets out actions across the health sector to support full representation of First Nations people in the health workforce by 2031.[64] This provides guidance on actions for healthcare settings to implement cultural safety programs to ameliorate racism and bias. This plan also provides detailed program logics and actions for building clear pathways for Aboriginal and Torres Strait Islander young people to follow a career in medicine.

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[61] Garvey, G, Rolfe, IE, Pearson, S, and Treloar, C, 2009. 'Indigenous Australian Medical Students' Perceptions of their Medical School Training', Medical Education, vol. 43(11), pp. 1047-1055

[62] Yeung, AS, Craven, RG, Wilson, I, Ali, J and Li B, 2013. 'Indigenous Students in Medical Education', Seeding Success in Indigenous Australian Higher Education (Diversity in Higher Education), vol. 14, pp. 277-300

[63] Closing the Gap, 2024.

[64] Department of Health and Aged Care, 2022. 'National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, <www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-workforce-strategic-framework-and-implementation-plan-2021-2031?language=en>

The priorities, principles and suggested actions set out in Closing the Gap and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan provide current direction and better practice guidelines against which to evaluate the STP in its efforts to achieve Aim 3. In particular, better practice would include:

- Active engagement and collaboration with Indigenous community leaders to ensure the program is fit for purpose and Indigenous led
- Investment across the sector in cultural safety and cultural awareness[65,66]
- Investment in the training experiences of First Nations trainees through professional and peer networks, alongside workplace flexibility and supervisor support[67]
- Prioritisation of community-controlled sector STP placements across all specialties. Experience in the sector supports non-Indigenous medical officers to build a deep understanding of Indigenous health, to help them to identify and eradicate their own unconscious bias about First Nations people, and to champion cultural safety in other settings where they go on to work.

Barriers faced by First Nations trainees and fellows

There are several barriers First Nations medical students, specialists-in-training, and practitioners face when studying and working. Core themes found across literature and policy reports include systemic racism and discrimination, biases and prejudice, financial hardship, distance from family, a lack of institutional support, a lack of Indigenous community, mentorship and leaders, and finally, a lack of cultural safety[68]. First Nations staff and students also frequently report feeling overburdened with all First Nations-related responsibilities (staff)[69] and acting as a spokesperson (students).[70,71] Within the healthcare sector, there can also be a false perception that First Nations peoples should be the only ones progressing First Nations issues and working towards equality in the healthcare sector, when this should be a partnership, and the involvement of non-Indigenous people is pivotal to translating understanding, knowledge and cultural awareness to the broader population.[72]

The Australian Indigenous Doctors Association (AIDA) estimates that approximately 0.3 per cent of all medical specialists identify as Aboriginal and/or Torres Strait Islander. In 2023, there were 201 self-identifying Aboriginal and Torres Strait Islander Fellows.[73] In Australia, 3.8 per cent of the population is Aboriginal and/or Torres Strait Islander.[74] Of the 52,632 registered non-GP specialists in Australia,[75] to achieve population parity, Australia would need to have 2000 Aboriginal and/or Torres Strait Islander specialists.

The provision of contact, support and mentorship from more senior First Nations medical students and practitioners is a key success factor for Aboriginal and Torres Strait Islander medical officers on their journey to specialist fellowship. Where universities partner with the community-controlled sector to improve curriculum and create genuine partnerships and education, this can create meaningful change for Indigenous health.[76] Ultimately, to achieve a meaningful increase in the numbers of First Nations specialists, end-to-end reform of the process of attaining fellowship is required. Cultural safety needs to be considered in recruitment and selection processes, orientation and pre-entry programs. University cultural safety needs to be enabled through the appointment of Indigenous academics and embedding Indigenous content throughout the curriculum.

[65] So, N, Price, K, O'Mara, P and Rodrigues, MA, 2023. 'The Importance of Cultural Humility and Cultural Safety in Health Care', *Medical Journal of Australia*, vol. 220(1), pp. 12-13

[66] Brumpton, K, Woodall, H, Evans, R, Neill, H, Gupta, TS, McArthur, L and Ward, R, 2024. 'Exploring how Australian General Practice Registrars Define Cultural Safety with Aboriginal and Torres Strait Islander Patients', *BMC Primary Care*, vol. 25(166)

[67] Taylor, EV, Lalovic, A and Thompson, SC, 2019. 'Beyond Enrolments', *International Journal for Equity in Health*, vol. 18(136)

[68] Garvey, G, Rolfe, IE, Pearson, S, and Treloar, C, 2009. 'Indigenous Australian Medical Students' Perceptions of their Medical School Training', Medical Education, vol. 43(11), pp. 1047-1055

[69] Saunders, P, 2024. 'Fulfilling Cultural Safety Expectations in Specialist Medical Education and Training', *Medical Journal of Australia*, vol. 221(1), pp. 8-12

[70] Garvey, G, Rolfe, IE, Pearson, S, and Treloar, C, 2009. 'Indigenous Australian Medical Students' Perceptions of their Medical School Training', *Medical Education*, vol. 43(11), pp. 1047-1055

[71] Taylor, EV, Lalovic, A and Thompson, SC, 2019. 'Beyond Enrolments', *International Journal for Equity in Health*, vol. 18(136)

[72] Saunders, P, 2024. 'Fulfilling Cultural Safety Expectations in Specialist Medical Education and Training', *Medical Journal of Australia*, vol. 221(1), pp. 8-12

[73] AIDA, 2023. 'Growing the Number of Aboriginal and Torres Strait Islander Medical Specialists 2023', <aida.org.au/app/uploads/2023/09/AIDA-Growing-the-number-of-Aboriginal-and-Torres-Strait-Islander-medical-specialists-2023_v3.pdf>

[74] ABS, 2023. 'Estimates of Aboriginal and Torres Strait Islander Australians', <www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release#:~:text=Methodology-,Key%20statistics,Queensland%20and%20Western%20Australia%20combined.>

[75] This excludes any specialists not from the 13 medical colleges administering the STP, with the exception of Oral and Maxillofacial Surgery, which are included in AHPRA surgeon figures but are affiliated with the Royal Australian College of Dental Surgeons.

[76] Manton, D, Williams, M and Hayden, A, 2024, 'It's about Rights', Health and Human Rights Journal, vol. 26(1), pp. 87-100

Flexibility in the delivery of content and providing social and financial support all make a material difference to the successful attraction, retention and graduation of Indigenous students into medical specialists.[77]

While the pathway to fellowship was not designed with these considerations in mind, consultation discussions indicated work, led by the Australian Medical Council (AMC), is underway to re-design accreditation for specialists. In consultations, AMC described requirements for Colleges to play an active role in Indigenous recruitment going forward. The AMC is monitoring this new role for Colleges, with an interest in how the STP can best be utilised to provide specific Indigenous training posts.

College approach to improving First Nations pathways

College First Nations data collection

The majority of Colleges collect some data regarding the participation of First Nations people as specialists, trainees and employees of their College. However, there are evident gaps in the data and, for some Colleges, data collection activities are in their infancy. For the 12 Colleges for which data was available, a total of 82 First Nations Fellows and a further 149 First Nations trainees were reported.[78] Given AIDA estimates approximately 0.3 per cent of medical specialists identify as Aboriginal and/or Torres Strait Islander, numbers provided by Colleges are likely an underestimate. If the AIDA estimate is accurate, we would expect to see at least 959 First Nations Fellows and 547 First Nations trainees across the Colleges.

While noting these discrepancies, College reporting suggests the number of First Nations specialists and trainees increased between 2019 and 2023.

Figure 8 - Number of First Nations trainees and specialists engaged in the STP over time

First Nations trainees and specialists
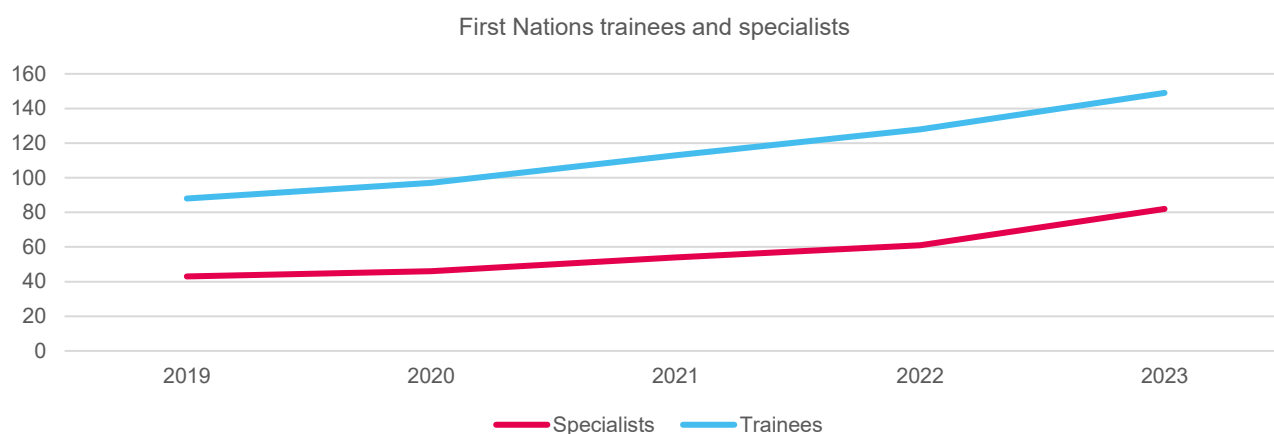
Source: College reporting for this evaluation

Most Colleges were not able to determine the number of STP posts currently occupied by a First Nations trainee. The nature of STP funding means that the STP post is allocated to a health setting rather than a specific trainee and is filled by trainees on a rotational basis, and data is not collected by Colleges about individual trainees in STP posts. This makes assessing the impact of STP on First Nations trainees difficult.

At the same time, the discrepancy between data reported by the Colleges and by AIDA may reflect the difference in the cultural safety of these organisations. While Colleges are demonstrating improvement in their cultural awareness and cultural safety, concerns about subtle, systemic racism were raised in consultations conducted for this evaluation, requiring consistent, long-term investment across the sector. There remains some reluctance to both ask and report the Indigenous status of Fellows and Trainees, indicating that further work is required to build the safety of Colleges for Indigenous Australians.

College approaches to their policies and workforces

Reconciliation Action Plans (RAPs) are documents, developed and approved by Reconciliation Australia, that codify meaningful action towards reconciliation within a framework. Reconciliation is defined as the process of strengthening relationships between Aboriginal and Torres Strait Islander peoples and non-Indigenous peoples

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[77] Taylor, EV, Lalovic, A and Thompson, SC, 2019. 'Beyond Enrolments', International Journal for Equity in Health, vol. 18(136)
[78] College reporting to this review. No data available for CICM.

and is based and measured on five dimensions: historical acceptance; race relations; equality and equity; institutional integrity and unity.[79]

An organisation must register with Reconciliation Australia, draft a plan, have it accredited, and then implement it.[80] There are four frameworks to choose from: Reflect, Innovate, Stretch and Elevate, which increase in the length and depth of commitment.[81] According to AIDA's Growing the number of Aboriginal and Torres Strait Islander medical specialists 2023 report, seven of the Colleges had Innovate RAPs, four had Reflect RAPs, one was developing their first RAP, and one had its own plan, separate to Reconciliation Australia's framework.[82]

In data requested for this evaluation, 12 Colleges reported having, or nearing finalisation of, a RAP at the Innovate level, the second level of the RAP Framework.[83] This level of RAP builds upon the first level, and focuses on organisational commitments to advance reconciliation through strengthening relationships with Aboriginal and Torres Strait Islander people. CICM was the only College with a 'Reflect' level RAP, the first level of the framework, which involves engaging with staff and leaders in the organisation to build a shared understanding of the importance of reconciliation. This RAP is to be implemented over 12 to 18 months. All Colleges reported requiring or strongly encouraging staff to undertake cultural awareness training, noting Colleges appear to have progressed well over the past 12 months in terms of their reconciliation activities.

Five First Nations people were employed by the Colleges, and an average 1.1 FTE per College were allocated to supporting First Nation's Fellows/Trainees.

STP places rarely go to community-controlled sector settings

At the frontline of direct service delivery, there are over 143 Aboriginal Community-Controlled Health Organisations (ACCHOs) and more than 500 clinics.[84] The community-controlled sector is recognised by stakeholders to be uniquely able to provide training to future specialists which provides exposure to Indigenous health issues, raises cultural awareness and cultural competency, and helps support long term improvement across the broader health sector when trainees leave the placement and move on to other roles. For this reason, prioritising STP placements in community-controlled settings would provide an important mechanism for the program to achieve Aim 3.

However, a review of the STP Post Dataset demonstrates that only a fraction of STP funding is for posts in community-controlled settings. Latest data indicates there were a total of 22 posts in community-controlled settings, representing just over two per cent of posts. While these settings are appropriate training locations for only a subset of specialties, this proportion of funding is unexpectedly low for a program with a key aim of supporting First Nations health outcomes. This is a missed opportunity for the STP to support a long-term improvement in First Nations health, through long term sector reform as well as through the day-to-day provision of registrar support to Indigenous communities via community-controlled healthcare.

Community-controlled settings may have unique challenges in filling STP posts

Fill rates in ACCHOs have been consistently below the STP average, however improved in 2023. In 2022, ACCHOs had a fill rate of 72 per cent, substantially below the STP core average of 93.3 per cent.[85] ACCHO fill rates increased to 90.5 per cent in 2023, compared to a fill rate of 94.7 per cent for the STP core program.

At the same time, consultation feedback reflected an observation that trainees coming into the community-controlled sector are often quite experienced, or have already become specialists in a different College, and their salary is higher than other trainees. The resourcing needs of the community-controlled sector are unique in providing additional holistic care services for Aboriginal and Torres Strait Islander people, and their funding, primarily government grants based, does not support additional salaries for STP posts. Often ACCHOs have limited funding and are financially disadvantaged by providing an STP post. This may help account for the low fill rates in these settings.

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[79] Reconciliation Australia, 2024. 'What is Reconciliation?', <www.reconciliation.org.au/reconciliation/what-is-reconciliation/>

[80] Reconciliation Australia, 2024. 'The RAP Process', <www.reconciliation.org.au/reconciliation-action-plans/the-rap-process/>

[81] Reconciliation Australia, 2024. 'The RAP Framework', <www.reconciliation.org.au/reconciliation-action-plans/the-rap-framework/>

[82] AIDA, 2023. 'Growing the Number of Aboriginal and Torres Strait Islander Medical Specialists 2023', <aida.org.au/app/uploads/2023/09/AIDA-Growing-the-number-of-Aboriginal-and-Torres-Strait-Islander-medical-specialists-2023_v3.pdf>

[83] Reconciliation Australia, 2024. 'The RAP Framework', <www.reconciliation.org.au/reconciliation-action-plans/the-rap-framework/>

[84] National Aboriginal Community Controlled Health Organisation - Aboriginal Community Controlled Health Organisations (ACCHOS), <https://www.naccho.org.au/acchos/>

[85] STP Core has been used as a comparator because, except for one IRTP FTE in 2021, all other Aboriginal and Torres Strait Islander Health Service (ATSIHS) FTE have been through the STP core program.

Identifying and responding to workforce need

Public Health, Community and Child Health, Psychiatry and General Paediatrics trainees made up the majority of STP FTE in ACCHOs. Stakeholders consulted in this evaluation described a high level of need in the community-controlled sector for Paediatrics, Cardiology, Renal, Endocrinology, Rheumatology, Infectious diseases, Psychiatry.

During consultation, stakeholders emphasised that collaboration with the community-controlled sector, Colleges and state and territory health departments would be an effective approach to determine the need for medical specialists in serving the needs of Aboriginal and Torres Strait Islander communities and allocating STP funding accordingly. This could take the form of a Reference Group to lead this element of the STP. This group could engage with Colleges, healthcare settings, community members, and ACCHOs. Colleges have recently established Indigenous governance mechanisms, which could lead their contribution to this process.

Settings with high First Nations proportion of population served

Along with the suggestion to increase STP funding of posts within the community-controlled sector, validation sessions also indicated that data regarding the proportion of population served by a setting would be useful in targeting funding. This would help identify posts where non-Indigenous trainees would have greater exposure to First Nations multidisciplinary health teams, client populations and cultural awareness. In this way, a higher proportion of non-GP specialists would have greater levels of cultural awareness and be better able to contribute to cultural safety in their future workplace, supporting First Nations colleagues and better serving the needs of First Nations clients.

To implement this change, data on the population served in healthcare settings applying for STP funding would be required as part of allocating that funding.

Program effectiveness in increasing the number of First Nations medical specialists	
Overall finding: **Poor**	Strength of Evidence: **Sufficient Evidence**
Performance was weak in relation to the overarching question of the evaluation domain. Minimum expectations or requirements were not met.	Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.

Overall finding

Overall, evidence available to this evaluation suggests the STP does little to support Aim 3 of the program. It rarely funds posts in the community-controlled sector and does not collect data regarding the populations served by settings where posts are based. Placing non-Indigenous trainees in these settings is the STP's most powerful lever to affect change in both Indigenous health outcomes but also in reducing systemic racism and increasing the quantum of Aboriginal and Torres Strait Islander medical specialists.

While Colleges have worked hard over recent years to improve their cultural competency, the sector overall remains immature in its engagement with Indigenous ways of knowing and being. In line with the priorities, principles and suggested actions set out in Closing the Gap and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, STP could be improved through more:

- Active engagement and collaboration with Indigenous community leaders to ensure the program is fit for purpose and Indigenous led
- Investment across the sector in cultural safety and cultural awareness
- Investment in the training experiences of First Nations trainees through professional and peer networks, alongside workplace flexibility and supervisor support
- Prioritisation of STP posts in community-controlled settings and settings with high Aboriginal and/or Torres Strait Islander populations served. This experience supports non-Indigenous medical officers to build a deep understanding of Indigenous health, to help them to identify and eradicate their own

Program effectiveness in increasing the number of First Nations medical specialists

unconscious bias about First Nations people, and to champion cultural safety in other settings where they go on to work.

Effectiveness in building the sector's capacity to support non-GP specialist trainees

To assess the effectiveness of the STP in achieving the objective of building the sector's capacity to support non-GP specialist trainees, the following criteria are of relevance:

- To what extent Support Projects achieve lasting improvement in the capacity of the sector
- To what extent FATES projects achieve lasting improvement in the capacity of the sector

Supporting the capacity and capability of the health care sector to train the future specialist medical workforce

While the three program aims for STP are focused on increasing access to training in expanded settings, in locations with unmet need and for priority groups, the objectives set out in program documentation for the STP are focused on building the capacity of the sector to support training in expanded settings. In its current form, the program uses the following five objectives in its funding arrangements:[86]

1. Contribute to enhancing capacity and building capability of the health care sector to train the future specialist medical workforce

2. Contribute to increasing the capacity of specialist training being undertaken in private settings

3. Contribute to enhancing availability of the specialist workforce in areas of unmet community need including rural and remote locations

4. Support and enhance high quality specialist training experiences for specialist trainees in STP posts

5. Enhance Indigenous health outcomes through increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists.

There are two funded areas of activity within the program which support sector capacity building as an aim of the STP. Support Projects and the FATES program are each focused on this broad concept, through short term, College-led projects. The design of STP provides funding for Support Projects for each College however, over time, the investment in these has expanded to more than double its original allocation.

Each year a sizeable proportion of STP funds remains unspent, where Colleges are unable to fill their allocated posts. At the end of 2022, the estimated underspend for the program was approximately $47 million, and an estimated further $31.5 million underspend has been identified in the recent acquittal process for the 2022-23 financial year.[87]

In previous years, unspent uncommitted funds were 'rolled over' and Colleges were able to continue to allocate and spend this funding. In the long term, this created a large underspend across the program. Subsequently, a number of changes have been made to the program to manage unspent funds, including:

- Reducing the targets and funds allocated to Colleges with sizeable underspends, and redistributing funding to Colleges with higher fill rates, better able to fill their target posts
- Redirecting funding into additional Support Projects, to enhance the capacity of Colleges to support trainee training experience. This has increased Support Project funding by approximately $25 million over the current funding period, above the $11.5 million budgeted in the program
- Providing additional funding to the FATES program, redistributing $29.5 million in unspent STP funds from the previous STP funding agreement (2018-21).

In managing underspends in this way, a substantial allocation of STP funding has been diverted away from posts and into projects to support the sector's capacity to provide positive training experiences in expanded settings. While there is merit in contributing to this aim, it is unclear to what extent projects have achieved this, and the feasibility of short term, time limited projects to create lasting change across the sector is in doubt.

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[86] Department of Health and Aged Care, 2021. 'Specialist Training Program (STP) Operational Framework 2022-2025',
<www.health.gov.au/sites/default/files/2023-03/specialist-training-program-operational-framework_1.pdf>
[87] Department of Health and Aged Care, Health Workforce Division, Supplementary Budget Estimates, February 2024 (internal document).

Support Projects

Support Projects aim to provide a baseline annual amount to Colleges to support the success and sustainability of specialty training places in expanded healthcare settings funded through STP. The program guidelines require Support Projects to:

- Be targeted towards the needs of STP trainees
- Prioritise support for rural and private posts, or
- Aboriginal and Torres Strait Islander trainees, or
- Cultural safety training in Indigenous healthcare delivery.

Additionally, according to the Support Project guidelines, each proposed Support Project must clearly outline the benefits to trainees in STP posts, and Support Projects may include investments in eLearning platforms and distance education tailored to the needs of trainees in STP posts. Under the guidelines, projects of 12 months' duration or longer are required to be evaluated. While evidence of outputs is visible across the support project documentation, no outcome measurement has been conducted to examine whether activities led to intended changes for participants or the sector.

While resources developed through Support Projects can also benefit the Colleges' broader training requirements within specialty training programs, this is not the intent of the funding. Various Support Projects are funded that are of benefit to all specialty trainees in the area or specialty, for example supporting network training models that incorporate STP posts, enhancing rural practice capabilities for trainees and increasing training capacity in expanded settings. These are not ineligible for funding, however some appear to be only loosely aligned with the intended use of Support Project funding.

There are also a range of activities which are not eligible for funding under the Support Project guidelines. Support Project funding should **not** include:

- Co-funded projects with other Commonwealth grants, unless prior written agreement from the Department has been obtained
- Direct payments to supervisors of trainees
- Direct costs associated with the accreditation of training posts, networks, programs, and sites, including operational expenses related to coordination and management of accreditation such as travel and accommodation
- College IT infrastructure acquisitions, such as new laptops, software or phones
- Trainee and supervisor workshops and seminars, except when STP trainees/supervisors are specifically targeted to attend through direct support, such as travel and accommodation expenses
- Service delivery projects that are not specifically aimed at supporting STP trainees and their specialty training
- Projects that are considered core college activities and/or functions
- Projects that support all trainees and are not specifically targeted to support trainees in STP posts

A high-level review of program documentation available to this evaluation indicates that through expanding the volume of Support Projects funded through STP, many of these 'ineligible' activities may have been supported with Support Project funding.

Funding Allocation for Support Projects

Funds available for Support Projects are set out in the Commonwealth Standard Grant Agreement (CSGA) for each College. Proposals submitted to the Department for consideration are to be within the funding allocated in each college CSGA. These funds are based on the following formula:

Support Project Funding per year = $100,000 + $1,210 per post / FTE

Utilisation and Impact of Support Project Funding

The total funding allocated in 2022 to all 13 Colleges for 127 Support Projects amounts to approximately $38 million (**Table 8**). A significant portion of this funding comes from an underspend of almost $25 million, in addition to core STPS funding of around $11.5 million, earned interest of $875,780, and external co-funding sources of $1,360,600. The combined total of funding allocated to Support Projects is more than three times the intended amount allocated through the STP funding agreements.

The Australian College of Sport and Exercise Physicians (ACESP) has funded the highest number of Support Projects, with a total of 30. This is followed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) with 19 projects and the Royal Australian College of Physicians (RACP) with 13 projects. RANZCP has allocated the most funding to projects, with a total expenditure of just under $8 million. A significant portion of underspend, amounting to just over $5 million, has been directed to the STP Psychiatry Post Initiative. This initiative supports additional trainee and training supervisor funding in rural areas, mandatory training, and services for Aboriginal and Torres Strait Islander communities. While this project aligns with the priority of supporting rural posts, it should be noted that direct payments to supervisors and funding trainee salaries or posts are ineligible according to the guidelines.

Similarly, the Australian College of Emergency Medicine (ACEM) has allocated over $6.5 million of underspend to the expansion proposal for an additional 11 Emergency Medicine Education Training (EMET) Hubs for the period 1 July 2023 to 31 December 2025. This will provide access to specialist emergency medicine support and training available to all GPs and medical officers working in Australia's regional and rural EDs and emergency care facilities. While this project aligns with the priority of supporting rural posts, it should be noted that service delivery projects not specifically aimed at supporting STP trainees and their specialty training do not meet the funding guidelines.

The Royal Australian and New Zealand College of Radiologists (RANZCR) has redirected an underspend of just over $2.7 million to the Clinical Radiology Regional and Rural Training Pathway (RRTP). This initiative will pilot 5 positions in areas with a known shortage of clinical radiologists. The primary goal of the RRTP is to retain clinical radiologists in these critical areas by offering trainees a comprehensive training experience in regional and rural Australia. The funds will be used to establish the RRTP, supporting the new positions, which are separate from STPS and IRTP posts. While this project aligns with NMWS Priorities 2 (rebalance supply and distribution), 3 (reform the training pathways), and 5 (build a flexible and responsive medical workforce), it does not align with Support Project funding guidelines. The project does not benefit trainees in STP posts, as it is a service delivery project not specifically aimed at supporting STP trainees. This project appears to be highly aligned to the intended outcomes of STP posts, and to largely mirror IRTP placements. Instead of introducing a new project with additional administrative requirements, this funding might be better used in IRTP placements for radiologists.

The Royal College of Pathologists of Australia (RCPA) had a significantly larger underspend than other Colleges and has a larger amount of Support Project funding in the current agreement period. This surplus has been used to fund 7 full-time training positions in genetic and molecular pathology for four years, aiming to enhance current training capacity and meet future demand for these services. However, since these positions are outside the STP allocation, there is no guarantee of ongoing funding beyond the current grant agreement, which ends in 2025. According to the Support Project guidelines, direct payments for trainee salaries or posts, such as these, are ineligible for funding.

The guidelines also stipulate that initiatives that assist Aboriginal and Torres Strait Islander trainees, or that promote cultural safety training in Indigenous healthcare delivery, should be prioritised in Support Projects. Only seven Colleges have focused here, representing just under 15 per cent of all projects. To improve Indigenous health outcomes, it is crucial to increase opportunities and training experiences for Aboriginal and Torres Strait Islander individuals aspiring to become medical specialists. Additionally, there is a need to foster inclusive consultation with First Nations people.[88]

Overlap and core activities

Support Projects are quite flexible, requiring Departmental approval for any changes. For example, the unavailability of key personnel caused one College to move from a workshop-style project to online delivery. Support Projects do have reporting requirements, with either yearly or biannual progress reports as well as financial reporting and a final report at the project's conclusion. Several projects are being used to fund short term posts which is not what the funding has been set up to achieve nor follows the eligibility guidelines.

An in-depth analysis of the cost-effectiveness of STP Support Projects, using a return-on-investment method, has not been undertaken. As the majority of support project funding goes towards College resourcing and learning support, any findings on the impact of these projects on the Australian healthcare system would be very tenuous. To say, for example, that an exam-preparation event for STP trainees contributes to Australian health

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[88] Closing the Gap, 2024.

outcomes is spurious. Further, no more direct conclusions can be drawn from the outcomes of Support Projects regarding national healthcare, so this analysis, while considered, has not be conducted.

Generally, STP Support Projects loosely follow guidelines for designing, developing, and delivering education and training initiatives. However, it is unclear how much overlap exists with the education and training already provided by college training programs. Additionally, some focus areas of Support Projects might fall under core college activities and functions within those programs. However, there is limited data collected to evaluate the project's successes and identify any barriers to success.

A number of projects are currently being used to fund short-term posts, which does not align with the intended purpose of the funding or adhere to the eligibility guidelines. To better achieve its goals, it may be beneficial to simplify and/or reconsider the objectives of Support Projects. This could involve tightening the criteria to ensure they specifically support STP trainees and prioritising projects that enhance the sector's capacity to provide positive training experiences in expanded settings. Alternatively, the funds might be more effectively used to increase the number of STP posts.

Table 8 - Support Projects for the 2022-25 Funding Agreement period

College	Number of projects	Total spent on support projects	STPS core funding	Interest funding	Underspend funding	External/co-funding	Number of projects supporting Aboriginal and Torres Strait Islander trainees, and cultural safety training in Indigenous healthcare delivery
Australasian College of Dermatologists (ACD)	4	$1,073,204.05	$540,360.00	$60,000.00	$472,844.05	$0.00	2 (50%)
Australasian College of Emergency Medicine (ACEM)	6	$7,189,060.00	$549,060.00	$0.00	$6,587,500.00	$52,500.00	2 (33.33%)
Australasian College of Sport and Exercise Physicians (ACSEP)	30	$811,551.00	$312,520.00	$0.00	$499,031.00	$0.00	5 (16.66%)
Australian and New Zealand College of Anaesthetists (ANZCA)	7	$984,501.00	$484,595.00	$212,545.45	$499,906.00	$0.00	
College of Intensive Care Medicine of Australia and New Zealand (CICM)	5	$965,260.00	$467,760.00	$0.00	$497,500.00	$0.00	
Royal Australasian College of Medical Administrators (RACMA)	7	$3,568,564.81	$482,280.00	$0.00	$3,436,827.28	$0.00	1 (14.3%)
Royal Australasian College of Physicians (RACP)	13	$2,484,767.00	$1,957,267.00	$527,500.00	$0.00	$0.00	6 (46.15%)
Royal Australasian College of Surgeons (RACS)	6	$1,363,834.77	$714,570.00	$61,234.77	$588,000.00	$0.00	1 (16.66%)
Royal Australian and New Zealand College of Ophthalmologists (RANZCO)	9	$952,350.00	$389,750.00	$14,500.00	$500,000.00	$48,100.00	
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	8	$1,954,880.00	$554,880.00	$0.00	$1,400,000.00	$0.00	

College	Number of projects	Total spent on support projects	STPS core funding	Interest funding	Underspend funding	External/ co-funding	Number of projects supporting Aboriginal and Torres Strait Islander trainees, and cultural safety training in Indigenous healthcare delivery
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	19	$7,988,870.00	$1,174,400.00	$0.00	$6,814,470.00	$0.00	2 (10.5%)
Royal Australian and New Zealand College of Radiologists (RANZCR)	4	$3,021,849.78	$321,000.00	$0.00	$2,700,849.78	$0.00	
Royal College of Pathologists of Australasia (RCPA)	9	$5,696,800.00	$3,511,600.00	$0.00	$925,200.00	$1,260,000.00	
TOTAL	127	$38,055,492.41	$11,460,042.00	$875,780.22	$24,922,128.11	$1,360,600.00	19 (14.96%)

The FATES program

Enhancing the quality and capacity for non-GP specialist medical training activities

The FATES grant opportunity was launched in response to the persistent issue of underspending in the STP. In the
2021-22 Federal Budget, the Australian Government allocated $29.5 million from this underspend, over four years to the FATES grant opportunity, to be awarded over 4 rounds. Of the $20.9 million allocated funds to date, just under $19.2 million has been used to award 30 project grants. Twelve of the 13 Colleges received FATES project funding (**Table 9**). RCPA is the only College which hasn't received FATES funding, after unsuccessfully applying for funding in round one, and not submitting a proposal in further rounds.

This one-off, time-limited seed funding is designed to address priority areas and actions identified in the NMWS. These parallel the aims of STP and include a focus on addressing maldistribution and undersupply issues, as well as meeting community need by increasing support for building capacity in regional, rural and remote locations and growing the First Nations specialist medical workforce. FATES is intended to provide the sector with the opportunity to think broadly and test innovative and flexible arrangements that could be piloted and replicated sustainably across the sector.

As per the grant opportunity guidelines, the objectives of FATES are to:

1. Improve and promote a positive medical education culture and support quality specialist medical training in regional, rural, and remote Australia

2. Reduce barriers and improve incentives for entering regional, rural, and remote medical practice

3. Improve the imbalance of distribution of the non-GP specialist medical training arrangements and workforce, particularly in areas of unmet need, and

4. Attract and support First Nations trainees to grow the First Nations workforce towards population parity.

In reviewing the design of the FATES program it is difficult to delineate between the first three objectives. These are all centred on rural and remote areas but are broad in their scope rather than clearly defining different outputs or intended outcomes. Similarly, program guidelines for FATES are detailed and extensive, however there is a high degree of overlap between the concepts underpinning the program, and documentation may benefit from simplification.

According to the guidelines, FATES projects must be training-focused, evidence-supported, and include an evaluation component. Additionally, they are chosen for their scalability, sustainability, and collaborative efforts. The guidelines encourage projects located in MM 2-7 areas and those focused on Aboriginal and Torres Strait Islander health settings. One of the criteria requires consultation and co-design with State and Territory Governments, the community, and stakeholders, including local health service providers.

Colleges can apply for FATES funding for projects aimed at increasing the First Nations workforce. While the assessment criteria encourage detail to be included about how Colleges will work with Aboriginal and Torres Strait Islander peoples, leaders, and elders, the guidelines do not specify engaging with First Nations stakeholders as a requirement. Updating the guidelines to state this expectation would ensure the opportunity to leverage valuable experience and knowledge is not missed, which is crucial for creating clear pathways for Aboriginal and Torres Strait Islander people to pursue careers in medicine.

Funding utilisation to date

Despite priority given in the guidelines, a review of FATES funded projects to date indicates projects targeted to First Nations outcomes, and projects with collaboration as part of their design, equate to a combined total of only 13 of 30 projects (43.33 per cent). Five Colleges led a total of 6 projects (20 per cent of FATES projects) featuring consortium arrangements, while 5 Colleges received funding for 7 projects (23.33 per cent of FATES projects) aimed at attracting and supporting First Nations trainees to grow the First Nations workforce towards population parity.

Four completed FATES projects have secured ongoing funding from other sources, with both jurisdictions and the Commonwealth committing to further support. The Australian Indigenous Doctors' Association Specialist Trainee Support Program (AIDA STSP) is a good example of this, initially funded by RANZCR, this program focuses on recruiting and retaining Aboriginal and Torres Strait Islander non-GP specialists and trainees. AIDA led the program, managing a consortium of 12 Colleges. RANZCR provided additional funding to extend the

project before transitioning funding responsibility to the Commonwealth, which committed $4 million under an agreement running until 2028.

Table 9 - FATES projects (Rounds 1-3 of 4 rounds) for the 2022-25 Funding Agreement period

Lead College	Funding	Number of projects	Number of Consortium projects	Number of projects that attract and support First Nations trainees	Outcomes
Australasian College of Dermatologists (ACD)	$2,200,289	4			2 projects secured ongoing funding from jurisdictions 2 projects ongoing
Australasian College of Emergency Medicine (ACEM)	$1,323,500	2			ongoing
Australasian College of Sport and Exercise Physicians (ACSEP)	$205,607	1			evaluation in progress
Australian and New Zealand College of Anaesthetists (ANZCA)	$1,297,844	2			ongoing
College of Intensive Care Medicine of Australia and New Zealand (CICM)	$1,930,947	3		1	1 project secured ongoing funding from jurisdictions 2 projects ongoing
Royal Australasian College of Medical Administrators (RACMA)	$1,116188	1	1		ongoing
Royal Australasian College of Physicians (RACP)	$1,468,921	3		1	ongoing
Royal Australasian College of Surgeons (RACS)	$3,196,012	2	2		ongoing
Royal Australian and New Zealand College of Ophthalmologists (RANZCO)	$692,935	1	1		ongoing
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	$2,146,000	4	1	1	ongoing
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	$2,136,300	3		1	1 project evaluation in progress 2 projects ongoing
Royal Australian and New Zealand College of Radiologists (RANZCR)	$1,484,469	4	1	3	1 project secured Commonwealth funding through to 2028 2 projects evaluation in progress 1 project ongoing

Lead College	Funding	Number of projects	Number of Consortium projects	Number of projects that attract and support First Nations trainees	Outcomes
Royal College of Pathologists of Australasia (RCPA)	N/A				N/A
TOTAL	**$19,199,012**	**30**	**6 (20%)**	**7 (23.33%)**	

Progress is monitored through progress reports, site visits, and ad hoc check-ins. Upon completion of the grant activity, a final report must be submitted. Currently, there are no significant red flags in the reporting process, aside from some timing issues on some individual projects. Each project is independently evaluated upon completion.

The evidence base for FATES

It is too soon to know the extent to which FATES has succeeded as a program in meeting its objectives, and unclear how it will be possible to evaluate this in the longer term. Of the remaining 26 FATES projects, 4 are currently under evaluation and 22 are still ongoing. While at the individual project level milestones have been achieved, the program, like the STP overall, lacks a coherent outcomes hierarchy and measurement framework, so it will remain difficult to evaluate the longer-term outcomes of these projects, and to explore how STP and FATES interact.

The FATES grant opportunity has been popular among most Colleges, and consultations indicate that stakeholders find FATES useful. FATES projects were most often raised as relevant in discussions around STP's contribution to First Nations outcomes. Despite only 7 of the 30 FATES projects having a First Nations lens, this remains the most effective aspect of the STP in supporting its First Nations aims. Feedback was also given by a range of stakeholders suggesting there could be merit in extending the FATES opportunity beyond Colleges to include health settings, rural training hubs, or other regional networks. The most recent round of FATES funding did not fully utilise the allocated budget suggesting, with a broader scope of funded grant recipients, new opportunities may be raised for innovative support for the sector's capacity to train non-GP specialists in expanded settings.

FATES, Support Projects and the STP more broadly

Given the history of FATES and Support Projects, it is interesting to consider their role in the STP if the high incidence of uncommitted, unspent funds within the program was reduced. More frequent acquittals and redistribution of uncommitted unspent funds may be beneficial here. This would mean that in any future iterations of the FATES program a substantial proportion of funding would no longer be available, having been redirected back to the funding of STP posts.

At the same time, there remains a need for the STP to retain a program element, similar to either FATES or Support Project funding, which supports the capacity of the sector to enhance trainees' experiences. The core STP grant includes $100,000 per College (plus $1,210 per STP FTE) to support this activity. Future iterations of the STP could retain this feature, and focus projects on building networks, mentoring programs and other holistic supports to enhance trainee's experiences. This could be at the regional level, bringing together all STP trainees in an area, across specialties and Colleges, or it could be a way of bringing together all trainees from a particular specialty. Features of the FATES program which prioritise collaboration and consortium arrangements would be particularly helpful in this. Over time, rigorous evaluation could be used to adapt the guidelines to better support the sector capacity building objective of STP.

Given the overlap in goals, intent and approach to FATES projects with Support Projects and STP post funding, a reduction in spending on short term, time limited projects may be warranted. At the same time, similar data limitations apply to all three program elements, and rigorous evaluation of their impact on the geographical and professional distribution of the non-GP specialist workforce is difficult to undertake in the absence of a cohesive evaluation and measurement framework.

Program effectiveness in building the sector's capacity to support non-GP specialist trainees

Overall finding: Good - **Adequate**

Good: Performance was generally strong in some areas relating to the overarching question of the evaluation domain. Some gaps or weaknesses were evident.

Adequate: Performance demonstrated some weaknesses in relation to the overarching question of the evaluation domain, however minimum expectations or requirements were met.

Strength of Evidence: **Some Evidence**

Where the evidence suggests the observation is true but there are data limitations, such that the find is qualified and further and/or different data (which may have been unavailable to this evaluation) would need to be sourced to be more confident in the conclusion reached.

Overall finding

Overall, the Support Projects and FATES program have injected a combined monetary value of almost $60 million over the current agreement period, to support the STP's objectives. While the focus and outputs of these projects are in line with the intent of the STP, over time funding for Support Projects has been provided outside of program guidelines. While FATES projects are regularly evaluated, this is focused on their short-term success at a project level. While there are positive aspects of the two components of the overall STP, there is little evidence to suggest that this funding would not be more effective if it were spent as originally intended, in funding posts in expanded settings.

Instead of redistributing unspent funds to ad-hoc, time limited projects run by Colleges, opportunities to prevent underspend within STP should be considered. The administration activity required to manage additional Support Projects and FATES could then be redirected to the additional effort required of the Commonwealth to more frequently acquit expenditure across the program. Over time, with improved data collection enabling more rigorous evaluation, the impact of each program component could be better understood, and funding could be targeted towards elements which are most effective in supporting the capacity of the sector to train non-GP specialists.

Key evaluation questions relevant to this section

KEQ5: How appropriate is the relationship with the states and territories and other key stakeholders?

KEQ12: How is the funding administered by the Colleges for the following? STP, IRPT, Tasmanian Project, STP Support Projects, STP Administration? What are the benefits and weaknesses; is one more effective than the other?

To assess how effectively the STP is administered, the following criteria are of relevance:

To what extent the relationships in place across the program support its effective implementation.

To what extent program activities are in line with operational guidelines.

To what extent decisions across the program are informed by strong management information.

As discussed in the Appropriateness chapter, there are several areas of the program design which could be strengthened. The following chapter considers data and evidence for how effectively the program is being implemented despite its design limitations.

Overall, while the design of the program is not aligned to its intended aims, the activities undertaken across the program are largely in line with the program guidelines. The program is generally well run by Colleges, bringing expertise and unique visibility of their specialist workforce to the delivery of the STP.

Additional investment in the overall collaboration and coordination of the STP to include stakeholders from state and territory governments would strengthen implementation of the program and align with expectations in the program guidelines. Including collaboration with the community-controlled sector and Indigenous peoples into the design and implementation of the program would strengthen its contribution to outcomes, however the current guidelines do not require this.

The guidelines themselves could also be strengthened in other ways, by providing more guidance and clarity around targets and post distribution, and by specifying a range of data and intelligence sharing that would support better management for outcomes by the Commonwealth.

Merit determination: Good Strength of Evidence: Sufficient evidence

Current approach to program administration

While the Commonwealth has overall responsibility for the administration of STP, an approach where the Commonwealth directly contracts with the health care settings to provide training was initially considered during the design of the Program but thought likely to be too onerous. Instead, the administration of STP funding is managed through agreements between the Commonwealth and the Colleges, who are then responsible for disbursing these funds to the relevant health care settings through contractual arrangements with the health care settings.

The Commonwealth currently depends on the Colleges to administer, deliver, and report on the STP, as well as to actively monitor and manage STP-accredited training posts. However, the guidelines for administering and delivering the STP are not adaptable to the unique operating environments of all the Colleges. Each specialty is different, and each College varies in size, number of STP posts/positions, training program requirements, internal management processes, approach to accreditation (whether setting or post/position), and interactions with healthcare settings, states and territories and other external stakeholders. Colleges also have other priorities and roles outside of the STP. Consequently, they have adopted different approaches to implementing the STP. Additionally, the type of specialist training program, and thus the type of trainee, differentially influences a College's ability to engage with accredited posts. The process to complete accreditation for Colleges varies in the length of time it takes, and the length of time the accreditation is valid for.

The Reserve List

To meet contractually funded and filled targets, the Colleges must keep Reserve Lists with newly approved posts funded under the STP. The only procedure for approving new posts for funding under the STP is the Reserve List Process. The reserve list of the appropriate College is updated with newly approved postings which then go through a Reserve List Process. The Reserve List is run through an online portal. The online

portal facilitates health settings to submit new posts that are assessed by Colleges, state and territory governments and the Commonwealth for suitability to be funded under the STP. Posts that are deemed "not suitable" by the College are not assessed by jurisdictions or the Commonwealth.

The Reserve List Process involves 4 stages held annually over 16 weeks. The portal opens for submissions for a period of 4 weeks. The Colleges then review applications over a 4-week period in alignment with the STP Operational Framework and with medical workforce and community needs in the relevant jurisdiction, taking into consideration relevant action areas of the Strategy. Once College assessment is complete, state and territory governments have four weeks to advise on specialist medical workforce needs for settings applying through the Reserve List Process in the relevant jurisdiction. At the conclusion of both College and Jurisdictional assessment, the Commonwealth has four weeks to review and finalise all decisions.

Relationships in place across the program

Like the health workforce, medical specialists require the appropriate education and training to enable Australians to receive the care they require across the country, including in rural and remote areas. Collaboration is necessary for the whole picture, from workforce planning at the local and jurisdictional levels to data exchange and evidence-based modelling from Colleges to the Commonwealth.

The STP Operational Framework 2022-2025 is an agreement to collaborate in extending vocational training for specialist registrars (trainees) into regional, rural, remote, and private settings in addition to traditional metropolitan teaching hospitals. The framework clarifies the roles of the Commonwealth, states and territories, Colleges, the CGH and settings but doesn't include the potential advantages or contributions that can be made by ACCHOs.

ACCHOs support the social, emotional and physical and cultural wellbeing of Aboriginal and Torres Strait Islander peoples, families and communities. Their services are relevant to increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists, however, are not currently engaged. One of the benefits of collaborating with ACCHOs could be their capability in supporting non-Indigenous medical officers to build a deep understanding of Indigenous health, to help them to identify and eradicate their own unconscious bias about First Nations people, and to champion cultural safety in other settings where they go on to work.

Consultation indicated positive collaboration of the Commonwealth with Colleges and Colleges with Health settings regarding administering and implementing the STP. Most interactions with states and territories appear to be transactional including the sign off on new site approvals, funding the salary gap of trainees, review and approval of STP posts and managing Reserve Lists. However, Colleges and states and territories are willing to work with the other stakeholders more regularly and with more directed purpose to better understand workforce distribution and needs. Information sharing among all stakeholders is unstructured, fragmented, and sometimes non-existent, resulting in challenges for each stakeholder to fulfill their responsibilities.

Key stakeholders

The effects of strong collaboration, if introduced in the short term, would lead to program change over the next 10 or more years, given the complexity of training across several specialties and the nature of medical education and training.[89] It is therefore imperative to invest now in better collaboration and knowledge sharing to achieve a shared view of what is required and how to get there. Key stakeholders include the Commonwealth, state and territory governments, Colleges, healthcare settings, ACCHOs, health peaks, regional training hubs, rural medical schools. Together these organisations and health bodies can contribute to the STP aims and objectives in ways such as:

- Providing a national lens
- Sharing workforce and accreditation knowledge
- Data collection alignment
- Providing clear guidance materials
- Sharing lessons learned
- Aligning decision making.

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[89] Department of Health, 2021. 'National Medical Workforce Strategy', Appendix D, <www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

Implementation Challenges

Commonwealth

The Commonwealth provides funding for the delivery of the STP and ensures the proper use and management of Commonwealth funds, as required under the *Public Governance, Performance and Accountability Act 2013*. They have a role in developing guidelines and criteria for the delivery of the STP to grow and distribute the specialist workforce according to community and geographical need. The Commonwealth also confirm annual allocations, as agreed by all partners, and continue to convene engagement with relevant stakeholders to inform and influence the best allocation and provision of STP posts.

Some of the identified challenges for the Commonwealth include:

- There is currently no reliable single source of medical specialist workforce data, and different data sets and methodologies used by the Commonwealth, Colleges and states and territories to understand supply and demand planning. Poor data sharing leads to conflicting ideas on workforce needs that do not advance on the common objectives of the STP.
- Relationships with Colleges are strong but there is very little engagement with states and territories, health settings or the community-controlled sector. Potential lack of information coordination with all stakeholders could lead to the allocation of posts not aligned to the priorities of the Commonwealth.
- The program guidelines lack clarity and flexibility relevant to sub/specialisations. Program guideline gaps cause Colleges to deliver programs based on their understanding of and priorities for pertinent subspecialties, which may not always correspond with the Commonwealth's priorities.

Colleges

The Colleges are key partners in the delivery of high-quality skills training due to their role in setting professional standards, accrediting training settings and the coordination and support for education and training of future specialists and College fellows.

Some of the identified challenges for Colleges include:

- The lack of alignment between data collection and other Colleges distorts the perception of where the need actually is.
- The specialist training pathway is complex, involving multiple decisions that are not always aligned to the Commonwealth guidelines or other Colleges, which makes it challenging to manage achieving the STP's overall goals.
- Relationships between Colleges are strong, which facilitates consistent administration; however variation in approaches across Colleges persists. At the same time, interactions with other stakeholders, particularly those with knowledge of remote and rural training and jurisdictional need, are more ad hoc. This limits the Colleges' ability to build on existing successes by not sharing or gaining additional knowledge and experience, which would improve decision-making and help them achieve the program's objectives.

States and Territories

States and Territories are also key partners in the delivery of specialist training arrangements. These key partners have a critical role in workforce policy and employment arrangements, and other funding programs, for regional and rural areas and, subsequently, this training.

Some of the identified challenges for States and Territories include:

- Typically, state and territory governments handle workforce development and planning on their own, projecting demand for local health services. Data sharing with Colleges and the Commonwealth to give a national perspective on the demand for specialists across Australia would be beneficial to support successful specialised training programs like the STP, particularly in places with unmet community needs like rural and remote areas. Improved data collecting, sharing, and transparency is crucial.
- States and territories' relationships seem to be restricted to transactional exchanges for the purpose of carrying out their roles through the Reserve List and STP post approval procedures. Transparency and awareness on the selection criteria for suitable STP posts and their compatibility with workforce needs within jurisdictions is therefore hindered.
- States and territories are not involved in the discussion or program planning early enough to contribute knowledge of local specialist demand and supply. Without a joint planning process around STP post

allocation, Colleges are making a decision about accreditation and training numbers without sufficient jurisdictional data or modelling outputs.

Community-controlled sector

ACCHOs support non-Indigenous medical officers to build a deep understanding of Indigenous health, to help them identify and eradicate their own unconscious bias about First Nations people, and to champion cultural safety in other settings where they go on to work.

Some of the identified challenges for ACCHOs include:

- ACCHOs are not involved in the program design, post allocation, or discussions about community needs within the community-controlled sector. The absence of experience in culturally safe training and expertise in Aboriginal and Torres Strait Islander health challenges the fulfillment of the STP objective to enhance opportunities and training experiences for Aboriginal and Torres Strait Islander individuals aspiring to be medical specialists.

Health Settings

Health Settings are important in achieving an expansion of specialty training opportunities across Australia by engaging in the establishment of posts in collaboration with the public sector to facilitate trainee rotations and allocations for the purposes of training. While STP provides a contribution to the costs of employing and providing training to a trainee, the funded setting is responsible for covering the remaining cost. In the case of public settings, this funding is allocated by state and territory governments.

Most Health Settings who responded to the Setting Survey believed the administration effort associated with STP was appropriate, though many acknowledged that it was complex.[90] Some of the identified challenges for Health Settings include:

- Although there are minimal reporting requirements, each College has its own unique reporting procedures. There is an increase in administrative work in health settings where there are multiple posts connected to different Colleges.
- The timing for health setting accreditation and STP funding release conflict with jurisdictions' recruiting seasons. This makes recruiting challenging, particularly in smaller healthcare settings. There is a chance of losing the STP post in that situation if it cannot be filled.
- Different Colleges provide contradicting information about the rules and guidelines for various programs. This suggests that Colleges are delivering in accordance with their own knowledge of and priorities for relevant sub/specialties, which makes it difficult for Health Settings to implement the programs in line with Commonwealth priorities.

Decision making is complex, requires strong management and needs to reflect the different priorities of the Commonwealth and individual states and territories. While recognising and respecting these differences, there is considerable value in working together towards shared priorities and program objectives where possible and practical.

Opportunities to improve

Stakeholders recognise the mutual sharing of information, advice and expertise is important for effective implementation of the STP. Well-coordinated collaboration is necessary for optimal medical specialist workforce planning to allow all stakeholders to provide their experience and knowledge to the shared objectives and therefore understand what levers they can modify within their power to reach those outcomes. Opportunities to improve include but are not limited to:

- Developing a collaborative planning framework to guide and coordinate decision making on the medical specialist workforce
- Formulating consistent demand-and-supply modelling methodologies to form a national view of medical specialist workforce planning
- Collaborating to develop a national medical specialist workforce data strategy, aligned with the priorities of the Commonwealth and the NMWS

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[90] Proximity 2024, Health Training Settings survey

- Reviewing the STP Operational Framework to better clarify program guidelines and define the roles and responsibilities of each stakeholder through a more collaborative process
- Early in the design/review process, consulting with the states and territories to better direct and coordinate posts to places most in need per jurisdiction while adhering to Commonwealth goals
- Align College decision making about accreditation and trainee numbers with the data, modelling outputs and decisions of a collaborative planning process with all stakeholders
- Consider basing trainee posts on demands for sub/specialty provision and historical trainee numbers, rather than modelling of future health system requirements as aligned with the Strategy
- Introducing more transparency from Colleges in their approach to managing the program, particularly around filling posts and the use of the STP Reserve List
- The STP is currently not administered in a way that is consistent with the National Agreement on Closing the Gap. There needs to be transformation in the way STP is governed and applied for it to be effective.

Activities in line with operational guidelines

There are common activities undertaken by Colleges to administer the STP set out in the Operational Framework.[91] These include managing applications for new posts/positions, performance and annual reporting, stakeholder engagement and managing RSL and PICS support. Colleges also administer the IRTP and Tasmanian Project which are known to require further administration and can be more challenging to implement. The operational guidelines have some gaps (as discussed in the Appropriateness chapter), and Colleges seem to deliver based on their expertise and priorities for the relevant sub-specialty.

Managing training posts including funding, filling, and selecting from Reserve Lists

As described above, the Commonwealth determines appropriate numbers of STP posts required in private settings, and in non-metropolitan locations. Through grant agreements with Colleges, the Commonwealth commits funding for an overall number of FTE (STP and Tasmanian Project) and posts (IRTP) in each specialty. These STP targets are then filled by Colleges entering into contracts with health settings who recruit trainees into funded posts. The process of selecting settings and setting locations is undertaken by the Colleges as they see fit, drawing on their knowledge of workforce need across specialties and sub-specialties, while also taking into consideration accreditation requirements for their trainees. The Commonwealth appears to have little to no involvement in the selection and prioritisation process, beyond the setting of high-level targets in funding agreements.

Under the Operational Framework, the Commonwealth manages the annual STP Reserve List processes to ensure adequate Reserve Lists for Colleges. Colleges are responsible for maintaining their own specialty Reserve List and the allocation of posts in line with workforce demand and the capacity of the health sector to support training and supervision requirements for trainees. The Reserve List Guidelines are not linked with the grant agreements as other program guidelines are, but are shared with the Colleges ahead of the annual Reserve List process and are available at any time should a College request them.

Although the number of posts on the Reserve List was not available to this evaluation, the 2024 Reserve List refresh includes 45 posts: 40 for STP posts and 5 for IRTP posts. What is unknown for this report is:

- College Reserve List selection and prioritisation criteria
- How long approved posts stay on the Reserve List
- How often the Reserve List gets reviewed for continued eligibility
- Areas identified by the Commonwealth to be of highest priority.

Consultations noted the process of having jurisdictions conduct their assessments after the Colleges results in some Colleges spending time and resources on applications that lack jurisdictional support. Additionally, jurisdictions and Colleges are not regularly engaged in discussions about reform options, including selection criteria and prioritisation of placements. It was also mentioned that it would be ideal if separate applications were submitted for IRTP and STP posts.

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[91] Department of Health and Aged Care, 2021. 'Specialist Training Program (STP) Operational Framework 2022-2025', <www.health.gov.au/sites/default/files/2023-03/specialist-training-program-operational-framework_1.pdf>

Networks and systems for training across all settings

Colleges actively ensure trainees are integrated into relevant College training networks and support health settings in delivering training experiences and delivering longer training experiences, particularly for rural settings, providing for a minimum, three-month continuous period (per academic year) training rotation under the program (or three months pro-rata where trainee is less than one FTE). Colleges ensure providers of STP funded training posts included in networks are equipped with resources and support mechanisms necessary for the sustainability of training posts.

Colleges however do not work with all key partners to improve rural and remote specialist workforce shortages and maldistribution. Interactions with other stakeholders, particularly those with knowledge of remote and rural training such as ACCHOs, Rural health peaks and rural training hubs and jurisdictional need, are lacking. Sharing or gaining additional knowledge and experience, would improve decision-making and help Colleges achieve the program's objectives.

Networks with expanded settings, including the private sector

Colleges successfully facilitate and coordinate specialty training in expanded settings, ensuring that trainees receive the necessary support to undertake training in these environments, including the private sector. Colleges support private settings to maximise specialty training opportunities and ensure training posts in private settings are integrated into the public training programs and networks where appropriate.

Stakeholders suggested that in rural areas, Colleges could enhance the training experience of non-GP specialist trainees by introducing inter-college arrangements to foster networks and connections across disciplines.

Well-being and safe training environments including cultural training for all trainees

Consultations with Colleges indicated that trainee well-being and safety are managed under standard College policies. Through accreditation practices, Colleges provide training courses, information sessions and inductions to educate trainees on what a safe training environment looks like. Colleges also indicated that they implement orientation and safety training, including cultural training to all trainees in STP funded posts.

As discussed in the Effectiveness chapter of this report, the STP is currently not administered in a way that is consistent with the National Agreement on Closing the Gap.

Reporting and data management limitations

Colleges annually reach out to health settings for reporting and conducting a mid-term review process. Data and outcome information are collected in separate reports, which are then combined for meaningful analysis. Consultation indicated that the reporting process differs for each College which creates a burden for health settings and supervisors. Colleges explained that collecting data from health care settings can be a time-consuming process and it wasn't unusual for health care settings to have not provided their performance report in time to be included in the reporting to the Commonwealth. Some Colleges mentioned the challenges involved with the different reporting periods for different stakeholders (e.g. financial year, academic year, funding agreement).

The development of a Commonwealth STP data portal is under consideration, and this could greatly enhance the ability to easily collate data and perform useful data analysis, guiding the future objectives and priorities of the program. Streamlining the administration of the reporting process and even invoicing arrangements for the settings would reduce the need for manual input of data by College and health settings staff.

Poor data and information management further reduces the Commonwealth's ability to manage the program's performance. Key data regarding drivers of program aims are not collected or analysed in a meaningful way, including information regarding STP post lengths, demographic and salary data about trainees, the MM placement of settings, the ongoing MM location of trainees and the quality of trainee experiences in placements. Without this data, ongoing monitoring of outcomes associated with the program is greatly constrained.

Effectiveness of the implementation of the STP

Overall finding: **Good**	Strength of Evidence: **Sufficient Evidence**
Performance was generally strong in some areas relating to the overarching question of the evaluation domain. Some gaps or weaknesses were evident.	Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.

Overall finding

Overall, while the design of the program is not aligned to enable achievement of its intended aims, the activities undertaken across the program are largely in line with the program guidelines. The program is generally well run by Colleges, bringing expertise and unique visibility of their specialist workforce to the delivery of the STP.

Additional investment in the overall collaboration and coordination of the STP to include stakeholders from state and territory governments would strengthen implementation of the program and align with expectations in the program guidelines. Including stakeholder collaboration with the community-controlled sector and incorporating Indigenous collaboration into the design and implementation of the program would strengthen its contribution to outcomes, however the current guidelines do not require this.

The guidelines themselves could be strengthened in other ways as well, by providing more guidance and clarity around targets and post distribution, and by specifying a range of data and intelligence sharing that would support better management for outcomes by the Commonwealth.

Efficiency - How cost effective is the STP?

Key evaluation questions relevant to this section

KEQ9: How efficiently have the STP Program resources been used?

KEQ10: How cost effective is the STP compared with how states and territories fund training posts?

To assess how efficiently the STP is administered, the following criteria are of relevance:

- To what extent the costs of administering the program meet a reasonable standard

- To what extent effort across stakeholder groups is proportionate to the value gained through the program.

Several research questions guiding this evaluation are relevant to the question of the relative cost effectiveness of the STP. The cost per position of funding STP posts across the funding streams in the program (STPS, IRTP and the Tasmanian Project) is relevant to understand the differential value across the three streams. At the same time, the administrative costs of each stream also vary, impacting the overall cost effectiveness of each stream and the program as a whole.

This evaluation sought to capture the total cost per training post funded by states and territories, outside of the STP. This data was requested of states and territories, but was not made available to this evaluation, precluding this analysis from being undertaken. The relative costs and benefits associated with length of trainee placement is also difficult to measure, in the absence of data regarding either the length of trainee placements or the rate at which trainees remain in or return to regional or rural areas after their STP post. Without this data a reliable calculation of this nature is not possible.

At the current stage of the project, reflections from the data regarding cost per position and administrative costs associated with the program are able to be calculated, and are presented below.

There are also a range of qualitative benefits associated with the STP, primarily in that it provides a unique opportunity for the Commonwealth to directly influence the supply and distribution of the overall medical specialist workforce in Australia. It also provides support for settings to meet the day-to-day health needs of their local community through funding trainee registrars. This is of value to settings and local health networks and the community more broadly.

Merit determination: Adequate   Strength of Evidence: Some evidence

Costs related to the STP are comprised of three elements:

- Commonwealth funding provided to the Colleges. This funding has seven components, which are explored further below

- Internal costs to the Commonwealth for the Department to undertake managerial activities and for the CGH to administer grants

- Costs incurred by other stakeholders as part of their participation in STP which are born by the stakeholders.

All of these costs must be taken into account when assessing the cost effectiveness of the STP.

Commonwealth funding provided to Colleges

Commonwealth funding components

In 2023, the Commonwealth provided a total of $164 million across the three STP streams. This included $134.1 million to the STPS, $15.2 million to the IRTP and $14.6 million to the Tasmanian Project. STPS funding is divided into five components: STP trainee salaries, PICS, RSL, STP Support Projects and STP administration.

IRTP and Tasmanian Project funding are provided as a single line item. Up to 5 per cent of IRTP funding can be spent by Colleges on administration. There is no administration component of Tasmanian Project funding.

The total value of Commonwealth funding peaked in 2018 because unspent funds from the 2010-2017 grant round were bought forward into 2018 as part of the STP Support Projects payment component. From 2019 onwards, the total value of Commonwealth funding has grown by an average of 0.6% per annum. The rate of increase will grow to 1.2% between 2023 and 2025 due to the indexation of some program payment components.
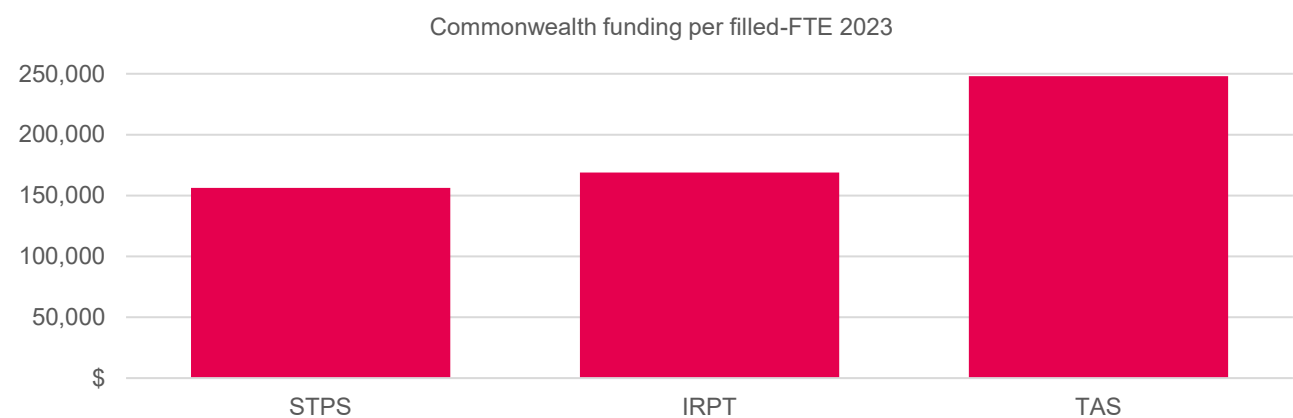
Figure 9 – Commonwealth STP funding 2018 - 2025

Commonwealth STP funding 2018-2025
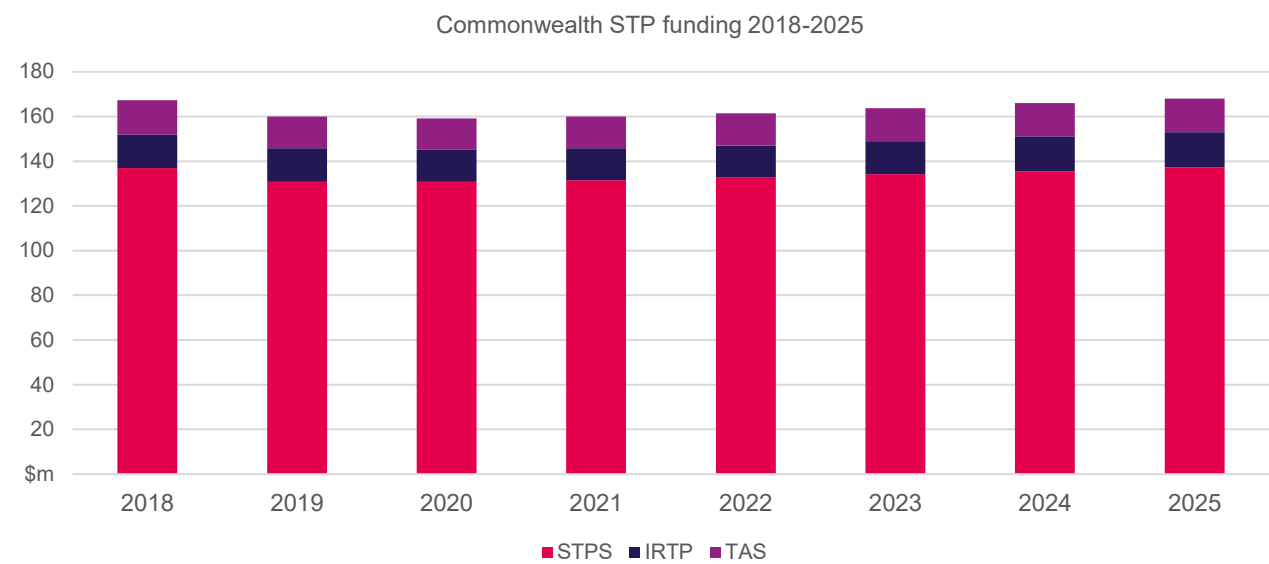
Source: Department of Health and Aged Care, STP Grant Agreements

Commonwealth funding per filled STP trainee

Total funding per trainee

In 2023, the average Commonwealth funding per filled STP post was $156,346 for STPS, $172,396 for IRTP and $248,121 for the Tasmanian Project. The total program average was $163,139.

Figure 10 - Commonwealth funding per filled-FTE 2023

Commonwealth funding per filled-FTE 2023

Source: Number of filled and funded FTE: Department of Health and Aged Care, STP Post Dataset. Funding per stream: STP Grant Agreements, 'Total STP Funding', 'Total IRTP Funding' and 'Total Tasmanian Project'.

Between 2018 and 2023, Commonwealth funding per post has been consistent with the overall Commonwealth STP funding (i.e. peaking in 2018 and rising gradually in subsequent years). Fill rates have an important impact on the funding per post ratio, with funding per post decreasing as the filled to funded ratio increases. This funding covers the equivalent of an early career registrar's base annual salary in a public hospital, however as discussed above, this is not an adequate amount to cover the salary costs of most STP trainees, who are as a cohort more likely to be more experienced.

Administrative components of Commonwealth funding

Total administrative funding

In 2023, the Commonwealth allocated $7.8 million to Colleges for STP administration funding. Colleges may also use up to 5 per cent of IRTP funding for administrative purposes. If Colleges use the entire 5 per cent, the total administrative component of the IRTP program would have been $758,542 in 2023. There is no administrative funding component of Tasmanian Project funding.

In total, up to $8.6 million of Commonwealth funding was allocated to administration across all program streams, amounting to 5.2 per cent of total funding for STP.

Administrative funding per filled post

Calculating the administrative funding cost per post is most pertinent for the STPS. This is because the IRTP administrative component is set at a maximum of 5 per cent and there is no administrative component of the Tasmania program. The average administration funding per filled STPS FTE was $9,086. This varied substantially across Colleges, including a low of $8,022 (RACS) and a high of $40,545 (ACSEP).

There was a modest negative correlation between the number of filled FTE and administration funding per filled FTE (r=-0.41). As the number of filled FTE increased, administration funding per filled FTE tended to decrease. However, the relationship between cohort size and administration funding was not determinative. For example, despite having a modest STP filled cohort of 32 FTE, RANZCOG's administration funding per FTE ($9,523) was relatively low. Conversely, RANZCP had the second largest filled STP FTE cohort (145.1 FTE), however had a higher administration to filled FTE cost ratio than Colleges with smaller cohorts, including RACS, RANZCR, RANZCOG, RCPA and ANZCA.

Figure 11 – Administration funding per filled FTE and total filled FTE by College 2023

Adminstration funding per filled FTE and total filled FTE by College 2023
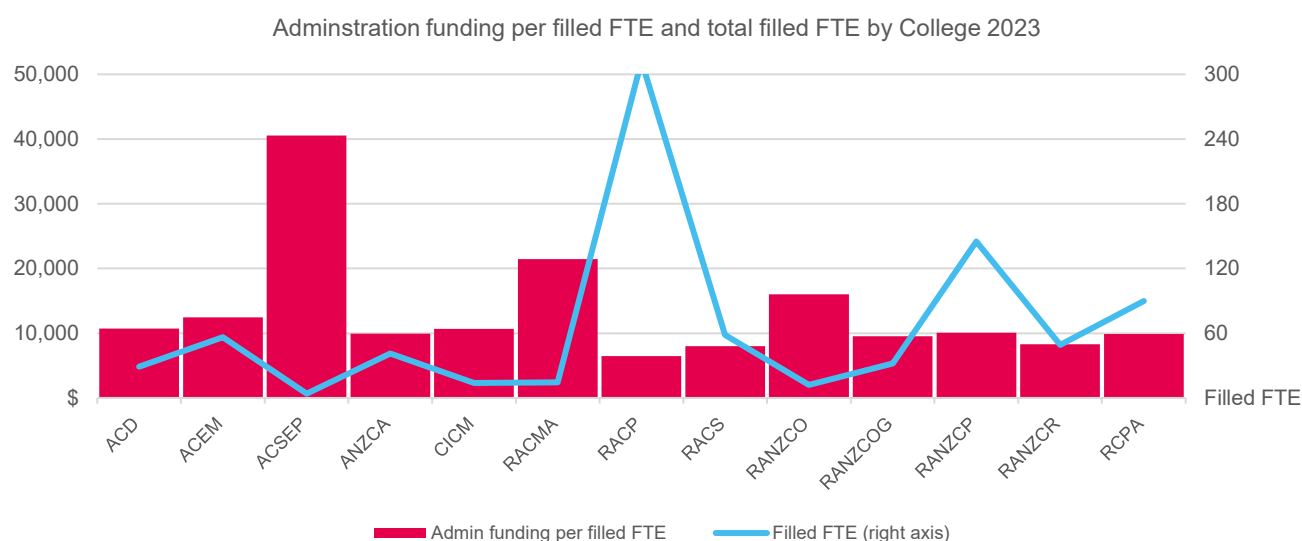
RACP filled FTE = 312.3
Source: Number of filled FTE: Department of Health and Aged Care, Funding per College: Department of Health and Aged Care, STP Grant Agreements.

Costs associated with the program

Internal costs to the Commonwealth

Costs for the Department to undertake managerial activities

The Department retains the overall policy and program oversight function for the STP, including liaising across the Colleges. The same section is also responsible for oversight of FATES. The Department estimates an annual FTE component of 6.85, with overheads of approximately $50,000 required, resulting in an estimated total annual cost for Departmental staff and overheads for the STP and FATES programs of $980,096.

Cost for CGH to undertake grants management activities

The CGH is engaged by the Department for both for the grants delivery elements of STP and FATES. CGH estimate their annual costs at $662,313 inclusive of FTE costs, noting CGH have had to second staff from other areas to administer the STP because the allocated two FTE is insufficient.

Costs incurred by other stakeholders as part of their participation in the STP which are borne by the stakeholders

Costs incurred by Colleges

During consultation for this review and in previous reviews of the STP, Colleges regularly note the administration component of Commonwealth funding does not cover the true cost of administering the program. The Department has made several efforts to establish the actual cost to Colleges of administering the STP. This includes requesting cost breakdowns from Colleges in both 2020 (seeking 2018 costs) and 2023 (seeking 2021 costs).

This review sought to build on past work and requested estimated administration costs using the same categories as the 2020 review of 2018 costs. Of the 12 Colleges that responded, a total of $387,888 in administration costs was reportedly spent over and above the amount provided by the Commonwealth. Unlike the 2020 review, no Colleges reported receiving more administration funding than was required to administer the program.

As past reviews have found, assessing the actual cost of administering the STP is challenging for several reasons, particularly the difficulty Colleges have in separating the cost of STP administration from their other activities. In several cases, Colleges reported how they allocated Commonwealth funding, but did not assess actual administration costs, which resulted in a difference of zero.

Despite these limitations, this review indicates Colleges incur a cost to administer the STP that is not that entirely offset by Commonwealth administration funding.

Table 10 - STP Administration Funding and Administration Costs, 2023/24

College	STP Administration funding received in 2024[1]	Total actual cost to administer STP in 2024[2]	Difference between administration funding and administration costs
ACD	$316,217	$405,502	-$89,285
ACEM[3]	$712,724	$922,163	-$209,439
ACSEP	$164,696	$209,253	-$44,557
ANZCA	$489,977	$489,977	$0
CICM	$152,031	$175,355	-$23,324
RACMA	$317,832	$317,832	$0
RACP	$2,057,037	$2,057,037	$0
RANZCO	$196,773	$217,158	$0
RANZCOG[4]	$309,483	$309,483	$0
RANZCP	$1,482,183	$1,482,183	$0
RANZCR	$414,977	$415,875	-$898
RCPA	$904,687	$904,687	$0
Total	$5,461,582	$5,849,470	-$387,888

[1] Administration component of STP funding
[2] Total estimated cost to deliver the STP reported by Colleges

Costs incurred by health settings

Additional trainee salary costs

The three STP streams cover a proportion of trainee wages. Training settings must cover the remainder in order to host a trainee. While salary data is not collected for STP trainees, analysis undertaken for this review and consultation with stakeholders indicates that, for STPS and IRTP collectively, health settings are likely to be paying at least 25 per cent on top of the salary funding received from the Commonwealth. Across all program streams, STP provided $127.7 million in salaries to trainees. If training settings are funding an additional 25 per cent of salaries, the additional cost incurred by stakeholders is $31.9 million.

Table 11 - Approximate additional trainee wages cost for training settings to host STP trainees

STP Salary	IRTP salary	Tasmanian Project salary	Total	Cost to stakeholder
$98.7 million	$14.4 million	$14.6 million	$127.7 million	$31.9 million (additional 25% of salary)

Source: STP Grant Agreements – STP salary, 95% of IRTP funding, 100% Tasmanian Project funding

Additional administration costs

This evaluation did not have access to reliable data on the amount of labour time spent by state and territory governments and health settings administering the STP. This is because these groups were engaged through verbal consultation, rather than a mixture of verbal consultation and formal data requests (as in the case of Colleges).

Responses to the Health Settings survey indicate that the time burden is substantial, however overall most settings believe the time burden is proportionate to the benefits of participating in the program.

The absence of labour time data for these groups means that the total cost estimate of STP is likely to be an underestimate.

Assessing program efficiency

Administration efficiency

In 2017, the ANAO found that for every grant dollar expended across a selection of programs, $0.03 was spent on administration.[92] These programs were administered between 2014-15 and 2016-17 and, as such, the comparable figure today would be $0.04-$0.05.

In 2023, STP expended $155.1 million at an administrative cost of $8.6 million. This amounts to $0.06 in administration funding per $1 expended. However, when internal costs to the Commonwealth through the Department and the CGH and the administration costs for Colleges beyond the funding provided by the Commonwealth are included, the total administrative cost of STP rises to $10.7 million. Taking this higher figure, the STP expends $0.07 for every $1 of grant funding, in contrast to the ANAO figure of $0.04 to $0.05 spent on administration for a range of government programs.[93]

This evaluation has not been able to confidently establish the actual administration costs for Colleges, which limits its ability to make a definitive statement regarding the efficiency of program administration. Comparison of College cost estimates between this evaluation and past reviews suggest administration costs have increased at a faster rate than administration funding, suggesting Colleges are unlikely netting additional funds through the administration funding component.

[92] ANAO, 2017, Efficiency of the Australia Council's Administration of Grants, Report No.7 2017–18
[93] ANAO, 2017, Efficiency of the Australia Council's Administration of Grants, Report No.7 2017–18

Administration costs appear to be higher than other government grant programs, however, given the complexity of the STP, higher administration costs could be considered efficient provided the program objectives are achieved, which in this case are questionable as per the evaluation findings.

Cost per FTE

Across the main cost domains of Commonwealth funding, internal Commonwealth costs and additional stakeholder costs, the total cost of the STP in 2023 was approximately $197.9 million, with a cost per FTE of $196,739. This is likely an underestimation due to limitations in College data and the absence of data regarding the costs incurred by state and territory governments and health settings.

Table 12 - Approximate actual cost breakdown of STP (all streams)

Commonwealth funding	Internal Commonwealth Costs	Stakeholder costs: administration	Stakeholder costs: trainee wages	Total cost	Cost per filled FTE
$164 million	$1.6 million	$387,888	$31.9 million	$197.9 million	$196,739

Source: Commonwealth funding – STP Grant Agreements; Internal Commonwealth costs and Stakeholder costs – Reporting to this review.

From a value for money perspective for use of public funds, the program shows reasonable levels of cost efficiency. The cost per-FTE across all programs, including internal costs is $164,609. This is comparable to the wage of an experienced registrar in a public hospital. The Commonwealth also receives the additional benefit of being able to influence the specialist trainee landscape.

From an overall program perspective, the cost efficiency is modest. Cost efficiency is predicated on the contributions made by other stakeholders. When these costs are included, the approximate cost per FTE is $196,739, which is above the top registrar wage bracket in all states and represents a modest level of cost efficiency.

Efficiency of the STP

Overall finding: _Adequate_

Performance demonstrated some weaknesses in relation to the overarching question of the evaluation domain, however minimum expectations or requirements were met.

Strength of Evidence: _Some Evidence_

Where the evidence suggests the observation is true but there are data limitations, such that the find is qualified and further and/or different data (which may have been unavailable to this evaluation) would need to be sourced to be more confident in the conclusion reached.

Overall finding

To understand the efficiency of the STP, the costs and value of the program to the Commonwealth must be considered.

On the cost side, the Commonwealth provided $8.5 million in administration funding to Colleges across the STP in 2023, with the aim of achieving a range of qualitative benefits associated with the program. While the total administrative cost of the program is within the general bounds of comparable government programs, the program has not successfully achieved its intended aims and so does not represent value for money.

At the same time, the program achieves value through positive unintended outcomes. The main value achieved by the program is the provision of support for settings to meet the day-to-day health needs of their local community through funding access to trainee registrars. This is of value to settings and local health networks and the community more broadly; however it is by no means the primary intent of the program, and other available funding streams from Commonwealth and state governments are intended to fund these healthcare costs.

While the program provides a unique opportunity for the Commonwealth to directly influence the supply and distribution of the overall medical specialist workforce in Australia, the current administrative settings do not enable it to do so. Without increasing the costs of administration, the Commonwealth could take a more active role in the supply and distribution of the medical workforce through the STP, providing long term value beyond meeting the day-to-day health needs of the community.

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Key evaluation questions relevant to this section

KEQ13: What are the risks associated with moving STP/FATES to a new mechanism (i.e. change the administrative structure)?

To assess how sustainably the STP is administered, the following criteria are of relevance:

•   To what extent do mechanisms within the program enable ongoing monitoring of the STP's contribution to its aims

•   To what extent do program settings enable STP funding to be redirected to better meet its aims and objectives

Across the domains of interest to this evaluation, several opportunities to strengthen the program have emerged. These have been validated with stakeholders and suggested recommendations are presented below.

While the program is valued for its contribution to meeting service needs of settings, and as a unique funding source targeting training funding to expanded settings, it would be substantially strengthened through being more responsive to the changing non-GP specialist workforce needs of Australia. The program would benefit from improved target setting processes, which in turn would assist Colleges to better support the aims of the program in delivering funding to settings.

Merit determination: Adequate   Strength of Evidence: Sufficient evidence

Enhancing the sustainability of the STP

As discussed in the Appropriateness chapter above, there are several aspects to the STP which, if improved, would strengthen the program's responsiveness and are directly relevant to its longer-term sustainability. The focus of these is to improve, or where necessary introduce, governance and data management to better enable monitoring of the program's contribution to its aims and objectives, and to introduce mechanisms to adapt the program in response to management information. In addition, a simplification of the program's design would resolve a number of areas of concern from stakeholders and make targeting of support through the program more straightforward and achievable.

Maintaining the current funding model

A key area of interest to the Department in commissioning this evaluation is whether the current funding model, and the roles and responsibilities of the Commonwealth, Colleges and other stakeholders, are appropriate. Overall, this evaluation has found that there are clear benefits to the current roles of the Commonwealth and Colleges. The Commonwealth is seen by stakeholders to be independent and impartial when determining the flow of funding into different specialties, while Colleges have a well-recognised deep expertise in the particular workforce needs of the specialties they represent. The findings from this evaluation suggest that the current funding model should continue, with Commonwealth oversight of Colleges administering the STP. Within this model, however, there are opportunities to strengthen the STP and its contribution to the medical specialist workforce in Australia.

National work underway on health workforce data and governance

When considering opportunities to strengthen the sustainability of STP, broader work currently underway to understand the changing nature of the non-GP medical specialist workforce nationally must also be considered. Since the development of the NMWS, much work has been pursued in this area.

Action 1 of the NMWS recommends establishing a joint medical workforce planning and advisory body with sufficient authority and expertise to advise and make recommendations in relation to the size and structure of the medical workforce. The Medical Workforce Advisory Collaboration (MWAC) has been established to oversee the ongoing implementation and evaluation of the NMWS.

MWAC membership includes Commonwealth, state and territory health departments, specialist medical colleges, worker representatives (including nursing and allied health representatives), peak bodies, regulatory organisations, and consumer representatives. The inaugural meeting was held on the 6 August 2024 in Canberra. At its first meeting MWAC considered its governance, terms of reference, priorities and draft Action Plan. The meeting also discussed health workforce data sharing and modelling. Members undertook to work together to provide more data and improve future modelling. MWAC's draft Action Plan includes the following priorities:

- Improving data and governance
- Reforming the medical workforce pipeline
- Increasing the generalist and GP medical workforce
- Increasing the First Nations medical workforce and improving cultural safety

In addition to the data related activities stemming from the NMWS, the Department is undertaking supply and demand modelling as part of Recommendation 17 of the Independent Review of Overseas Health Practitioner Regulatory Settings (Kruk Review).[94] A list of professions has been prioritised by the Health Workforce Taskforce and supply and demand modelling will be conducted in phases concluding in 2025. Following consultation with key stakeholders, the Department will publish high-level results.

At the same time, the Department is in the process of negotiating Data Sharing Agreements with Colleges and has proposed a Minimum Dataset (MDS) that includes recognising Indigeneity. Discussions are ongoing with Colleges to ascertain if this data is collected and if it can be included in the MDS.

Opportunities to strengthen the STP

Over time, much of the Department led work underway to strengthen workforce demand and supply modelling will be highly relevant to the STP. In the meantime, improvements to the operation of the STP would enable the program to be better considered through these broader processes, and also enable it to better respond to strategic planning and directives arising from these forums.

Various aspects of the following suggestions to strengthen the program have been discussed and broadly validated with stakeholders across the program, however further consultation and collaboration would be required to implement each one.

Introducing an STP Strategic Framework and Outcomes Hierarchy

Introducing an STP Strategic Framework and Outcomes Hierarchy would enable the articulation and measurement of the program's strategic objectives in a systematic and rigorous manner. As discussed above, the program currently operates with a range of similar but slightly varying aims, objectives and outcomes, set out across documentation such as the Operational Framework, Support Project Guidelines, Reserve List Guidelines and FATES grant guidance. The aims of each of the various elements of the program all broadly align, however a clearer mapping of outcomes, activities and performance measures would support efficient and effective program management, including helping to determine the best use of funding and in assessing the performance of the program over time.

Investing in improved program data and reporting

Investing in improved program data and reporting, particularly if linked to a Strategic Framework and Outcomes Hierarchy, would enable a strong and sustainable program response to the training needs of the non-GP specialist workforce.

A number of key data areas are currently missing from the administration of STP. Data scoping should be undertaken with Colleges and healthcare settings, with a view to building on the MDS which is currently also under development for the national medical workforce. Data which would improve the strength and sustainability of the STP includes:

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[94] Kruk, R, 2023. Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners

Table 13 - key data items which would enhance STP management information

Focus	Potential data items	Collected by
Trainees	• Number of individual trainees funded through STP	Colleges

	• Demographics, including:
	  - Gender
	  - Rural origin
	  - Indigeneity
	  - Specialty/sub-specialty
	  - Year of practice/level of experience
	• STP funding information
	  - Salary support ($ value) provided
	  - Additional support ($ value) provided
		Settings

Placements	• Setting type (public/private/community-controlled) • Geographical locations • Demographics of the population served • Placement duration • Quality of training experience (qualitative measure) • Links to other settings, services, pathway programs and/or placements	Settings

The absence of this data prevents conclusive evaluation of the extent to which the program is serving its intended population (e.g. First Nations trainee specialists), in its intended locations (rural, regional and remote areas), or its intended settings (expanded settings or metropolitan teaching hospitals with pathways to rural placements). The duration of placements, known to be a key driver of trainee likelihood to move permanently to regional or rural areas, is also unknown.

Note that while the geographical location of trainees throughout their careers would also be of interest to understand the extent to which STP placements are associated with later practicing in the long term in rural or regional areas, data on this is not currently considered feasible to collect. Instead, given the strong evidence for the link between length of rural placement and likelihood of longer term rural practice, data regarding the length of placement could be used as a proxy for measuring long term outcomes, with periodic formal evaluation processes undertaken to test whether the nature of this relationship endures.

Publication of activities, outputs and outcomes data for the STP

In future iterations of the STP, data collected across the program should be made publicly available through the sharing of key performance indicators on a regular basis. This could be through quarterly publication showing performance against targets on College websites, and could also include publishing of College Reserve Lists, and movements of posts on and off these lists. The publication of this data would promote greater transparency across the program and provide insights to support the ongoing management of funding. If combined with reallocation of funding where necessary, data transparency could also support reduction of the level of unspent, uncommitted STP funding.

Indigenous governance committees in each College

Over recent years the Colleges have been working with AIDA to establish Indigenous governance committees to support them in their work as stewards of the medical specialties they represent. These committees could be used to great effect in future iterations of the STP, to help direct funding towards settings with high First Nations populations served, towards community-controlled settings for relevant specialties, and to guide efforts to support the cultural safety of trainees, clients and the health sector more broadly.

Linking to national medical specialist workforce data and modelling

As discussed above, during and since the development of the NMWS, the Commonwealth has increased investment in medical workforce demand and supply modelling. Introducing a mechanism to link this analysis to the STP in the long term would enable the targeting of STP funding towards geographical areas, specialties, sub-specialties and trainee demographics which would best support Australia's medical workforce needs in the long term.

Establishing a tripartite governance group

To ensure future funding is responsive to Australia's specialist workforce needs, target setting should be undertaken by a tripartite governance group, comprising the Commonwealth, state and territory health bodies and the Colleges. The suggested role of this group would be to:

- Examine workforce supply and demand modelling for each specialty (in line with broader processes such as through MWAC) to ensure alignment between the identified need, program response and the intended outcomes
- Set targets for regional and rural, First Nations focused and private setting posts for each College, to be included in funding agreements. College Indigenous governance committees would be integral to First Nations related targeting of the program
- Set criteria, standards and rubrics for selection of posts against each target for use throughout the next agreement. These would guide the Reserve List process and provide transparency and rigor to the process of funding selection.

Funding agreements are the mechanism through which College targets for STP placements are set. The current STP funding agreements expire at the end of February 2026. This provides a tight timeframe for an STP governance group such as this to be established and to begin to shape the future focus of the program. Once established, its early priorities would be to:

- Endorse the STP Strategic Framework and Outcomes Hierarchy
- Approve the program grant opportunity guidelines, including reporting and publishing requirements under the agreements
- Determine the list of Colleges through which STP could be administered.

Work would also be required to support the governance group, including stakeholder engagement on the details of these priority action areas. Upon completion of the inaugural work suggested here, this group would only be required in the lead up to subsequent grant agreements. In future, the work of this group would be more streamlined, building on artefacts developed in its first iteration. It would also likely be more effective over time, as improved STP management information is able to be combined with workforce modelling. This would allow rigorous evaluation of the effectiveness of the program over time and would enable data informed decision making to improve the program's overall impact.

Returning to a simplified, streamlined program design

The current design of the program funding elements is overly complicated, with multiple streams of funding which have been added over time to respond to emerging government priorities. Some funding elements have similar intent but different funded amounts and components, for example the IRTP, Tasmanian Project and RSL all target regional, rural and remote settings, but with different designs. While IRTP funding follows the trainee, Tasmanian Project, RSL and STPS funding goes to settings for trainees to cycle through posts. The funded amounts for each of these program elements also varies, as does the indexation arrangements applied. It is unclear whether these design differences were intentional, and available data and reporting of the different elements does not provide sufficient insight into whether the differences are associated with different outcomes.

Future iterations of funding for specialist training should use enhanced governance arrangements and improved program data to ensure the funding mechanism is responsive to particular or emerging needs, such as those designed to be met through the Tasmanian Project and IRTP. A simplified model of the STP which includes only the elements of the STPS (as set out in

Table 14 below) could be targeted through these enhanced mechanisms to private posts, First Nations posts, and regional, rural and remote areas, without additional funding rules and administration being required.

Table 14 – A simplified STP model based only on the elements of STPS

Specialist Training Placements and Support (STPS)

STPS provides $107,268 per annum (pro rata, per FTE) in salary support for around 920 trainee placements each year.[95] At least half of each placement must be spent in an expanded setting. Placements must be for a minimum of 3 months.[96] STPS funding includes, where applicable:

- **The Rural Support Loading** (RSL) allowance of $25,000 per annum per post, pro rata per FTE, paid to eligible rural training settings. Eligible costs are reimbursed when incurred by the trainee, such as relocation expenses, or by facilities, such as training room renovations or videoconferencing facilities.[97]
- **Private Infrastructure and Clinical Supervision** (PICS) allowance of $30,000, pro rata per FTE, paid to eligible private training settings to support infrastructure, such as training room outfitting, and supervision of trainees, such as programs which enhance a supervisor's leadership and management skills.[98]

The benefits of the IRTP model, where 66 per cent of training is required to be based in regional, rural or remote locations, could be applied to STPS funding where it is targeted to non-metropolitan sites.

Posts which currently attract Tasmanian Project funding would (continue to) be eligible for STPS funding, and state and territory target setting could be used to ensure the distinctive health challenges of different regions are accommodated in funding priorities.

Over time the value, adequacy and indexation of salary and support contributions of a simplified STP funding model could be reviewed through enhanced governance mechanisms introduced for the program.

With a simplified funding model, and reduced underspends leading to a return to the intended volume of Support Projects, complexity across the program operational guidelines would be removed, and existing Commonwealth and Colleges forums used to ensure consistent interpretation of funding rules are applied across Colleges. In this way, many of the pressure points currently identified by settings, supervisors and trainees would be removed, and the complexity of administering the program reduced for all stakeholders.

Sustainability of the STP	
Overall finding: *Adequate*	Strength of Evidence: *Sufficient Evidence*
Performance demonstrated some weaknesses in relation to the overarching question of the evaluation domain, however minimum expectations or requirements were met.	Where the evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data with no major quality issues and which consistently point to the conclusion reached.

Overall finding

The sustainability of the STP could be improved through the introduction of mechanisms to enable ongoing monitoring of the program aims, and to enable STP funding to be redirected to better meet its aims and objectives. Additional program governance, along with a return to a simplified funding design would greatly enhance the overall sustainability of the program.

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[95] In 2023, the STP base salary was $107,268 per FTE. Salaries will increase at a rate of 1.55 per annum in 2024 and 2025. IRTP salaries will also increase by 1.55 per cent. Tasmanian Project salaries will increase at 1.35 per cent (2024) and 1.30 per cent (2025).
[96] Department of Health and Aged Care, 2021. 'Specialist Training Program (STP) Operational Framework 2022-2025',
<www.health.gov.au/sites/default/files/2023-03/specialist-training-program-operational-framework_1.pdf>
[97] Department of Health and Aged Care, 2021. Rural Support Loading (RSL) Guidelines
[98] Department of Health and Aged Care, 2021. Private Infrastructure and Clinical Supervision (PICS) Guidelines

Conclusion

Conclusion

The STP is valued by stakeholders and represents an important opportunity for the Commonwealth to contribute to the geographical and professional distribution of the non-GP specialist medical workforce. In its current form, however, the program comprises disparate but overlapping elements which could be streamlined. Its impact in the longer term would be enhanced by a strategic framework, improved data collection and reporting, and the introduction of governance mechanisms to respond to changing demand and supply of the medical workforce and ensure ongoing value for public money is realised.

The overall findings against each domain of the evaluation are as follows:

Appropriateness of the design of STP

Overall finding: **Adequate**

Strength of Evidence: Sufficient Evidence

Overall, while the program is unique as a contribution to funding non-GP specialists outside of public metropolitan settings, in its current form, the STP does not respond to the changes in the evolving national non-GP specialist medical workforce. STP targets generally remain static over time, based on historic funding levels and largely determined by Colleges, and the program does not draw on data and modelling around workforce need.

While, to date, a reliable source of insight into workforce demand and supply has not been available to the Commonwealth, recent investment has focused on maturing the workforce modelling in this area through the NMWS. Introducing mechanisms to target the program towards changing workforce need would greatly enhance the STP in its ability to contribute to a specialist workforce that is well distributed and aligned to need.

Program effectiveness in funding placements in private settings

Overall finding: **Good**

Strength of Evidence: Sufficient Evidence

Evidence available to this evaluation indicates the program is supporting trainees to gain experience in private settings, by enabling Colleges to drive post selections to serve the training needs required for specialty and sub-specialty fellowship. Fill rates for private settings are high, indicating the program is successfully meeting targets for funding this type of expanded setting. At the same time, a proportion of funded FTE is targeted at specialties which may not require training in private settings. While this training is beneficial, this funding could be better focused on the other aims and objectives of the program. An enhanced governance mechanism, such as the tripartite forum identified in the program Appropriateness chapter above, could support better targeting of funding to long term need rather than maintaining historical funding levels across the program.

Program effectiveness in enhancing the rural and remote specialist workforce

Overall finding: **Adequate**

Strength of Evidence: Sufficient Evidence

Evidence available to this evaluation indicates that overall, maldistribution of the specialist medical workforce is a key feature of the current Australian health system, and the STP is one of the few funding sources available to help ameliorate it. Fill rates for the STP indicate the program meets targets for funding posts in regional, rural and remote settings. At the same time, however, the need for different specialists is likely to vary with relative remoteness, and a national, Commonwealth funded program like the STP should target investment in MM2-7 carefully and consider prioritising generalist specialties in areas where multidisciplinary teams and substantial infrastructure are not available. A rudimentary calculation of the STP funding for posts in Colleges which provide generalist specialisations indicates the program does not currently align to specialisations needed in each location, with around half of funding in the program going to MM1 settings. The current minimum placement length in the program is three months and there are no explicit incentives for longer-term placements. This does not support the long-term aim of the program to encourage specialists to relocate away from metropolitan areas and support a correction of the workforce maldistribution across Australia. A range of factors influence trainee registrar decisions to live and work in regional, rural and remote areas, and the timing of training in those areas

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is within scope of the STP. While some program elements support longer term placements, the STP as a program is not actively pursuing this aspect of the aim.

Program effectiveness in increasing the number of First Nations medical specialists

Overall finding: **Poor**

Strength of Evidence: Sufficient Evidence

Overall, evidence available to this evaluation suggests the STP does little to support Aim 3 of the program. It rarely funds posts in the community-controlled sector and does not collect data regarding the populations served by settings where posts are based. Placing non-Indigenous trainees in these settings is the STP's most powerful lever to affect change in both Indigenous health outcomes but also in reducing systemic racism and increasing the quantum of Aboriginal and Torres Strait Islander medical specialists.

While Colleges have worked hard over recent years to improve their cultural competency, the sector overall remains immature in its engagement with Indigenous ways of knowing and being. In line with the priorities, principles and suggested actions set out in Closing the Gap and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, STP could be improved through more:

- Active engagement and collaboration with Indigenous community leaders to ensure the program is fit for purpose and Indigenous led
- Investment across the sector in cultural safety and cultural awareness[99],[100]
- Investment in the training experiences of First Nations trainees through professional and peer networks, alongside workplace flexibility and supervisor support[101]
- Prioritisation of STP posts in community-controlled settings and settings with high Aboriginal and/or Torres Strait Islander populations served. This experience supports non-Indigenous medical officers to build a deep understanding of Indigenous health, to help them to identify and eradicate their own unconscious bias about First Nations people, and to champion cultural safety in other settings where they go on to work.

Program effectiveness in building the sector's capacity to support non-GP specialist trainees

Overall finding: Good – Adequate

Strength of Evidence: **Some Evidence**

Overall, the Support Projects and FATES program have injected a combined monetary value of almost $60 million over the current agreement period, to support the STP objectives. While the focus and outputs of these projects are in line with the intent of the STP, over time funding for Support Projects has been provided outside of program guidelines. While FATES projects are regularly evaluated, this is focused on their short-term success at a project level. While there are positive aspects of the two components of the overall STP, there is little evidence to suggest this funding would not be more effective if it were spent as it was originally intended, in funding posts in expanded settings. Extensive stakeholder consultation undertaken with the sector for this evaluation strongly suggests that there is unmet demand for posts in priority areas for the program, indicating that current administrative settings require adaptation to reduce underspend and enable posts to be filled.

Instead of redistributing unspent funds to ad-hoc, time limited projects run by Colleges, opportunities to prevent underspend within STP should be considered. The administration activity required to manage additional Support Projects and FATES could then be redirected to the additional effort required of the Commonwealth to more frequently acquit expenditure across the program. Over time, with improved data collection enabling more rigorous evaluation, the impact of each program component could be better understood, and funding could be

[99] So, N, Price, K, O'Mara, P and Rodrigues, MA, 2023. 'The Importance of Cultural Humility and Cultural Safety in Health Care', Medical Journal of Australia, vol. 220(1), pp. 12-13

[100] Brumpton, K, Woodall, H, Evans, R, Neill, H, Gupta, TS, McArthur, L and Ward, R, 2024. 'Exploring how Australian General Practice Registrars Define Cultural Safety with Aboriginal and Torres Strait Islander Patients', *BMC Primary Care*, vol. 25(166)

[101] Taylor, EV, Lalovic, A and Thompson, SC, 2019. 'Beyond Enrolments', *International Journal for Equity in Health*, vol. 18(136)

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targeted towards elements which are most effective in supporting the capacity of the sector to train non-GP specialists.

Effectiveness of the implementation of the STP

Overall finding: **Good**

Strength of Evidence: Sufficient Evidence

Overall, while the design of the program is not entirely aligned to its intended aims, the activities undertaken across the program are largely in line with the program guidelines. The program is generally well run by Colleges, bringing expertise and unique visibility of the specialist workforce to the prioritisation of funding for STP. More transparency from Colleges in their approach to managing the program would allay concerns from stakeholders in the wider sector.

Additional investment in the overall collaboration and coordination of the STP to include stakeholders from state and territory governments would strengthen implementation of the program and align with expectations in the program guidelines. Including stakeholder collaboration with the community-controlled sector and incorporating Indigenous collaboration into the design and implementation of the program would strengthen its contribution to outcomes, however the current guidelines do not require this.

The guidelines themselves could be strengthened in other ways as well, by providing more guidance and clarity around targets and post distribution, and by specifying a range of data and intelligence sharing that would support better management for outcomes by the Commonwealth.

Efficiency of the STP

Overall finding: **Adequate**

Strength of Evidence: **Some Evidence**

To understand the efficiency of the STP, the costs and value of the program to the Commonwealth must be considered.

On the cost side, the Commonwealth provided $8.5 million in administration funding to Colleges across the STP in 2023, with the aim of achieving a range of qualitative benefits associated with the program. While the total administrative cost of the program is within the general bounds of comparable government programs, the program has not successfully achieved its intended aims and so does not represent value for money.

At the same time, the program achieves value through positive unintended outcomes. The main value achieved by the program is the provision of support for settings to meet the day-to-day health needs of their local community through funding access to trainee registrars. This is of value to settings and local health networks and the community more broadly; however it is by no means the primary intent of the program, and other available funding streams from Commonwealth and state governments are intended to fund these healthcare costs.

While the program provides a unique opportunity for the Commonwealth to directly influence the supply and distribution of the overall medical specialist workforce in Australia, the current administrative settings do not enable it to do so. Without increasing the costs of administration, the Commonwealth could take a more active role in the supply and distribution of the medical workforce through the STP, providing long term value beyond meeting the day-to-day health needs of the community

Sustainability of the STP

Overall finding: **Adequate**

Strength of Evidence: Sufficient Evidence

The sustainability of the STP could be improved through the introduction of mechanisms within the program to enable ongoing monitoring of the STP's contribution to its aims, and to enable STP funding to be redirected to better meet its aims and objectives. Additional program governance, along with a return to a simplified funding design would greatly enhance the overall sustainability of the program and alignment to the outcomes of the NMWS.

Appendices

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Specialist Training Program Evaluation and Targeted Stakeholder Engagement Consultation Report

Department of Health and Aged Care

15 November 2024

We acknowledge the Traditional Custodians of the land on which we live and work.

We pay our respects to them, their cultures and their Elders past and present.

We recognise their deep and enduring connection to land, sea and community, and the ongoing cultural and spiritual significance it holds.

Contents

Introduction and approach to consultation

Introduction

The Department of Health and Aged Care (DOHAC) commissioned Proximity Advisory Services (Proximity) to conduct an independent evaluation of the Specialist Training Program (STP), complimented by targeted stakeholder consultation on the findings of the evaluation, with the findings and consultation to inform future direction for the program. The evaluation was to include an assessment of the appropriateness, implementation and effectiveness of the STP program to date. This report should be read in conjunction with the Final Evaluation Report.

Flowchart showing a three-stage process. Stage 1: Data mapping produces qualitative and quantitative data, which are synthesized. Stage 2: Synthesized data informs an interim report. Stage 3: The interim report is validated, synthesized again, and results in a final report. Stages are listed vertically on the leftThis report describes:

Figure 12 - Consultation stages

- the primary modes of consultation undertaken as part of the independent evaluation of the STP
- a list of stakeholders
- key themes, ideas, suggestions and matters of concern or interest to stakeholders
- a summary of outcomes of the surveys.

Consultation was conducted in three stages:

- **Stage 1**: Data mapping
- **Stage 2**: Semi-structured stakeholder interviews (qualitative) and surveys (quantitative)
- **Stage 3**: Validation.

In accordance with the evaluation methodology (Figure 1), during stage 1 and 2, the evaluation team gradually narrowed the consultation focus, seeking to focus on repeated, emergent themes. In stage 3, the consultation was broadened again, to test the key findings and synthesise them into practical recommendations to enhance the STP.

Approach

Stage 1: Data Mapping, May–June 2024

During this stage, Proximity engaged with DoHAC Workforce Training team under the Health Resourcing group. The Workforce Training team oversees training for medical professionals, delivering targeted programs or incentives across all disciplines and demographics. Through these consultations, Proximity was provided with STP program governance documents and data, grant agreements, Medical College reporting and details about STP support projects and Flexible Approach to Training in Expanded Settings (FATES) programs.

Proximity then engaged with each of the 13 non-General Practitioner Specialist Medical Colleges (the Colleges) receiving STP funding.[102] The goal of these conversations was to assess the availability and quality of data collected and held by the Colleges. Recognition of data gaps during this stage led Proximity to send a formal data request to Colleges, which sought demographic and geographical details about specialist trainees and Fellows.

Stage 2: Semi-Structured Stakeholder Engagement, the Specialist Trainees and Fellows survey and the Training Setting survey, July–August 2024

Semi-structured interviews

Semi-structured interviews provided the opportunity to explore issues in moderate detail in a conversation while retaining reasonably high levels of objectivity and providing comparable results across groups.[103]

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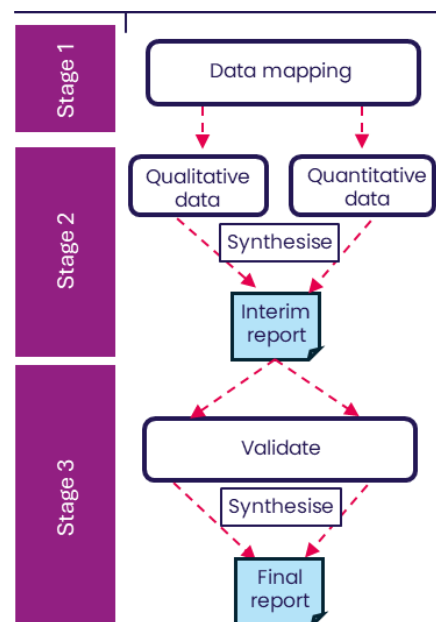
[102] A list of the 13 Colleges, and all other consultation participants, is at Attachment A.
[103] Ruslin, Mashuri S, Rasak MSA, Alhabsyi M, Alhabsyi F, Syam H. 2022, Semi-structured Interview: A Methodological Reflection on the Development of a Qualitative Research Instrument in Educational Studies. vol. 12, no. 1, pp. 22-29.

During this stage, the evaluation team re-engaged with the 13 Colleges, eight state and territory jurisdictions (jurisdictions), Indigenous health stakeholders and other organisations with direct involvement in the STP. The interview questions were based on the key evaluation question domains (appropriateness, implementation, effectiveness, efficiency and sustainability) and all stakeholders were provided with the consultation themes in advance.

In accordance with ethics approval obtained by Proximity for the evaluation, at the outset of each session, stakeholders were informed their participation was voluntary and there would be no negative outcomes associated with non-participation. Stakeholder participation in stage 2 semi-structured interviews was enthusiastic and led to rich data collection. In many cases, stakeholders sought to extend the length of the one-hour session because of the amount of feedback they had about the STP and, in some cases, FATES.

Stakeholder input was then noted, analysed and sorted into key themes. These key themes, together with quantitative analysis of program data, formed the basis for the interim and final evaluation report.

Specialist Trainees and Fellows surveys

Proximity also designed an online survey to be completed by medical specialist trainees and Fellows. The survey was distributed to trainees and Fellows as a link by the Colleges through a routine newsletter or via a custom email. The survey took approximately 10 minutes to complete. No incentives were offered for participation.

The survey received 812 responses from medical trainees (n= 212) and specialist Fellows (n=600). All 13 Colleges were represented in the responses.

Training Settings survey

Proximity also designed an online survey to be completed by health facilities that have hosted an STP trainee (currently or in the past). The survey was emailed to health facilities by the Colleges. The survey took approximately 10 minutes to complete. No incentives were offered for participation.

A total of 134 survey responses were received. Ninety-three per cent of survey respondents reported having visibility of the STP. Seventy-nine per cent of respondents had been working at the setting for more than three years; 95.5 per cent had been at the setting for more than a year.

Survey results were not available during the drafting of the Interim Report, instead their findings were provided to DoHAC separately and then incorporated into the Final Report. Summaries of the survey results are at Attachment B and C of this report.

Stage 3: Validation, October 2024

In the context of an independent evaluation, a validation workshop or session refers to a meeting that brings the evaluators and stakeholders together to review the evaluation findings.[104] The purpose of these validation sessions was to ensure consistency between the evaluation findings and key stakeholder views and to test the proposed report recommendations.

In consultation with DoHAC, stakeholders were formed into 7 groups for the validation sessions. The stakeholder groups were: Colleges (across two sessions based on availability), healthcare settings, medical officers, university deans, and Indigenous health and rural health peak bodies.[105]

Stakeholders were grouped into like-streams. Like-streams were used because they allow the focus to be on the most relevant components of the evaluation for the stakeholder group and to allow stakeholders the space to interact and elaborate on the experience of their group. It also allowed for bespoke presentation material to be developed, specifically suited to the stakeholder group.

The validation sessions brought together stakeholders in a group atmosphere for the first time in the evaluation. This format displayed the strength and, at times, the diversity, of opinion across parties. Given the time constraints and the high level of engagement in the sessions, participants were encouraged to provide written feedback through the meeting chat function and to contact the evaluators following the session if they had further input.

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[104] Gullickson, A. and Stufflebeam, D. L. 2001. Feedback workshop checklist, Western Michigan University Evaluation Centre.
[105] The Evaluation Framework had envisioned 4 stakeholder groups, however additional groups were added due to strong stakeholder interest and a recognition that smaller groups would provide more opportunities for stakeholders to contribute.

Stakeholder Summary

Stakeholders engaged as part of the evaluation process

The following table outlines which stakeholders, and at what stage they were engaged in the project.

Stage 1: Data Mapping	
Colleges	
Australasian College of Dermatologists (ACD)	Royal Australasian College of Surgeons (RACS)
Australasian College for Emergency Medicine (ACEM)	Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
Australasian College of Sport and Exercise Physicians (ACSEP)	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Australian and New Zealand College of Anaesthetists (ANZCA)	Royal Australian and New Zealand College of Psychiatrists (RANZCP)
College of Intensive Care Medicine of Australia and New Zealand (CICM)	Royal Australian and New Zealand College of Radiologists (RANZCR)
Royal Australasian College of Medical Administrators (RACMA)	Royal College of Pathologists of Australasia (RCPA)
Royal Australasian College of Physicians (RACP)	
Government	
Department of Health and Aged Care (Federal)	

Stage 2: Semi-structured stakeholder interviews	
Colleges	
Australasian College of Dermatologists (ACD)	Royal Australasian College of Surgeons (RACS)
Australasian College for Emergency Medicine (ACEM)	Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
Australasian College of Sport and Exercise Physicians (ACSEP)	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Australian and New Zealand College of Anaesthetists (ANZCA)	Royal Australian and New Zealand College of Psychiatrists (RANZCP)
College of Intensive Care Medicine of Australia and New Zealand (CICM)	Royal Australian and New Zealand College of Radiologists (RANZCR)
Royal Australasian College of Medical Administrators (RACMA)	Royal College of Pathologists of Australasia (RCPA)
Royal Australasian College of Physicians (RACP)	
Government	
Department of Health and Aged Care (Federal)	Government of South Australia
Government of New South Wales	Government of Tasmania
Government of the Northern Territory	Government of Victoria
Government of Queensland	Government of Western Australia
Peak bodies and representative groups	

Aboriginal Health & Medical Research Council (AHMRC) NSW	Australia Rheumatology Association (ARA)
Aboriginal Health and Community Services (ACT)	Australian College of Rural and Remote Medicine (ACRRM)
Aboriginal Health Council of SA (AHCSA)	Australian Medical Association (AMA)
Aboriginal Health Council of Western Australia (AHCWA)	Australian Medical Council (AMC)
Aboriginal Health Service Tasmania (AHST)	Australian Medical Students' Association (AMSA)
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	Council of Rural Doctors Committee
Australian Indigenous Doctors' Association (AIDA)	National Rural Health Alliance (NRHA)
National Aboriginal Community Controlled Health Organisation (NACCHO)	National Rural Health Commissioner
Queensland Aboriginal and Islander Health Council (QAIHC)	Public Pathology
	Rural Doctors Association of Australia (RDAA)
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	Rural Doctors Association of Australia Rural Specialists Group
Winnunga Nimmityjah (Strong Health)	The Council of Presidents of Medical Colleges (CMPC)

Survey respondents

Specialist trainee and Fellow survey

The survey received 812 responses from medical trainees (n= 212) and specialist Fellows (n=600). All 13 Colleges were represented in the responses. The Colleges with the highest number of responses were RANZCP (n=243), RACP (n=147) and RCPA (n=128).

Settings survey

A total of 134 survey responses were received. Ninety-three per cent of survey respondents reported having visibility of the STP within their organisation. Seventy-nine per cent of respondents had been working at the setting for more than three years; 95.5 per cent had been at the setting for more than a year.

Stage 3: Validation sessions

Colleges

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

Government

Stage 3: Validation sessions

Department of Health and Aged Care (Federal)	Government of Tasmania
Government of New South Wales	Government of Victoria
Government of the Northern Territory	Government of Western Australia
Government of Queensland	

Peak bodies and representative groups

Aboriginal Health Council of SA (AHCSA)	Australian College of Rural and Remote Medicine (ACRRM)
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	Australian Medical Association (AMA)
Australian Indigenous Doctors' Association (AIDA)	Australian Medical Council (AMC)
	Australia Rheumatology Association (ARA)
National Aboriginal Community Controlled Health Organisation (NACCHO)	Medical Deans of Australia and New Zealand
Queensland Aboriginal and Islander Health Council (QAIHC)	National Rural Health Alliance (NRHA)
	Public Pathology
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	Rural Doctors Association of Australia (RDAA)

Survey respondents

Medical Officers	Training Settings

Key consultation themes

Key consultation themes

Several key themes emerged during consultation sessions across the course of the evaluation. These are summarised at a high level below and grouped by stakeholder type.

Effectiveness in funding expanded settings

Private and expanded non-hospital settings are not a key issue within STP. No stakeholder group shared significant complaints about this aspect of the program. It was noted that, for some specialties predominantly practicing in private settings, STP funds a substantial proportion of total trainee positions.

Effectiveness in enhancing the rural and remote specialist workforce rural regional

As per the program intent, STP is an important tool in correcting the maldistribution of the medical specialist workforce in Australia. There is a firm belief among Colleges that STP has helped upskill the rural specialist workforce and driven accreditation of more rural training sites. In their view, it is also the only direct mechanism available to Colleges to address workforce maldistribution. However, despite the STP, stakeholder groups agreed the capability and capacity of the specialist medical workforce in rural and regional Australia has not improved.

Health peaks questioned how rural areas are classified, particularly the coherency of grouping MM2-7. MM2 locations, such as Hobart or Townsville, can support a full suite of specialists and provide most types of training. However, MM3-6 towns offer narrower training opportunities and have different workforce needs, for example requiring a more generalist specialist workforce to best service the rural caseload.

All stakeholders acknowledged STP faces multiple challenges in attracting and retaining specialist trainees in rural areas. Colleges cited factors such as family ties, access to equipment and supervisors and a perceived 'prestige' bias which draws trainees to metropolitan hospitals. In a similar vein, medical officers believe trainees are afraid of losing skills, or 'missing out' if they undertake a rural rotation. Jurisdictions noted that, once training is completed, widespread vacancies mean new Fellows have the choice to work anywhere. When given the option, Fellows overwhelmingly choose to practice in major cities.

Effectiveness in increasing the number of First Nations medical specialists

For most stakeholders, increasing the First Nations medical specialist workforce through the STP was not a primary focus, relative to other outcomes such as expanded settings and the rural and regional workforce. Most support for First Nations outcomes occurs through STP support projects or inadvertently through pursuing other program objectives.

State-based community-controlled organisations did not believe the STP catered appropriately for Indigenous health settings. This was primarily associated with inflexible recruitment, the gap between STP funding and trainee wages, the administrative burden and a lack of cultural safety training.

Community-controlled organisations reported having limited relationships with Colleges, jurisdictions and the Commonwealth.

Efficiency of administration and program costs

Colleges believe they are best placed to continue leading program delivery because they have superior knowledge about their speciality workforce and have experience selecting and accrediting suitable settings. However, engaging and working across the breadth of 13 different Colleges can be challenging for the Commonwealth and training settings. Colleges request data in different formats and at different cadences from training settings, which increases the reporting burden for settings. In some cases, the consultation showed that some Colleges have required appeasement through ad hoc deals outside STP agreements in order to meet their needs.

The relationship between Colleges and jurisdictions is minimal and transactional. The role of jurisdictions is primarily limited to reviewing placements, progress reports and new site approvals. For individual training settings, the relationship with Colleges is generally restricted to invoicing, reporting and accreditation requirements. Jurisdictions advocate for more involvement in STP, however, they also believe private sector funding is the Commonwealth's responsibility. Jurisdictions are therefore primarily interested in the public health components of the STP.

Stakeholders were generally unable to provide an assessment of the overall cost-efficiency of the STP. Colleges reported having no visibility of the administration and cost of specialist training outside STP. Jurisdictions generally reported they would be unable to fund most of the training positions currently funded by the STP, indicating that, without the STP, total trainee numbers across Australia would be likely to decline.

Administratively, stakeholders at both ends of the process see the STP as complex and burdensome. For Colleges, staffing is the primary cost, with most time spent on reporting and financial management. Several Colleges reported the cost of administering the STP is higher than the administration funding provided by the Commonwealth. Medical officers overseeing trainees (supervisors) explained the administration is quite burdensome for settings in small practices without administrative teams. Private settings also reported having difficulty receiving their funding from a public setting when a trainee resource is shared.

There is also confusion and frustration around program timelines and funding rules. Administratively, STP funding may not be guaranteed until after recruitment rounds have begun, inhibiting recruitment efforts. Eligible uses for PICS and RSL are not well understood, leading to uncertainty for trainees, supervisors and health settings.

FATES

All stakeholder groups were specifically asked about the FATES program. While noting it was early days for FATES delivery, jurisdictions, and health peaks were generally positive, particularly regarding its ability to encourage collaboration between Colleges.

Colleges were more mixed in their assessment of FATES. Seven of the 13 Colleges said the program was yielding significant results. However, others cited a lack of transparency regarding what other Colleges are doing, leading to duplication of effort.

Application windows, administrative burden and continuity of funding were consistently raised as issues. It can also be difficult to find a College to lead consortia projects. Jurisdictions expressed frustration because they believe they are left with the onus of funding projects in the long-term, however have limited input into which projects are initiated.

Colleges generally did not support merging FATES and STP support project funding. In their view, these changes would come with risks, such as reducing the Colleges' ability to fund programs that improve trainee experiences in regional areas and by increasing the level of funding uncertainty, which already complicates College planning processes.

Sustainability/improvements to the program

Across the consultation mediums, there was strong engagement regarding the potential to improve the STP. Generally, this reflected a broad agreement about the importance and potential of the STP and a desire to ensure its long-term sustainability and efficacy. Dissatisfaction with the program was primarily limited to inefficiencies, lack of transparency and sub-optimal implementation, rather than disagreement about the program aims or its overall rationale. Stakeholders stressed changes to the program should be carefully considered, flexible and appropriately nuanced to account for the unique aspects of each College and speciality.

Effectiveness in funding expanded settings

The importance of STP in facilitating training in private settings was relatively uncontroversial, particularly for specialities that primarily work in the private sector. Stakeholders were asked to consider whether STP funding in expanded settings could be restricted to private-setting focussed specialities. While this may work for some specialties, it was viewed to potentially create bottlenecks in the training pathway. For example, trainee anaesthetists must undertake a neurosurgery rotation. These cases are predominantly found in private settings. As such, even though anaesthetists were generally not considered a private setting focussed specialty, by limiting STP funding for anaesthetists to the public sector, anaesthetist trainees may not be able access the necessary cases to complete their training in a timely manner.

Effectiveness in increasing the number of First Nations medical specialists

The magnitude of suggested changes was greatest in relation to Indigenous outcomes, where it was generally recognised the STP needed to do more, including in relation to data collection, sustained cultural safety training and Indigenous consultation and co-design. Stakeholders believed it was premature to mandate a certain number of Indigenous STP trainees, or a particular allotment of trainees to the Community Controlled sector (which is not equipped to supervise most specialty types). Addressing other issues in the program, such as

financial support, administrative burden and the distribution of trainees, is more likely to improve Indigenous health outcomes than a focus on position numbers in the short term. Longer-term, more consideration is required about how the STP can address this outcome or whether the outcome is appropriate for the program.

Effectiveness in enhancing the rural and remote specialist workforce

Most stakeholders acknowledged the need for, and challenge of, rural and regional training. However, this did not translate into consensus regarding actions that would encourage more trainees to choose to train, and later practice, outside of metropolitan areas. For example, while longer placements were generally believed to result in greater retention in regional areas, requiring longer placements (e.g. 12 months) was opposed by some stakeholders on the grounds it would make it more difficult to recruit trainees. Similarly, many non-metropolitan settings don't have the facilities or caseload to sustain 12-month placements.

It should be noted that the general caution about stronger rules in relation to rural and regional placements was not shared by regional health settings, who overwhelmingly reported being outcompeted for trainees by metropolitan centres. They expressed a strong opinion that more should be done to increase MM2-7 positions, including increasing the expectations on Colleges to ensure trainees and Fellows practice outside of MM1 regions.

Suggestions with the broadest agreement included improving training facilities/opportunities in non-metropolitan areas, preferencing trainees with rural and regional backgrounds for STP positions, supporting rural and regional trainees to become embedded in the community, increasing the financial incentives and ensuring supervisors are available/supported so they can provide a positive training experience.

Efficiency of administration and program costs

Financial support and administration burden

Most stakeholders were concerned about the growing gap between STP funding and trainee salaries. If the gap is not reduced, participation in the program may become limited to larger hospitals which can cover the additional cost. Jurisdictions are also concerned because they are covering an increasing share of funding for each trainee.

Similarly, financial support for supervisors is limited and is likely to discourage participation from smaller settings.

Administration burden also has the potential to limit program participation. Some stakeholders believe the administration burden should be reduced through actions such as reduced reporting frequency, uniform reporting requirements and automation.

Data

All stakeholders agreed data could be used to better inform decisions and evaluate program efficacy. There is no quantifiable standard on what represents adequate trainee and specialist employment numbers in a particular location. Without a benchmark or target, decisions about which type of trainees should be funded by the Commonwealth or College, or about where to place trainees, are difficult to understand. In the absence of robust workforce modelling, Colleges use informal networks which are opaque to other stakeholders.

Similarly, no data is collected about the demographics of STP trainees, their training experience, and subsequent practice location decisions. This inhibits stakeholder understanding of who is participating in the STP, the quality of their experience and STP participant retention rates in private or rural and regional settings. This also impacts the ability for the Commonwealth to best apply funds by understanding the need, and future areas of under, or oversupply of trainees.

Transparency/collaboration

While Colleges were generally happy with the level of collaboration and transparency, jurisdictions and health peaks believe the cohesion between the Colleges could be improved. Colleges are generally believed to represent the interests of their specialities, rather than the health system overall. Jurisdictions and health peak bodies believe they could bring a more objective lens to positions and placements if they were provided with more access to information about the program and consulted about the allocation of trainee positions between Colleges and in the placement of trainees.

Specialist trainee and Fellows survey outcomes summary

Specialist trainee and Fellows survey outcomes summary

Survey participant overview

Proximity designed an online survey to be completed by medical specialist trainees and College Fellows. The survey was distributed to trainees and Fellows as a link by the specialist medical Colleges (Colleges) through a routine newsletter or via a custom email. The survey took approximately 10 minutes to complete. No incentives were offered for participation.

The survey received 812 responses from medical trainees (n= 212) and specialist Fellows (n=600). All 13 Colleges were represented in the responses. The Colleges with the highest number of responses were RANZCP (n=243), RACP (n=147) and RCPA (n=128).

Relationship between upbringing and rural intentions

Several questions asked about respondent upbringings, current place of residence and future practice intention. The goal of these questions was to understand the association between where a respondent "grew up", and their intention (trainees) or decision (Fellows) on where to live and practice.[106]

Impact of metropolitan and regional/rural background on current place of residence

Respondents that grew up in a metropolitan location were more likely to be currently residing in a metropolitan area than respondents with a rural background. For example, 77.2 per cent of respondents with a metropolitan background reported currently residing in an MM1, compared to 59.7 per cent of respondents with a rural background. Respondents with a rural background were twice as likely to reside in an MM2 than respondents with a metropolitan background.

Table 15 - Relationship between current place of residence and where you grew up

| Current residence	Metro Background		Regional/rural Background	
	Count	Share of responses	Count	Share of responses
MM1	363	77.4%	158	60.5%
MM2	72	15.4%	81	31.0%
MM3	16	3.4%	14	5.4%
MM4	10	2.1%	5	1.9%
MM5	7	1.5%	3	1.1%
MM6	1	0.2%	0	0%
MM7	0	0%	0	0%

Impact of metropolitan and regional/rural background on further practice intentions

Amongst trainees, background was closely correlated with future practice location intentions. Most trainees with a rural background intended to practice outside metropolitan areas (66.2 per cent), whereas trainees with a metropolitan upbringing have considerably more interest in a career in a major city (75.8 per cent). This aligns closely with the Medical Schools Outcomes Database report, which surveys final-year medical students at university. In 2024, it found 79.6 per cent of students with a metropolitan background intended to practice in a

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[106] The Modified Monash Model was used to classify location. This analysis is imperfect, as interpretation of the Monash Model is unlikely to be consistent across respondents. However, in most cases, responses could be interpreted with a high-degree of confidence. See Department of Health and Aged Care, 2023. 'Modified Monash Model', <www.health.gov.au/topics/rural-health-workforce/classifications/mmm>

metropolitan location. Conversely, only 35.7 per cent of rural-background students intended to practice in a metropolitan location.[107]

Figure 13 - Trainee place of upbringing and intended future practice location

Specialist trainee place of upbringing and intended practice location

n=191 (Metro background=120, rural background=71)
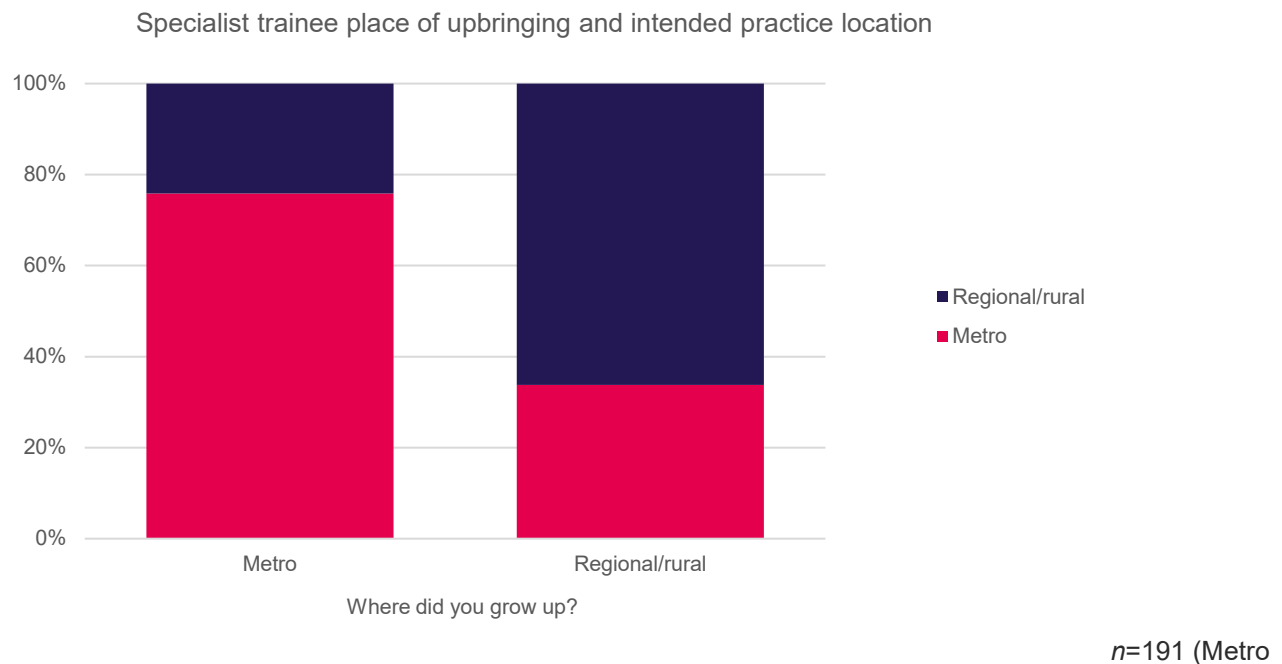
Source: Specialist trainee and Fellows survey

Just under half of the respondents (42.7 per cent) were born outside of Australia. The most common non-Australian birth countries were the UK (6.1 per cent), India (3.9 per cent) and Malaysia (3.5 per cent). Country of birth was not a strong predictor of future practice location intention.

Trainee decision making: The role of rural rotations and other factors

Impact of undertaking regional or rural training on future practice intentions

Most (78.5 per cent) trainees reported undertaking a regional or rural placement as part of their training. Two-thirds (65.9 per cent) had undertaken two or more regional or rural placements. For some of these trainees (37.9 per cent), regional/rural training was mandatory, however most (62.1 per cent) chose to undertake their non-metropolitan rotation/s.

The impact of undertaking a regional/rural placement on future practice location was mixed. For 45.9 per cent of trainees, the rotation had a positive impact on their intention to practice outside of an MM1 location. For others (9.8 per cent) the experience was positive, however they did not believe practicing rural was practical, generally due to their family situation. For 29.5 per cent of trainees the experience was either negative (22.1 per cent) or mixed (7.4 per cent).

Elective rotations were more likely to have a positive impact (52 per cent) on a trainee's view of practicing in a regional or rural location than mandatory rotations (36.2 per cent). Negative experiences were more likely to occur in mandatory rotations.

Table 16 - Impact of regional/rural placement on future practice intention by placement type (mandatory or voluntary)

	Mandatory Rotation		Elective Rotation	
Impact of rural placement	Count	Share of responses	Count	Share of responses

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[107] Medical Deans Australia and New Zealand, 2024. 'National Data Report 2024', Medical Schools Outcomes Database, <medicaldeans.org.au/md/2024/05/MSOD-National-Data-Report-2024.pdf>

	Mandatory Rotation		Elective Rotation	
Positive	17	36.2%	39	52.0%
Mixed	3	6.4%	6	8.0%
Negative	15	31.9%	12	16.0%
Positive - Impractical	2	4.3%	10	13.3%
Already decided	10	21.3%	8	10.7%
Total	47	100%	75	100%

Trainee: "Absolutely [positive experience on regional placement]. I was challenged to care for complex patients in a resource limited setting and was given more responsibility as a junior than I currently have working in a tertiary hospital. The responsibility forced me to rapidly upskill clinically, and I feel I am a better clinician as a result. The rural intensivists were incredibly inspiring. I joined CICM after this experience with the intention of practicing rurally on completion of my training."

Trainee: "I had a bad experience at one mandatory placement and would not willingly return to that hospital. I had an excellent experience at a subsequent mandatory placement and happily elected to return to that training setting for two further years. This experience brought home to me that the rest of the team and organisational culture have a much larger influence than the regional/remoteness of the site."

Trainee: "I was born, raised and educated in a combination of rural and regional areas. I returned to these areas to complete university medical studies and clinical placements. I then stayed in these areas for my internship and resident years. I left briefly thereafter to experience metropolitan medicine. I returned to these areas again for specialty training."

Trainee: "It did not change my mind; I have always planned to live and work in the city where my family lives."

Impact of the length of placement on future practice location intentions

This survey had two key findings in relation to the impact of placement length on future practice location intentions of specialist trainees:

a) regional/rural placements of any length are associated with an increased intention to practice outside of MM1 regions once qualified; and

b) longer placements are likely to have a greater impact than shorter placements.

From the group of 45 trainees who had never undertaken a placement in an MM2-7 region, only 4 (8.9 per cent) said they intended to practice outside of an MM1 region. Of the 91 trainees who had a longest regional/rural placement length of between one month and 12 months, 25 (27.5 per cent) intended to practice in an MM2-7 region. Of the 75 trainees who had a longest placement of 12 months or more, 51 (68 per cent) said they intended to practice in an MM2-7 region once qualified.

Figure 14 - Relationship between length of regional/rural placement and intended location of future practice

Length of longest regional/ rural placement and intended location of future practice
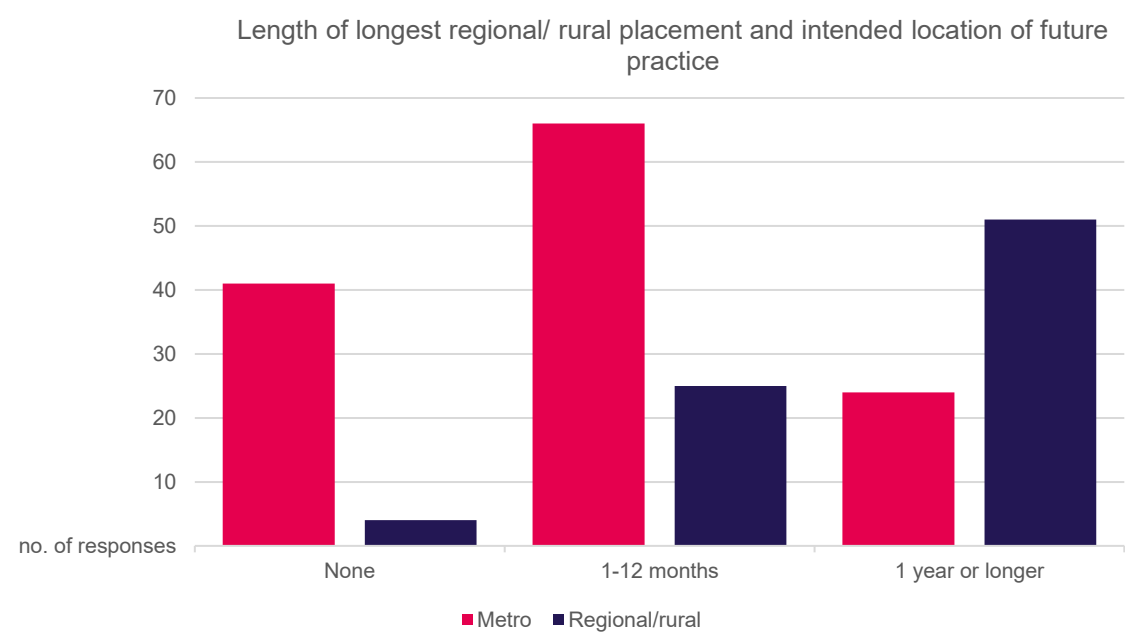
n=211 (none=45, 1-12 months=91, 1 year or longer=75)

Source: Specialist trainee and Fellows survey

Factors influencing trainee practice locations

Both trainees and Fellows were asked what factors most influence trainee decisions about where to practice. For trainees, this was a personal question about their intention to practice in a metropolitan or non-metropolitan region in the future. Fellows were asked to comment on what they *believe* influences the practice location decisions of trainees. Ninety-seven per cent of Fellows had experience supervising trainees, so were well placed to provide insights.

A wide range of responses were received from both trainees and Fellows. Overall, trainees listed factors outside of work as most important in shaping their future practice location intention. These included responses related to family (28.8 percent), such as proximity to parents and the ability of their spouse to find work, lifestyle (10.2 per cent) and an existing connection to the location (8 per cent). Work factors included professional development (13.3 per cent) and job availability (10.6 per cent). Only one trainee nominated 'salary' as an important factor.

Fellows placed greater emphasis on work-related factors. This included a higher proportion of responses citing professional development (19.6 per cent), job availability (13.9 per cent), prior experience (6 per cent) and salary (5.3 per cent). While still recognised by Fellows, less emphasis was placed on non-work categories, such as family, community and access to services.

Figure 15 Factors reportedly influencing trainee future practice location intentions

Factors trainees report impact their future practice location intentions

29%

71%
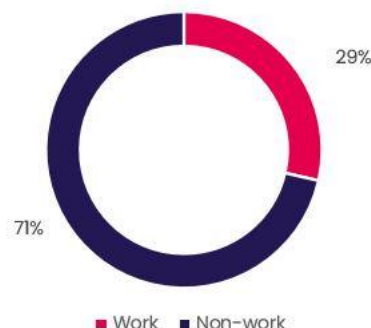
■ Work ■ Non-work

Factors Fellows belive impact trainee future practice location intentions

46%

54%
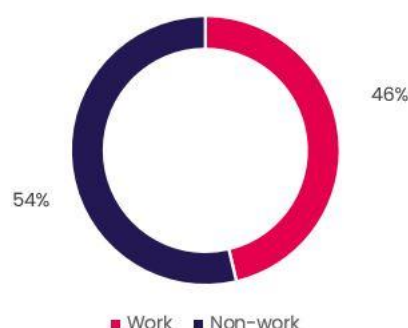
■ Work ■ Non-work

Trainees: *n*=175 (work=50, non-work=125)

Fellows: *n*=566 (work=262, non-work=304)

Source: Specialist trainee and Fellows survey

Trainee: "[I want a] simpler lifestyle. Avoiding unnecessary traffic and access to nature."

Trainee: "My life and relationships are already set up firmly within Sydney. By the time I finish training I will be 37."

Fellow: "We need to encourage junior doctors to experience (and hopefully enjoy) living and working in regional/rural areas, but importantly continue to ensure job security and opportunities for Staff Specialists. Many new Fellows who have trained regionally and have cultivated an interest in continuing to work regionally as a consultant are provided no job security due to lack of funding for permanent positions."

Fellow: "Lifestyle factors, marriages/partnerships, partner's work place, childcare, school opportunities for children and the work-life balance that a particular specialization offers are all important."

Factors influencing choice of medical speciality

All respondents were asked what factor was most important in choosing their current (Fellows) or intended future (trainees) speciality. Responses were relatively consistent across both groups, with some interesting distinctions. The most common response related to the variety and scope of the work, followed by a general interest in the area scientifically and medically. Prestige and professional recognition and salary were more important to trainees. Work-life balance was slightly more important for Fellows than trainees.

Figure 12 - Primary reason for choosing current or intended future specialty, trainees and Fellows

Primary reason for interest in specialty (current or intended future)
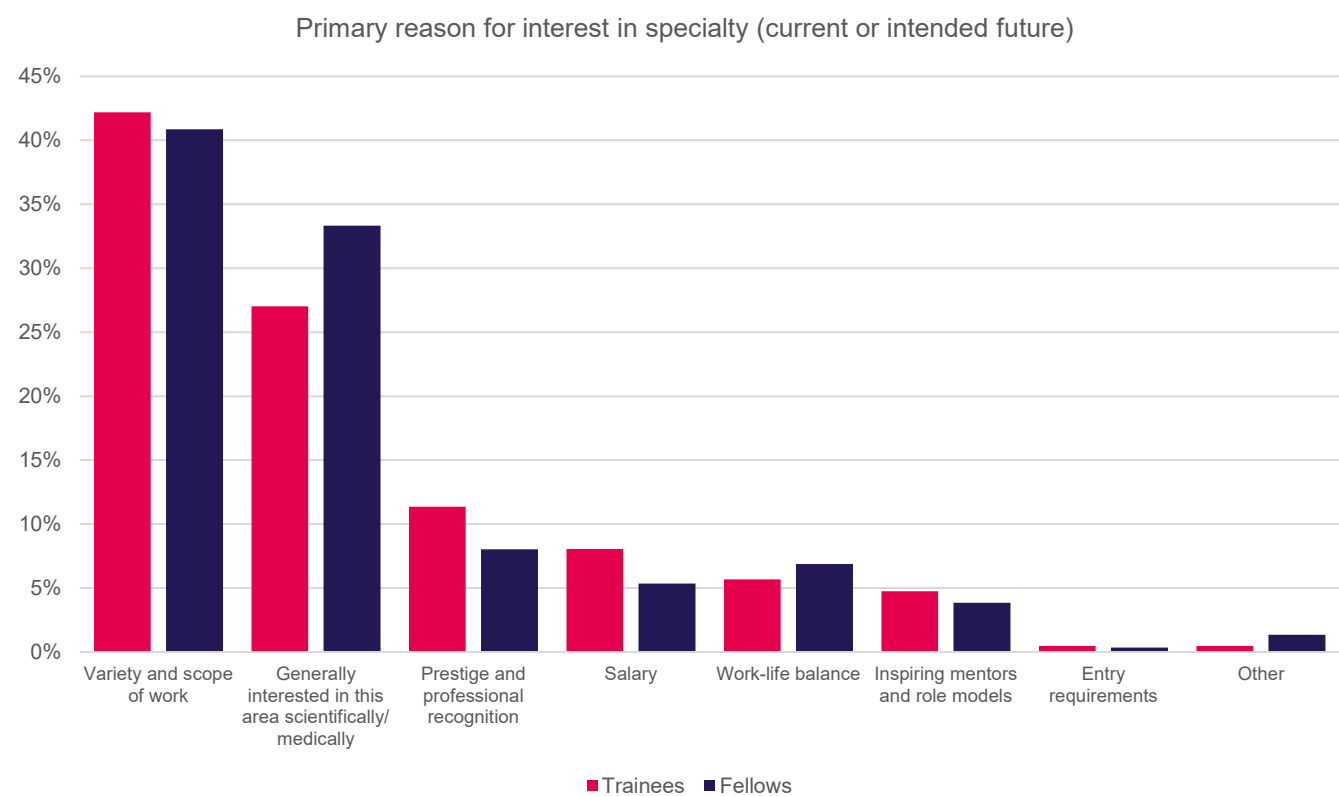
n=808, variety=333, generally interested=256, prestige=72, salary=49, work-life balance=53, inspiring mentors=33, entry=3, other=9

Source: Specialist trainee and Fellow survey

Conclusion

This survey supported previous research in finding:

c) Rural and regional placements increase the likelihood that a trainee will intend to practice outside of a metropolitan area once qualified. However, the quality of the experience matters.[108,109] For 22.6 per cent of trainees, their regional/rural placement reduced their likelihood of practicing regionally/rurally in the future.

d) Where people grow up is an important predictor of where their place of practice will be. Trainees who grew up in metropolitan areas were much less likely to intend to practice outside of a metropolitan area.[110]

e) Placement length matters. Respondents who spent 12 months or more in a regional/rural placement were much more likely to intend to practice outside of a major city. Shorter placements had an impact, however it was much smaller.[111,112]

There was a slight divergence between trainees and Fellows when asked what factors impact trainees future place of practice intentions. For trainees, factors outside of work accounted for 71 per cent of responses.

[108] Malhi, RL, Ornstein, J and Myrhe, D 2017, 'The impact of rural rotations on urban based postgraduate learners: A literature review', *Medical Teacher*, vol. 41, pp. 830-838.

[109] Brodribb, W, Zadoroznyj, M and Martin, B 2016, 'How do rural placements affect urban-based Australian junior doctors' perceptions of working in a rural area?', *Australian Health Review*, vol.40, pp. 655-660.

[110] Kondalsamy-Chennakesavan, S, Ranmuthugala, G and Darshan, D 2015, 'Determinants of rural practice: positive interaction between rural background and rural undergraduate training', *Medical Journal of Australia*, vol. 202, pp. 41-45.

[111] O'Sullivan, BG, McGrail, MR 2020, 'Effective dimensions of rural undergraduate training and the value of training policies for encouraging rural work', *Medical Education*, vol. 54(4), pp. 364-374.

[112] McGrail, RM, Gurney, R, Fox, J, Martin, P, Eley, D, Nasir, B and Kondalsamy-Chennakesavan, S 2023, 'Rural medical workforce pathways: exploring the importance of postgraduation rural training time', Human Resources for Health, vol. 21, 31.

Fellows placed greater emphasis on work-related factors, though still believe non-work factors were the most important.

Settings survey summary

Settings survey summary

Survey participant overview

Proximity designed an online survey to be completed by health facilities (settings) that have hosted an STP trainee (currently or in the past). The survey was emailed to settings by the specialist medical colleges (Colleges). The survey took approximately 10 minutes to complete. No incentives were offered for participation.

A total of 134 survey responses were received. Ninety-three per cent of survey respondents reported having visibility of the STP within their organisation. Seventy-nine per cent of respondents had been working at the setting for more than three years; 95.5 per cent had been at the setting for more than a year.

Location and setting type of responses

Responses were received from settings in all states and territories across MM1, MM2 and MM3 regions.[113] Two responses were received from MM4. Several settings reported multiple locations, including where the setting had multiple practices or serviced a broader region for a central location.

Table 17 - Setting survey responses by state and territory jurisdiction and MM region

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	MM total
MM1	1	24		5	3	6	11	7	57
MM2		9	1	20		1	13	4	48
MM3		14	2	1	1		7	2	27
MM4		1						1	2
Jurisdiction total	1	48	3	26	4	7	31	14	134

Responses were received from public (59.7 per cent) and private (33.6 per cent) settings. A small proportion of settings reported being both public and private or were community controlled. One response was received from a regional training hub. The low number of responses from community controlled and regional training hubs reduces the likelihood that these responses are generalizable to this setting type.

Table 18 - Setting survey responses by setting type

|	Total responses	Share of responses
Public	80	59.7%
Private	45	33.6%
Both public and private	6	4.5%
Community controlled	2	1.5%
Regional training hub	1	0.7%

Ease of engaging trainees and supervisors

Engaging trainees

Half of all settings reported having difficulty securing trainees. The strongest predictor of difficulty securing trainees was MM region. Sixty-three per cent of respondents working in MM2-4 based settings reported their

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[113] The Modified Monash Model was used to classify location. See Australian Government Department of Health, Modified Monash Model.

organisation had difficulty securing specialist trainees, compared to 33.7 per cent of respondents in MM1 settings. Difficulty securing trainees increased as remoteness increased.

Figure 13 - Share of respondents reporting that their organisation has difficulty securing specialist trainees

Share of respondents reporting their organisation has difficulty securing specialist trainees
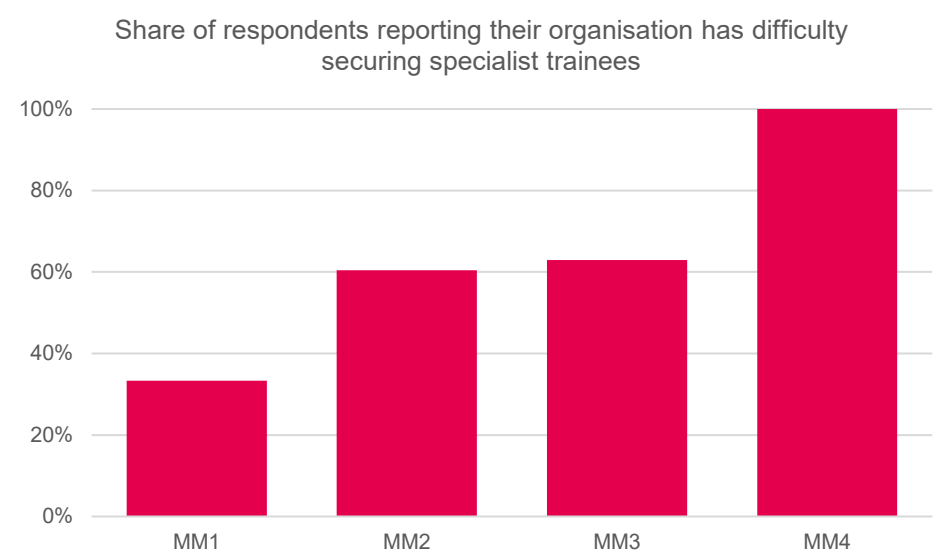
n=134 (MM1=57, MM2=48, MM3=27, MM4=2).

Source: Setting survey

Public settings (56.9 per cent) were more likely than private settings (37.8 per cent) to report having difficulty securing trainees. However, this difference largely disappeared when practice location was considered. This indicates the location of a setting has a greater impact on trainee recruitment than a setting's public or private funding model.

Figure 18 - Share of public setting respondents reporting that their organisation has difficulty securing specialist trainees

Share of public setting respondents reporting their organisation has difficulty securing specialist trainees

■Yes ■No
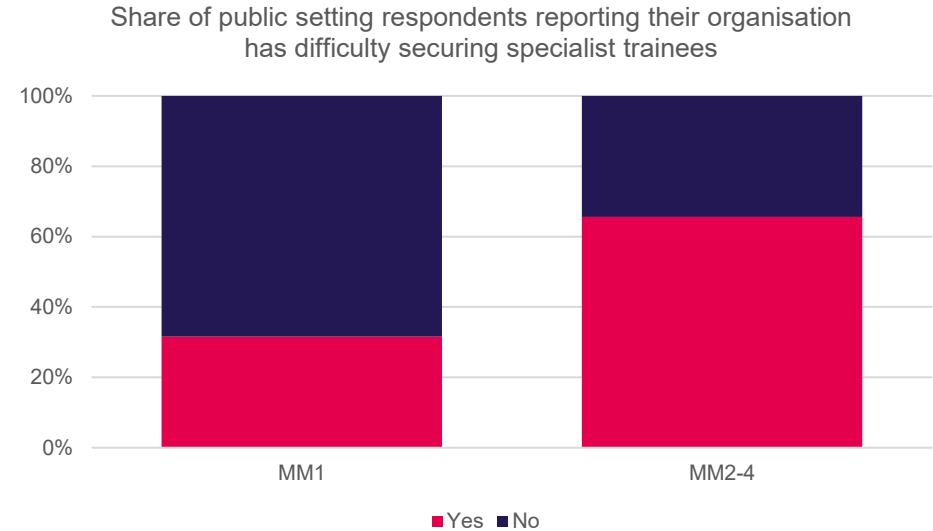
n=80 (MM1=19, MM2=61)

Source: Setting survey

For MM2-4 settings, competition with metropolitan hospitals was the most common reason reported for trainee recruitment difficulty (n=24). Respondents believed trainees generally preferred to train in metropolitan settings because of the real or perceived lack of career opportunities outside of MM1 and the impact of relocation on the trainee's family. This was supported by testimony from some MM2-4 settings noting the number of trainee positions regularly exceeds the number of applicants and recruitment cycles are often lengthy.

These challenges were compounded in some instances by difficulty gaining training accreditation or a lack of encouragement/requirement from some Colleges for trainees to work outside of MM1 areas.

> MM2 Regional Training Hub: "Insufficient regional anchored training pathways that provide extensive regional training means we lose trainees to metro areas at critical stages of their life and training."
>
> MM3 Public setting: "We have rotations from an urban hospital, but when trainees are scarce, the urban hospital keeps the trainees to maintain their numbers."

Some respondents reported the self-fulfilling nature of recruiting difficulties, where a lack a trainees creates workload issues, further compounding recruitment challenges.

> MM2 Public setting: All areas have a shortage of trainees at present. Post-COVID, many don't want to move to Tasmania, or work fulltime. We often have difficulty filling all our trainee positions and maintaining safe hours and attractive positions as a result."

Engaging supervisors

Settings reported lower rates of difficulty securing trainee supervisors than trainees. Seventy-nine per cent of settings reported they did not have difficulty securing supervisors. MM2-4 locations were the most likely to report difficulty securing supervisors for trainees.

Figure 19 - Share of respondents reporting their organisation has difficulty securing supervisors for specialist trainees

Share of respondents reporting their organisation has difficulty securing supervisors for specialist trainees
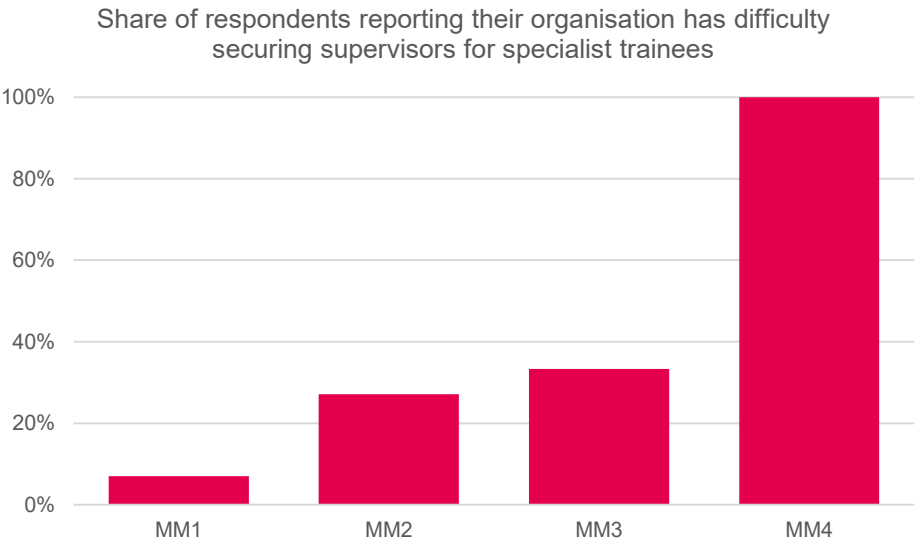
n=28 (MM1=4, MM2=13, MM3=9, MM4=2)

Source: Setting survey

Like trainees, supervisors are generally believed to find non-metropolitan locations less attractive to practice in. This leads to a general lack of consultants, challenges filling vacant consultant positions and reduces the availability of supervisors for potential trainee placements.

> MM3 Public setting: "Many of our specialties are very locum-dependent. It's a vicious cycle; if trainees are not encouraged and supported to try a rural lifestyle, getting them to return as senior clinicians is difficult."

Smaller, regional locations reported the greatest difficulty, where workloads are high and consultants may only be present on part-time basis.

> MM4 Private setting: "I am a solo practitioner in rural area, I tried for over 10 years to advertise a position for a specialist to join but unsuccessfully. Rural areas seem to be less attractive to the young generation of specialists. I trained 16 registrars in the past 10 years, but none decided to settle in the rural area, they all settled in metropolitan areas."

STP funding arrangements

When asked about potential improvements to STP funding arrangements, the most common response (n=27) from settings related to reducing the gap between trainee salaries/costs and the funding received. Sixteen respondents believed the administration burden should be reduced, or the administration effort financially compensated. A further 16 settings believed STP funding should do more to direct trainees into regional areas. Recruitment was also a major concern, both in relation to the potential for positions to be lost if recruitment was unsuccessful and the timing differences between STP recruitment and clinical cycles.

Twenty-two respondents did not suggest changes because they were satisfied with the current arrangements.

Table 19 - Funding arrangement improvement suggestion categories

Funding arrangement improvement suggestion	Total responses	Share of responses
Reduce salary shortfall	27	21.3%
No improvements	22	17.3%
Reduce and or compensate administration	16	12.6%
Greater regional focus	16	12.6%
Improve flexibility, stability and timing of funding	12	9.4%
Recruitment assistance	12	9.4%
Increase the number of positions	9	7.1%
Improve College relationship	4	7.1%
Other	9	3.1%

n=127

Funding shortfall, stability and timing

The growing gap between trainee salaries and STP funding was the most common concern for respondents. Feedback from settings suggest STP is generally covering 70 per cent of salaries, leaving settings with an additional $30,000–$40,000 or more in salary costs per STP trainee, plus additional administration expenses. Settings underscored that the shortfall was increasing because STP funding had not kept pace with wage rises.

MM1 Private setting: "The funding for both the trainee and the supervisors has not changed in approximately 10 years. The hospital administration is now impacted significantly from a $$$ point of view and are increasingly frustrated."

MM1 Public setting (respondent also has regional and private experience): "Short fall in funding is definitely a concern, with at least 30% of registrar salary needing to be subsidised, not to mention the on-costs and additional management expenses"

Some respondents noted this gap was particularly pronounced in regional settings, which might require flights or incur relocation costs.

MM3 Community Controlled setting: "[Funding] needs to reflect the reality of the extra costs associated with remote placements: provision of accommodation, flights (expensive ones)."

Smaller, private practices also noted the difficulty they had in finding the additional funding to cover STP. These challenges are compounded because payment is made in arrears.

> MM1 Private "Our practice has to subsidize the registrar and depending on their grade and experience the STP funding can lead to a significant shortfall. As a private practice we should not be asked to subsidize what is essentially a government responsibility."
>
> MM1 Private setting: "It may not be financially viable for private groups to continue to subsidise [the cost of a trainee]. This is the main short-coming of the [STP] scheme."

Funding stability and timing was also a common concern. Settings were anxious to establish the status of the funding for beyond 2025 to ensure they can recruit. Similarly, settings suggested payments be made up front, or in regular instalments, rather than in arears.

> MM1 Private setting; "Remuneration is insufficient, as it:
>
> 1. covers less than half the cost of a trainee seconded from the WA Health Service; and
>
> 2. is paid in arrears, so the service must cover the salary (plus oncosts) for 6-7 months, affecting cash-flow in a small clinic."

Funding does not account for recruitment challenges and recruitment schedules

The challenge of recruiting trainees and specialists was common throughout the responses to all survey questions, particularly in MM2-4 settings. In relation to the funding structure, five MM3 respondents, said the potential for positions to be lost if left unfilled does not properly consider how difficult it can be to recruit in regional areas. They saw this requirement as favouring larger population centres, which can more easily fill positions. They believe regional settings should be given more leniency before funding is lost. It should be noted these settings were concerned about the potential to lose positions; they did not state funding had actually been lost.

Misalignment between funding and recruitment cycles and trainee qualification progression was also an area of suggested improvement. For some settings, trainees may become qualified during a posting, making them ineligible for STP funding. For others, STP funding announcements occur too close to the registrar intake period, meaning recruitment has largely concluded before STP funding has been confirmed.

> MM3 Public setting: "STP funding arrangements don't take into account the difficulties faced with recruitment. When a position is not filled, we face imminent risk of STP funding being lost. This means that if a suitable candidate comes up later, we miss out on the opportunity. The system perversely favours metropolitan and outer metropolitan centres with STP funding."
>
> MM3 Public setting: "More leniency for vacancies. We try so hard every year to secure a trainee, and whilst we have managed to scrape by at the last minute, it's very likely one year we will miss out. I don't think it is reasonable to punish our rural community (who are the ones who will suffer the most) if we have recruited successfully for 10 years, and then miss out on the 11th year and lose our position altogether."

## STP administrative effort and administrative roles

Administrative effort

Most (95) respondents believe the administrative effort associated with the STP was appropriate or acceptable. This high figure is somewhat at odds with the feedback received in other consultations undertaken during this evaluation and may be partially explained by:

1. Respondents to the survey currently host STP trainees. These settings have already decided the benefit of hosting an STP trainee is sufficient to offset the administration burden.

2. Respondents were typically not responsible for administrative duties, and therefore noted a general level of satisfaction while stating they were not across all aspects of the work.

Figure 20 - Appropriateness of STP administrative effort

In your view, is the administrative effort associated with STP appropriate?

Unacceptable
23%

Appropriate/
acceptable
77%
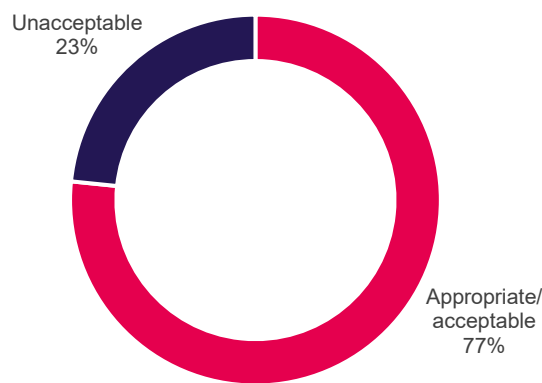
n=126 (Appropriate/acceptable=95, Unacceptable=29)

Source: Setting survey

> MM2 Public setting: "There needs to be accountability. Fortunately, it's not my role to administer the position, it belongs to the medical admin manager."
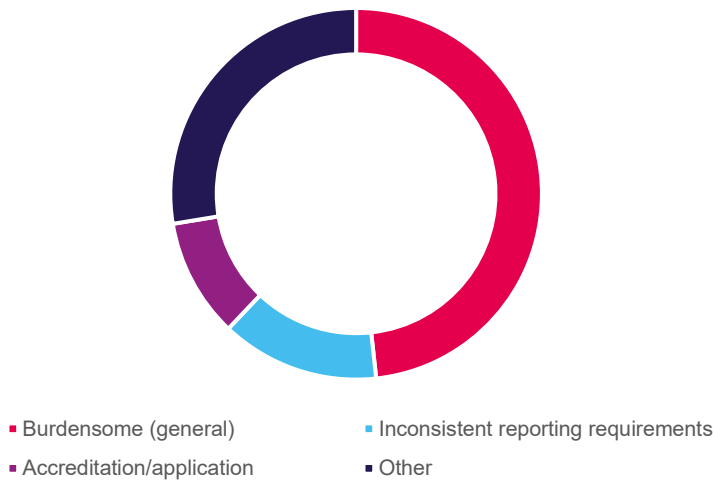>
> MM3 Public setting: "Yes, it's worth it. Without STP funded trainees, we wouldn't be able to service the oncology needs of our community."

For the 27 per cent of respondents who reported administration was burdensome, the accreditation and application process was the most common area of concern. The frequency of reporting, differing expectations across the Colleges and the "clunky" online portal were also raised.

There was no overall difference in the rate of acceptable/unacceptable administrative efforts across MMs or setting types. However, PICS funding was raised by private settings in response to several questions. Private facilities with less administrative staff find the time taken to claim PICS through hospital finance departments challenging. They would like to see this funding provided directly to the private facility.

Figure 14 - Most common reasons cited for inappropriate administration effort

Admin efffort is unacceptable - Response breakdown

- Burdensome (general)
- Inconsistent reporting requirements
- Accreditation/application
- Other

n=29. Burdensome (general)=14, Inconsistent reporting requirements=4, Accreditation/application is onerous=3, other issue=8

MM1 Public setting (respondent also has regional and private experience): "Speaking personally, writing the initial application required several hours. Co-ordinating various private settings and hospitals also needs further attention. Finally, dedicated admin staff are essential for ensuring the contract/payroll/insurance etc continues. While this is not unreasonable, it is impossible to budget within the current funding."

MM4 Private setting: "I have been chasing for my PICs to be paid for 5 months. It has been a time consuming exercise to get part of my funding."

Administrative roles and responsibilities

Most respondents reported administrative roles and responsibilities for STP were appropriate (86.3%) or acceptable (4.3%). Negative responses (9.4%) tended to cite the overall administrative burden of the program, particularly for small practices. The relationship between public and private settings can also be complex, particularly where the private setting claims funds from the public hospital (e.g. RSL and PICS) or where a trainee resource is shared across settings.

Table 20 - Respondent views on the appropriateness of administrative roles and responsibilities

	Responses	Share of responses
Appropriate	101	86.3%
Acceptable	5	4.3%
Unacceptable	11	9.4%

n=117.

Administrative feedback for Colleges

When asked to provide feedback regarding College administration of the program, 59.6% of responses provided positive feedback and/or did not suggest any improvements. This included general positive comments about the administration of the STP, and specific comments related to dealings with a particular College.

MM1 Public setting: "I have always found the [College] STP team to be very responsive and supportive. I have always felt that they have kept me up to date with any changes to the program."

MM3 Public setting: "RANZCO provide a well-structured training framework with clear guidelines and milestones for trainees. This structure ensures that trainees meet specific competencies and are prepared for their roles as specialists."

The most common negative feedback topics related to a lack of transparency about placement priorities and College staff churn, which leads to a lack of expertise about STP.

For some settings, the reason trainees are, or aren't, assigned to their facility are opaque. Greater transparency about trainee location decisions by Colleges would help settings to more efficiently apply for positions where they have a greater likelihood of success. While most settings had positive reflections about College staff, some respondents cited staff churn and a general lack of expertise about STP as an issue. For example, some settings said they were required to educate College staff about the STP and that Colleges did not always know what activities where eligible for RSL or PICS funding.

	Responses	Share of responses
Positive feedback and/or no improvements suggested	56	59.6%
Negative feedback topics		

	Responses	Share of responses
Lack of transparency	7	7.4%
Lack of expertise about STP/staff churn	6	6.4%
Lack of communication	5	5.3%
Overly bureaucratic	4	4.3%
Funding issues	3	3.2%
Inconsistency between Colleges	3	3.2%
Overly metro-focused	3	3.2%
Other	7	7.4%

n=94

Source: Setting survey

MM2 Public setting: "Undertaking the application to be placed on a priority list is fairly annoying. Especially when we have no idea what the College is prioritising. It would be helpful if with each round of STP funding, each College can indicate what they are looking for, so the suitable locations can apply and the less suitable positions can save some effort."

Commonwealth activities that could increase the medical specialist workforce practicing outside of metropolitan areas

Respondents provided a broad set of responses when asked what the Commonwealth could do to increase the number of specialists practicing outside of metropolitan areas. Twelve responses simply suggested increased funding for specialists and or trainee positions. Other responses fell into four main categories:

- increase the attractiveness of moving from a metropolitan to a regional area;
- train and keep specialists in regional areas;
- mandate or strongly encouraging regional service by trainees/specialists; and
- improve regional access to metro-based specialists.

Increase the attractiveness of moving from a metropolitan to a regional area

Respondents noted there were financial, reputational and long-term career planning barriers to working regionally. Financial barriers include the additional costs associated with relocating to a regional area. To reduce this barrier, they suggested greater support for trainees and specialists to relocate, particularly in relation to housing, flights (for both trainee/specialist and family) and other travel expenses.

The reputation of regional training and regional practice also impacts specialist and trainee decision making. In many cases, regional work is seen as less prestigious than city-based placements. For trainees, this reputational barrier may be compounded by limited specialist positions in the region, making it difficult for them to envision building a career outside of a metropolitan region.

MM3 Public setting: "Promotion of rural and regional ICU [Intensive Care Unit/s] as an attractive option to live and work rather than being looked down upon and assuming those working outside of metropolitan centres only do so as they are unable or not competent enough to work in a tertiary or quaternary ICU."

Other respondents referred to the overall experience of working regionally which, due to existing staff shortages and reliance on temporary staff, was characterised by high-stress. This creates a "vicious cycle" by driving high turnover and discouraging metro-to-regional career changes.

Train and keep specialists in regional areas

Recognising the difficulty of encouraging specialists and trainees to move out of metropolitan areas, 10 respondents suggested the Commonwealth should focus its efforts on trainees with pre-existing links to regional Australia and on improving access to training in regional areas. In relation to STP, this included encouraging Colleges to select trainees with regional backgrounds. More broadly, it was suggested the Commonwealth could work with state governments to further develop regional training hubs so trainees could be based regionally and undertake metropolitan rotations, rather than the other way around.

> MM3 Public setting: "[Fund] rural medical schools. Encourage those from the country to study in the country and then work in the country. It's very hard to find people from metro areas willing to move to the country to work long term. There needs to be a pipeline starting from even before university. Targeting high schools in regional areas. Or alternatively, offer more significant incentives to move rural."

> MM3 Public setting: "Expanding the Regional Training Hubs program. A lot of funding is spent on bringing medical students to rural regions with the hope they practice rurally. But post-graduation the availability of support to these individuals is greatly diminished."

Mandate regional training/practice

Settings showed a strong appetite for increased regional training and practicing requirements. Most of these responses suggested Colleges should increase their focus on regional areas by requiring regional/rural practice as part of training programs and as part of a Fellow's ongoing registration. It was generally believed longer placements (e.g. 6 months of more) were required to have an impact on trainee/specialist work location choice.

> MM2 Public setting: "Ensure all Colleges have service to the rural community (which makes up a third of the population) firmly on their agenda. This should include targets for RRR [regional, rural and remote] based Fellows and trainees and accreditation guidelines that outline how regional sites can be (appropriately) considered for training."

Improve regional access to metro-based specialists

For some specialities and locations, respondents believe sharing of resources across metro/regional settings would be more effective than incentivising people to move. The most common suggestion was to provide opportunities (and funding for flights/accommodation) for specialists to go on exchange to a regional health setting (and vice-versa) and supporting outreach and fly-in-fly-out models of care. Two psychiatry focussed respondents specifically referred to telehealth, which has enabled them to provide some services at low-cost to non-metropolitan settings.

> MM1 Public setting: "This is a very difficult area. Apart from financial incentives, building links with metropolitan hospitals and practices and having some form of an exchange program may help."

Figure 22 - Setting suggestions for new Commonwealth actions to increase the number of specialists practicing outside of metropolitan locations

What can the Cwth do differently to increase the number of medical specialists practicing outside of metropolitan locations?

- Encourage relocation
- Train and keep
- Mandate regional
- Improve access
- Fund positions
- Other

n=103 (Increase the attractiveness of moving from a metropolitan to a regional area [Encourage relocation]=38, train and keep specialists in regional areas [train and keep]=15, mandate or strongly encouraging regional service [mandate regional]=18, improve regional access to metro-based specialists [improve access], fund more specialists and/or trainees [fund positions]=12, other=5).

Source: Settings survey

Conclusion

Settings were generally positive about the STP, with several commenting on the vital role it plays supporting trainees in their setting.

Recruitment of trainees in non-metropolitan settings was the key issue raised across the responses. Settings believe more should be done in this area through the STP and by Colleges/governments more generally. The growing gap between STP funding and trainee costs was frequently commented upon. The requirement to find additional funding is particularly challenging for smaller practices and potentially limits their participation in STP.

There were high-levels of satisfaction with the STP administrative arrangements though some settings felt administration was overly burdensome. Smaller settings without administration departments are disadvantaged. No setting suggested significant changes to the administrative roles and responsibilities.

Most respondents provided positive feedback regarding the role of the Colleges. Suggestions for improvement ranged from increased transparency regarding trainee funding position decisions, increasing the STP expertise within Colleges, reducing bureaucracy and standardising the reporting requirements across the College cohort.

Settings believe there is more the Commonwealth can do to increase the number of medical specialists practicing outside of metropolitan locations. The most common suggestion was financial incentives. However, many responses recognised this was only part of the solution. Settings believe the overall attractiveness of moving to a non-metropolitan location could be improved and there is scope for increased mandated non-metropolitan training and practice. They also believe more training should be done regionally and more specialist positions should be funded regionally so trainees can continue to practice regionally once qualified.

Appendix 2: Responses to each key evaluation question

The Data Matrix set out below maps the various data sources available to the evaluation questions of interest to the Department.

Evaluation questions	Evaluation response	Data source during this evaluation
Appropriateness: Is the STP (still) the right response?		
1. To what extent, does the STP demonstrate alignment between the identified need, the program response (activities and outputs) and the intended outcomes	The STP demonstrates poor alignment between identified need and program response. In its current form the STP does not respond to the changes in the evolving national non-GP specialist medical workforce. The STP targets generally remain static over time, based on historic funding levels and largely determined by colleges, and the program does not draw on data and modelling around workforce.	• Review policy and program establishment material • Review of program data • Semi-structured stakeholder consultations • Previous Departmental review (2017) and ANAO audit (2015) • National Health Workforce Dataset • Medical Education and Training Dataset
2. Is the STP an appropriate way to address inequities in the quality and distribution of Australia's rural, regional and remote specialist workforce	The extensive consultation conducted through this evaluation indicates that there is a high degree of unmet demand for rural, regional and remote placements, from both healthcare settings and from trainees seeking non-metropolitan opportunities to train and work in the longer term. This indicates that a program to fund non-GP medical specialist training costs, such as the STP, is a valuable mechanism to support trainee aspirations to practice in rural, regional and remote areas, and is therefore an appropriate way to address inequities in the quality and distribution of Australia's rural, regional and remote specialist workforce.	• Academic literature review • Semi-structured stakeholder consultations • Comparison of approaches in Australia and other similar countries

PROXIMITY

Evaluation questions	Evaluation response	Data source during this evaluation
3. Should the STP and/or FATES program/s continue to be administered by the Commonwealth and, if not, how should it be administered and through what mechanism	The findings from this evaluation suggest that the current funding model should continue, with Commonwealth oversight of Colleges administering the STP. The Commonwealth is seen by stakeholders to be independent and impartial when determining the flow of funding into different specialties, while Colleges have a well-recognised deep expertise in the particular workforce needs of the specialties they represent.	• Semi-structured stakeholder consultations • Comparison of approaches in Australia and other similar countries

Implementation: How effective has the implementation of the STP been to date and what can we learn from it?

Evaluation questions	Evaluation response	Data source during this evaluation
4. To what extent is the program effective in increasing specialist training numbers?	The evidence available to this evaluation indicates that other factors, such as trainees being of rural origin, and having positive early mentorship experiences, drive specialist training numbers. In its current form, STP does not contribute directly to enhancing these factors.	• Review of program data • Semi-structured stakeholder consultations
5. How appropriate is the relationship with the states and territories and other key stakeholders	Relationships amongst stakeholders vary across colleges, and while some states actively engage with the Commonwealth on STP, others are less involved. Strengthening relationships across the stakeholder landscape would support the STP to better contribute to correcting workforce maldistribution, and to improving First Nations outcomes.	• Semi-structured stakeholder consultations • Survey
6. Is there early evidence to show FATES is contributing to achievement of STP policy intents and vice versa?	While at the individual project level milestones have been achieved, the program, like the STP overall, lacks a coherent outcomes hierarchy and measurement framework, so it will remain difficult to evaluate the longer-term outcomes of these projects, and to explore how STP and FATES interact.	• Review policy and program establishment material • Semi-structured stakeholder consultations • Review of program data • Survey

Effectiveness: How effective has the STP been in meeting its intended objective?

PROXIMITY

Evaluation questions	Evaluation response	Data source during this evaluation
7. How effective has the program been in influencing trainees' choices or actions, particularly around Fellows choosing to continue their careers in expanded setting due to the program?	There is no evidence that the program has directly impacted trainees' choices or actions, although it is likely to have provided the opportunity, through salary funding of trainees and supervisors, to those with an interest in careers in expanded settings.	• Semi-structured interviews • Survey
8. What is the likelihood of the program contributing to the desired long-term outcomes (rectifying the maldistribution of specialists maintaining medical specialists to rural and remote locations)?	In its current form, the STP is unlikely to directly contribute to long-term outcomes around maldistribution of non-GP medical specialists.	• Semi-structured interviews • Survey
• **Efficiency: How cost effective is the STP?**		
9. How efficiently have the STP Program resources been used?	While the total estimated administrative cost of the program is within the general bounds of comparable government programs, this evaluation has not been able to confidently establish the actual administration costs for Colleges, which limits its ability to make a definitive statement regarding the efficiency of program administration.	• Review of program data • Semi-structured stakeholder consultations •
10. How cost effective is the STP compared with how states and territories fund training posts?	This evaluation was unable to draw a conclusion regarding the cost-effectiveness of STP compared to state and territory funding models. While requested, data from states and territories regarding the cost per training post funded was not made available to this evaluation.	• Review of program data • Semi-structured stakeholder consultations • Comparison with other Australian models.

PROXIMITY

Evaluation questions	Evaluation response	Data source during this evaluation
11. Is there a minimum length of rural rotation required for cost-effective delivery of the STP and/or to improve the chances of trainees returning to work in rural areas following a Fellowship?	No conclusion can be drawn from the data available about a minimum length of placement for cost-effective delivery of STP, however qualitative data indicates that longer placements are associated with increased likelihood of trainees returning to work in rural areas.	• Review of program data • Semi-structured stakeholder consultations • Survey

12. How is the funding administered by the Colleges for the following:
 	
   - STP
   - IRPT
   - Tas project
   - STP support project
   - Administrative costs?
 	
What are the benefits and weaknesses, is one more effective than the other?
	The data required to answer this KEQ was not available to this evaluation. While financial and performance reporting, and copies of grant agreements, were provided by the Department, detailed breakdowns of funding administration by program elements, while requested, was not captured or shared by Colleges.	• Review of program documentation
		• Review of program data
		• Semi-structured stakeholder consultations
		• Survey

Sustainability: How can the program be improved?

Evaluation questions	Evaluation response	Data source during this evaluation
13. Are there any changes required to the design and implementation arrangements of the STP and FATES to enable it to meet its objectives?	Introducing a mechanism to link medical workforce demand and supply modelling to the direction of specialist training in the long term would enable the targeting of Commonwealth funding towards geographical areas, specialties, sub-specialties and trainee demographics which would best support Australia's changing medical workforce needs. To ensure future funding through the STP is responsive to Australia's specialist workforce needs, and not solely reliant on data received, target setting for the STP should be undertaken by a tripartite specialist training governance group, comprising the Commonwealth, state and territory health bodies and the Colleges, taking a national, coordinated lens to specialist training needs. A simplified model of the STP should be introduced to remove separate rules and funding streams for the Tasmanian Project and the Integrated Rural Training Pipeline (IRTP), retaining only the elements of the Specialist Training Placements and Support (STPS) funding. This funding could be targeted through enhanced governance mechanisms to private posts, First Nations posts, and regional, rural and remote areas, without additional funding rules and administration required. This change would not necessarily lead to the loss of funding to sites with IRTP or Tasmanian Project funding, as this could be accommodated within targeting processes where these are found to be appropriate. As part of a simplified program design, more frequent acquittals and reallocations of underspends would enable a return to the original intended volume of Support Projects. With these changes, complexity across the program operational guidelines would be removed, and existing Commonwealth and Colleges forums could be used to ensure consistent interpretation of funding rules are applied across Colleges. In this way, many of the pressure points currently identified by settings, supervisors and trainees would be removed, and the complexity of administering the program reduced for all stakeholders. In addition, value for money for Commonwealth investment would also be realised.	• Review of program data • Semi-structured stakeholder consultations

PROXIMITY

Evaluation questions	Evaluation response	Data source during this evaluation
14. Are there changes required to the funding of the STP such as integration of the STP Support Project funding being moved into the FATES program and/or consolidation of existing successful FATES pilot projects into ongoing programs via a college consortia arrangement?	This evaluation indicates that both Support Project funding and FATES funding should continue, however the volume of funding should be re-considered. Opportunities to strengthen program administration should be prioritised to reduce program underspends which have historically inflated the volume of Support Project and FATES grants. While these program elements have benefits in supporting the sector to train non-GP specialists, they should not reduce funding available for the direct costs of training.	• Review of program data • Semi-structured stakeholder consultations
15. Is there a risk in reducing the focus on the STP to rural and remote locations only?	STP is an important source of funding for specialties which require training in metropolitan expanded settings, if the focus was reduced to rural and remote locations only this would remove the only source of funding for key training opportunities in these specialties.	• Semi-structured stakeholder consultations
16. What are the risks of associated with moving STP/FATES to a new mechanism (i.e. change the administrative structure)?	Overall, this evaluation has found that there are clear benefits to the current roles of the Commonwealth and Colleges. A change in mechanism could lead to a loss of the deep sector expertise available from Colleges, while the objectivity the Commonwealth brings to the role is highly regarded and should not be lost.	• Semi-structured stakeholder consultations

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