Review of the Rural Health Workforce Support Activity

Department of Health

Final Report

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Glossary

The glossary below sets out abbreviations and definitions, including those specific to the Rural Health Workforce Support Activity, so that these terms are used consistently throughout this report to ensure continuity in the analysis and in the methodological approach.

The below definitions are the agreed definitions for the terms used throughout the review.

- ACCHS - Aboriginal Community Controlled Health Organisation

- ACRRM - Australian College of Rural and Remote Medicine

- AHW - Aboriginal Health Worker

- ASGS-RA - Australian Statistical Geography Standard - Remoteness Areas

- AWP - Activity Work Plan

- BMP - Bonded Medical Places

- CPD - Continuing Professional Development

- FPS - Flexible Payment System

- GP - General Practitioner

- HWNA - Health Workforce Needs Assessment

- HWSG - Health Workforce Stakeholder Group

- IMG - International Medical Graduate

- Jurisdiction - Jurisdiction refers to the Northern Territory, Queensland, Western Australia, South Australia, New South Wales, Victoria and Tasmania (1).

- km - Kilometre

- LHD - Local Health District

- LHN - Local Health Network

- MBS - Medicare Benefits Schedule

- MDRAP - More Doctors for Rural Australia Program

- MM - Modified Monash

- NSW - New South Wales

- NT - Northern Territory

- OTD - Overseas Trained Doctor

- PHN - Primary Health Network

- PPERS - Primary Health Networks Program Electronic Reporting System

- RHW - Rural Health West

- QLD - Queensland

- RACGP - Royal Australian College of General Practitioners

- RCS - Rural Clinical School

- RHOF - Rural Health Outreach Fund

- RHWA - Rural Health Workforce Australia

- RHWSA - Rural Health Workforce Support Activity. Means the Program, and encompasses the three elements: Health Workforce Access Program; Improving Workforce Quality Program; and Building a Sustainability Workforce Program (2).

- RTO - Regional Training Organisation

- RWA - Rural Workforce Agency. RWAs are the administrative bodies for the RHWSA, and recruit and support rural health professionals in each State and the Northern Territory (2).

- RWAN - Rural Workforce Agency Network

- SA - South Australia

- SEIFA - Socio-Economic Indexes for Areas

- STP - Specialist Training Program

- TAS - Tasmania

- The Department - The Commonwealth Department of Health

- VIC - Victoria

- WA - Western Australia

- WAPHA - WA Primary Health Alliance

Executive summary

Background and Context

In March 2020, the Commonwealth Department of Health (the Department) engaged KPMG to undertake a review of the Rural Health Workforce Support Activity (RHWSA) program. The RHWSA program, funded by the Department, is a major source of funding for the Rural Workforce Agencies (RWAs), located in each state and the Northern Territory (NT). The RWAs provide a range of activities and supports designed to improve the recruitment and retention of the health workforce to rural and remote areas.

The RHWSA program aims to meet current and future regional, rural and remote community health workforce needs through workforce planning. The RHWSA program comprises three program elements:

- **Health Workforce Access:** to improve access and continuity of access to essential primary health care, particularly in priority areas, through jurisdictional workforce assessment process involving health workforce stakeholders.

- **Improving Workforce Quality:** to build local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised medical professionals in rural communities.

- **Building A Sustainable Workforce:** to grow the sustainability and supply of the health workforce with a view to strengthening the long term access to appropriately qualified health professionals (1).

Review Objectives

The objective of the review was to assess the effectiveness, efficiency, appropriateness and engagement of the RHWSA program. Findings of the review will inform decisions about the future design, funding and implementation of the program beyond June 2021.

The review considers the following two overarching Key Review Questions, which are considered below.

1. Whether the program is currently best meeting Government policy and strategic objectives related to the distribution and retention of health professionals working in rural and remote locations?

2. What are preferred future directions for the RHWSA program that promote continuous improvement?

The review was guided by four domains of inquiry, defined as:

- **Appropriateness:** measuring the extent to which the program addresses an identified need and the program's alignment with government priorities.

- **Effectiveness:** measuring the extent to which the program is achieving the intended objectives and producing results (activities, outputs and outcomes).

- **Efficiency:** measuring how well resources are used to produce outputs / initiatives for the purpose of achieving program objectives.

- **Engagement:** measuring the extent of stakeholder engagement and input in the achievement of program objectives, and whether duplication and / or synergy exists in relation to wider objectives (particularly of the Primary Health Networks (PHNs)).

Review Methodology

The review used a mixed-methods approach and collated data from a range of existing qualitative and quantitative sources.

Qualitative Analysis

- Document review: key program documents reviewed include the RHWSA operational guidelines, Health Workforce Needs Assessment (HWNA), Activity Work Plans (AWP), performance reports and Standard Funding Agreement Schedules.

- Literature scan: focused on identifying the program's alignment to contemporary good practice and suitable options to improve outcomes into the future.

- Stakeholder consultation: data on stakeholder perceptions were collected through semi-structured interviews with a range of stakeholders.

Quantitative analysis

- Program data analysis: to explore program activity data including the Key Performance Indicators.

- Program financial analysis: to explore the apportionment of funds to RWAs and program elements, along with opportunities to improve efficiency in the program.

The qualitative and quantitative analysis was considered together to support the findings in the review.

Review strengths and limitations

The approach taken to the review had some important strengths:

- The stakeholder engagement involved 49 consultations across 15 stakeholder groups, providing a range of stakeholder perceptions on the RHWSA program. This provided insights into jurisdictions where innovation or better practice was occurring.

- The review utilised a range of different data sources and applied a mix of methods to triangulate findings across the four domains of inquiry.

There were also a number of limitations and challenges:

- The activity and other program data provided by various stakeholders were not independently validated. However, initial quality checks of the data were undertaken to identify outliers which were discussed with the relevant data custodians.

- Detailed data on the cost of activities was not available, limiting the ability for a unit cost by program activity to be determined. The financial analysis instead focused on the apportionment of costs at the RWA, program element and funding stream levels.

- The data available to inform potential overlaps or synergies with other programs (e.g. the PHNs) was limited to qualitative information obtained from stakeholder interviews and publicly available data.

Other considerations for the review

COVID19 presented a challenge with undertaking stakeholder consultations, as organisations focused on the safety and wellbeing of their communities. The approach for completing stakeholder consultations was determined in collaboration with the Department and stakeholders. The approach focused on having minimal impact on stakeholders' day-to-day activities, while ensuring that the consultations were structured to enable valuable information to be obtained in a time effective manner. All planned consultations occurred over the course of the review.

While the scope of this review was limited to the RHWSA program, it is acknowledged that some findings relate to broader rural, regional and remote health workforce challenges and contextual jurisdictional factors. It is important to note the complex and varied stakeholder and system environment within which the RWAs operate and the impact this may have on their effectiveness to drive change.

There are also concurrent activities being undertaken at the same time as the review (e.g. National Medical Workforce Strategy, Evaluation of the Rural Health Multidisciplinary Training Program). Where relevant, outcomes from these activities should be considered in the future design of the RHWSA program.

Overarching findings

Program achievements

The majority of stakeholder groups recognised that three years was a limited period of time for the program to demonstrate change for access, quality and sustainability of the regional, rural and remote health workforce. Some RWAs and jurisdictional stakeholders noted that short-term improvements have been demonstrated, particularly for workforce access and quality, however this is difficult to solely attribute to the RHWSA program.

RWAs have administered a range of activities, including More Doctors for Rural Australia Program (MDRAP) (formerly the Rural Locum Relief Program), the 5 Year Overseas Trained Doctor (OTD) Scheme, the Workforce Incentive Program, Flexible Payment Scheme (formerly the General Practice Rural Incentive Program) and provided grants, scholarships and bursaries. Implementation of these activities has supported the program

with achieving the intended objective to "*contribute to addressing workforce shortages and maldistribution in regional, rural and remote Australia*" (2)*.*

The RHWSA program resulted in the recruitment of 714 and 659 health professionals to rural Australia in 2017-18 and 2018-19, respectively. Stakeholder consultations identified that RWAs are increasingly focusing on improving access to health professional and para-professional roles outside of the medical workforce. In the performance reports, four of the RWAs provided detail of the health professionals recruited, by health profession. In 2017-18 and 2018-19, for the four RWAs, 471 placements were for GPs, and 418 of the placements were for allied health and nursing professionals. The RWAs also undertook a range of activities to promote rural health careers, including facilitating rural exposure for undergraduate students, medical students, junior doctors and GP registrars.

In addition to grants and incentives provided to support the recruitment of health professionals and for locum support, grants and incentives were also provided to improve the quality and sustainability of the rural health workforce. During consultations, RWAs, RCSs and Specialist Training Colleges discussed that the provision of medical training, continuing professional development and education bursaries and scholarships are an effective mechanism to maintaining and improving the capability of the medical workforce within the RWA's. During the program, RWAs provided a range of grants within the Quality element, such as CPD grants (e.g. for attendance at workshops, exam preparation), upskilling grants, Aboriginal student support grants, and pre-exam support for IMGs.

Various grants were provided by the RWAs in the Sustainability element, such as facilitating rural exposure for undergraduate students, medical students, junior doctors and GP registrars, attending conferences or industry events (e.g. for practice managers and receptionists), rural health careers promotions and business training. The majority of stakeholder groups reported limited effectiveness of the program in achieving rural health workforce sustainability since it began in 2017. However, it was acknowledged that this is a longer-term goal for the rural health workforce and there are multiple contributing factors that impact on maintaining a viable rural health workforce model within a community that are outside the scope of the RHWSA program.

Key findings by domain of enquiry

Outlined below are the summary findings in relation to the review of the RHWSA program with regard to appropriateness, effectiveness, efficiency and engagement.

Appropriateness

While there is evidence that the RHWSA program is meeting an identified need, there is a complex ecosystem of stakeholders operating in each jurisdiction providing support for regional, rural and remote community health workforce needs. Clarifying each stakeholder's role and remit may assist with demonstrating change from the RHWSA program at a jurisdictional and national level and would also reduce any duplicative or competing activities being undertaken. Stakeholders identified that the three program elements (Access, Quality and Sustainability) are relevant now and into the future and the RWAs reported having a degree of

flexibility in how the program is delivered to meet the identified need. The review found there is a need to shift towards focusing on sustainability and undertaking in-depth area-specific planning to anticipate future workforce issues and requirements.

Effectiveness

While there was evidence of the effectiveness of the program in contributing towards achieving the RHWSA program objective, this varies by jurisdiction and is impacted by the degree to which an RWA successfully engages and builds relationships with key stakeholders. Some external stakeholders were unable to provide a view on whether the program resulted in a change in the access, quality and sustainability of the regional, rural and remote primary health workforce, due to low awareness of the program or the inability to attribute any changes to this program specifically. The majority of stakeholders acknowledged that contemporary service delivery models (e.g. telehealth, fly-in-fly-out service delivery) are important considerations in the future to improve rural workforce sustainability and viability.

Efficiency

Limitations with the available data impacted on the ability for analysis of unit cost per program activity, limiting the ability to comment on whether there was efficient use of resources to produce outputs/initiatives in the program. The analysis focused on the funding arrangements for the RWAs, program elements and the funding streams, and perspectives from stakeholder interviews. During consultations, most RWAs communicated that the notional splits between program elements and funding streams were unhelpful and may not support responding to the identified need in the communities. Some RWAs commented that having more flexibility to move funding between program elements and program streams would support the delivery of the program in a manner that more directly aligns with the identified needs in their jurisdiction. The funding model may not support RWAs developing and implementing discretionary and innovative solutions to meet an identified community need, and may limit collaboration and undertaking co-design with stakeholders. The review also found that there are opportunities to coordinate processes with other stakeholders to achieve efficiencies in the program and reduce duplication with other stakeholders.

Engagement

While there was evidence that all RWAs complete stakeholder engagement in delivering the program, the level of stakeholder engagement completed by each RWA varies and can be linked to the complexity of the stakeholder environment, organisational structures and individual relationships. The awareness of the role of the RWAs is low among some stakeholder groups at a jurisdictional and national level. There is also a lack of clarity regarding the roles and responsibilities of different organisations operating in the sector, often with competing objectives. The review found that there is some duplication of activities completed by different stakeholders (e.g. the role of PHNs in undertaking health workforce support activities). The review found that there are opportunities to improve the level of stakeholder engagement in the program, at both the community level and across the broader rural health workforce. There are also opportunities to support more efficient and effective national representation of the program.

Evidence to inform future program design

This section provides findings from the review to inform the future design of the program.

Improve the health workforce needs assessment process

The health workforce needs assessment process is critical in identifying areas of need and understanding what support could be provided for specific locations. Most RWAs reported that the HWNA is a useful tool for framing engagement with external stakeholder groups and with providing a nationally consistent approach to localised health workforce planning. A key strength was identified to be the lens and focus on community needs and challenges. This focus allowed agencies to collaborate to address a common issue rather than focus on pursuing their own organisational agenda. The HWNA template allowed jurisdictional agencies sufficient flexibility to adapt and develop their own methodologies to suit jurisdictional need.

However, in some jurisdictions, stakeholders commented that as a state-wide mapping activity, the HWNA was too highly aggregated and did not provide detail on the nuances of local areas. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. These include the number of different service providers, market maturity and the population size and demographics. Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages (i.e. the Access element) and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements.

Effective workforce planning needs to be directly connected to the service model that is appropriate for that area. While workforce availability can alter the choice of service model, a model on which workforce (form) follows the service model (function) is needed to ensure that recruitment is seen in the context of all the local actors and workforce roles. Place-based service planning is undertaken to a degree in each jurisdiction. Stakeholders identified there is an opportunity for RWAs to further utilise this approach, to develop tailored workforce solutions for individual communities based on place-based workforce needs assessment and planning. Findings from the literature scan have identified that place-based approaches can be effective for changing health outcomes or health-related behaviours in target populations. Place-based approaches typically address underlying social determinants associated with poorer health outcomes and can be successful in influencing change in built environments, social cohesion and economic environments within defined geographic locations. Key to the success of place-based approaches is the use of collaborative partnerships between local health services/ providers and relevant local/state/national government agencies to design and implement health programs and services (3).

This review found that multiple agencies (e.g. PHNs, Regional Training Organisations (RTOs), Regional Training Hubs and State Governments) complete needs assessment processes. Whilst each differ in objective and depth, it was identified that, generally, agencies were gathering their own workforce data separately thereby duplicating effort. An opportunity exists for more streamlined stakeholder collaboration to occur in the data

collection, analysis and reporting of health workforce need with a focus on data-sharing and minimising the burden on health care providers. Most stakeholders also identified a need to clarify roles of PHNs and RWAs with regard to needs assessment and subsequent workforce planning. Multiple workforce needs assessment processes result in a lack of role clarity and differences in workforce activity and initiatives.

Examples that would assist with improving service planning include:

- Working towards a singular data source and sharing medical, nursing, allied health and para-professional workforce planning data between stakeholders. This can be formalised through data-sharing agreements.

- Undertaking area-specific, long-term workforce needs analysis planning and activity definition in collaboration with the relevant regional stakeholders.

- Clarifying the planning cycle with PHNs for service and workforce planning. The Department has a key role in setting expectations around the linkage between the role of PHNs and RWAs with service and workforce planning. This could be supported through a policy and planning framework.

Stakeholder engagement

The stakeholder engagement completed by each RWA varies and can be linked to the complexity of the stakeholder environment (e.g. number of PHNs), structure (e.g. the Northern Territory Primary Health Network is both the PHN and the RWA), and individual relationships. Variability in relationships and collaboration with key stakeholder groups reduces the opportunity for collaborative approaches in the assessment, planning and implementation of workforce activities.

Several key external rural health workforce organisations support the delivery of the RHWSA program. RWA's engage with these stakeholders through various mechanisms, most frequently through their involvement on the jurisdictional Health Workforce Stakeholder Group (HWSG).

Health Workforce Stakeholder Group

RWAs are responsible for convening and the ongoing administration of the HWSGs. During consultations, it was identified that while the HWSG provides a positive platform to bring stakeholders together to support the development of the HWNA, some stakeholders noted they had no involvement with the HWSG in either the development of the HWNA and / or the AWP. The operational guidelines for the RHWSA program provide a list of stakeholder groups that membership of the HWSG should comprise. Some of the stakeholders outlined in the operational guidelines noted during interviews that they had no involvement in the HWSGs (e.g. Specialist Training Pathway Provider).

A key criticism with the HWSG was centred around the forums lack of clear direction in terms of actions for stakeholders involved. Stakeholder consultations identified this forum was viewed as simply a sense checking exercise for stakeholders to validate and endorse the HWNA with no tangible actions to then address the identified need. The Department advised that following feedback from stakeholders, the HWSG members are to 'support' the HWNA and AWP, rather than 'endorse' the documents.

There is scope for RWAs to better leverage the HWSG to identify key activities that can be delivered in collaboration with other key stakeholders to address needs and issues identified through the HWNA process. Additionally, the HWSG can be utilised to explore innovative solutions that draw on the various resources, skills and knowledge of all agencies involved.

Governance arrangements

There is a lack of clarity regarding the roles and responsibilities of different stakeholders, and the governance arrangements may not support synergy and coordination across RWAs, Rural Health Workforce Australia (RHWA) and PHNs. Stakeholders may be operating in a duplicative manner with the RWAs, or there may be competing objectives between different stakeholders.

Some stakeholders reported a view that the role of the RHWA is unclear, and there was a view that the functions could be better fulfilled by the individual RWAs. There is an opportunity to clarify the roles and responsibilities of Rural Workforce Agency Network (RWAN) and RHWA with specific respect to stakeholder engagement, reporting and program delivery, or consider opportunities to support more efficient and effective national representation of the program.

Considerations for national representation of the program include:

- Supporting a level of synergy nationally between the RWAs.

- Preventing duplication of effort with other stakeholders (e.g. Specialist Training Pathway Providers).

- Promoting innovation within the RHWSA program.

- Supporting reallocation of resources to areas of need between jurisdictions.

- Undertaking national reporting of the outputs and outcomes of the RHWSA program.

Awareness of the program

Stakeholder consultations identified that there is low awareness of the RHWSA program and of the role of the RWAs in rural and remote health workforce planning. This has the following impacts:

- Individuals or organisations in a community may not know who to contact to request support within the RWA, limiting the effectiveness of the program.

- There is a lack of awareness of the jurisdictional and national priorities for the RHWSA program.

- National peak bodies and organisations may not have awareness of how to engage with the RWAN to discuss health workforce planning and initiatives.

- Some stakeholders were unable to comment on whether the program has had an impact in addressing workforce shortages and maldistribution in regional, rural and remote Australia.

There is an opportunity for the RWAs to establish a strategic vision / priorities with their jurisdictional stakeholders and define the role of stakeholders in delivering activities to achieve this. There are also

opportunities to strengthen national engagement with the RWAs collectively, including providing a clear contact for stakeholders nationally.

Areas of duplication or overlap in health workforce activities

The following areas of duplication or overlap were identified during the stakeholder consultations:

- **State and Territory Governments:** The RWAs and State and Territory Governments both participate in crisis and short-term workforce initiatives through establishing locum placement opportunities for health professionals in areas of high need. RWAs identified long standing locum arrangements, particularly for GPs delivered by the State and Territory Governments reduce the effectiveness of the RWA to embed a long term sustainable health workforce model of care in a community, as locum positions provide services to a significant portion of the local community and reduce the need for full time primary health professionals within the region.

- **RHOF fundholders:** During consultations, RHOF fundholders reported a level of duplication in providing allied health outreach services to remote locations, which is also an activity delivered by the RWAs.

- **PHNs:** RWAs are restricted to delivering activities for the three program elements in MM 2 - 7, except activities can be undertaken in MM1 for Aboriginal Community Controlled Health Organisations (2). Currently 17 PHN boundaries align and / or overlap with the MM 2 – 7 regions in which the RWAs operate within (4). In establishing the PHNs, the Australian Government identified seven priority areas to guide their work, including; mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged care, and alcohol and other drugs (5). Consultation with the RWAs and PHNs identified areas of duplication and overlap may occur where the 17 PHNs and the RWAs are both delivering rural health workforce activities within the same region. While the RHWSA program guidelines acknowledge the need for collaboration with the PHN through representation on the HWSG, there is a greater need for a more formalised partnership arrangement in the future, and to further differentiate the specific role and responsibility each organisation has in regards to workforce planning in regions where both are operating.

Noting a limitation that only three Aboriginal and Torres Strait Islander State Peak Bodies completed a stakeholder consultation, the consultations did not identify duplication in services provided in the RHWSA program in MM1.

Clarity of the roles, responsibilities and remit of key stakeholders within the system is important to reduce the risk of duplication across agencies and support a cohesive and coordinated approach to providing support to the regional, rural and remote health workforce. It was consistently identified throughout consultation that the RWAs should aim to collaborate and coordinate processes and activities with stakeholders across the continuum of the health workforce pipeline. This includes RHOF fundholders, Rural Clinical Schools (RCSs), PHNs, and State and Territory Governments. The mechanisms through which the RWAs can facilitate collaboration with stakeholders includes coordinating processes, information and data sharing, and establishing formalised agreements and partnerships.

In the future design of the program, there is an opportunity to review linkages or synergies with other Commonwealth funded programs and clarify the roles and responsibilities of different organisations operating in the rural health workforce sector to support ongoing collaboration.

Reporting

RWAs are required to develop a number of reports annually during the program, including the HWNA, AWP, performance reports for the three elements and annual financial reports.

Outcomes-based reporting

During stakeholder consultations, the RWAs identified that the reporting is compliance and outputs focused and does not provide the opportunity for the RWAs to demonstrate the depth of the outcomes that have been achieved. RWAs identified that outcomes-based reporting would better communicate the progress in addressing workforce shortages and maldistribution in regional, rural and remote Australia, and better align with the three program elements. Some RWAs reported that they are required to provide outcomes-based reporting to their Board of Directors. There is an opportunity for RWAs to demonstrate the outcomes they are achieving through provision of this reporting to the Department. This will also support the Department in the development of a consistent outcomes-based reporting framework.

The literature recommends benchmarking services against desired outcomes postulated during planning to ensure funders can understand to what extent services are achieving positive outcomes for their target population. Care must be taken when designing such frameworks to ensure they are not so onerous, in terms of complexity and time, that they conflict with service delivery. The literature identifies that these types of reporting tools, when correctly applied, can be used by providers as a real-time, strategic resource supporting the ongoing delivery and adjustment of health services (6; 7).

There are practical challenges associated with moving to outcomes-based reporting. Short-term actionable activity can be undertaken by the Department in ensuring reporting is consistent by the RWAs and providing feedback to RWAs on the quality of the reporting and opportunities for improvement.

Reporting mechanism

The reporting mechanism is not dynamic. There is an opportunity to implement a digital platform (e.g. web-based portal) to support information, outcomes and risks to be updated efficiently.

National reporting

There is currently no national reporting completed on the outputs and outcomes of the RHWSA program, by RHWA or by another organisation. There is an opportunity to complete national reporting to provide a summary of the overall impact of the program.

Funding and innovation

The RWAs receive allocated funding for each program element, which is to be allocated to three funding streams (grants and incentives, operational funds and program delivery). During consultations, most RWAs communicated that the notional splits between program elements and funding streams were unhelpful. Some of the challenges with the funding model include:

- The funding model has constraints on how the RWAs can use the funding, due to the allocation of funding to program elements and funding streams. This may limit RWAs in undertaking activities that meet an identified need in a community.

- It is difficult to move funding between program elements (requires a Deed of Variation). Written agreement from the Department is required to move funds between funding streams.

- The funding model may not support RWAs developing and implementing discretionary and innovative solutions to meet an identified community need. This may include limiting collaboration and undertaking co-design with stakeholders.

There is an opportunity to consider revising the funding model to be more flexible, to support the RWAs in delivering the program to meet the identified needs in their jurisdiction.

Providing transparency in program reach

Since the establishment of this program in 2017, there has been a shift in the focus of the RWAs with wider inclusion of health professionals, including nursing and allied health, in workforce initiatives and programs. During consultations, the majority of stakeholders reported that it has been a positive shift to expand the program to include a wider group of health professionals. Some stakeholders noted that the shift to including a wider group of health professionals in the RHWSA program was still in its infancy. This is an important component in establishing an integrated approach to program delivery, and in implementing place-based approaches.

Two RWAs reported a view that there is an opportunity to expand the remit of the program to accommodate the disability and aged care sectors, which are often integrally linked and interdependent on primary health services in rural and remote locations. There is a need to ensure the current scope of the program is mature across all RWAs before looking to further expand the remit of the program.

Building an evidence base

The RWAs have flexibility to undertake eligible activities to meet identified needs in a community. As such, RWAs all undertake different activities across the three program elements. Building the evidence base, through monitoring and evaluation, to assess the design, development and implementation of activities will support identification of what does and does not work, to support continuous improvement of the RHWSA program.

The literature scan also identified the need for robust and ongoing data collection, analysis, monitoring and evaluation of all strategies implemented to instigate health workforce improvements in rural, regional and remote settings. The literature scan highlights the importance of implementing evaluation frameworks from the outset when designing programs that aim to support the recruitment and retention of healthcare providers in rural and remote communities, as opposed to completing these retrospectively (8; 9; 10).

Recommendations

The following recommendations are provided for the RHWSA program. The link between recommendations and findings from the review are also provided in Table 1 below.

The proposed implementation timeline is provided below for the recommendations, as short term (less than one year), medium term (one to three years) and long term (greater than three years). The recommendations that are medium to long term are identified to require more effort or coordination with stakeholders to support successful implementation. There are aspects of some medium to long term recommendations that may require less effort to implement which can be achieved within a shorter timeframe than listed.

Table 1: Recommendations for the RHWSA program

Proposed implementation timeline	#	Recommendation	Relevant Section(s)
Short term	1	Clarify the roles and responsibilities of RWAN and / or RHWA with specific respect to stakeholder engagement, reporting and program delivery, or consider opportunities to support more efficient and effective national representation of the program. This should include providing a clear contact for stakeholders nationally.	Refer to Sections 3.2.3 and 3.4 for further detail.
	2	Develop a Monitoring and Evaluation Framework for the RHWSA program to support continuous improvement of the program at a jurisdictional and national level.	Refer to Section 3.1.5 for further detail.
	3	Consider revising the funding model to be more flexible, to support the RWAs in delivering the program to meet the identified needs in their jurisdiction. This may include: Establishing an innovation funding pool, whereby RWAs can submit a proposal to the Department for funding specific activities (e.g. collaborative activities).	Refer to Section 3.3.4 for strengths and challenges of different options for the future funding model.

Proposed implementation timeline	#	Recommendation	Relevant Section(s)
		Allowing for additional flexibility with moving funds between the program elements and / or the funding streams.	
`Medium term	4	Consider opportunities for the RWAs to: Coordinate the dissemination of the information and data for the various needs assessments across stakeholder groups. This should inform the development and implementation of particular health workforce activities. This could include formalised mechanisms such as Memorandums of Understanding, formal partnership agreements or data sharing arrangements. Clarify the planning cycle with PHNs for service and workforce planning. The Department has a key role in setting expectations around the linkage between the role of PHNs and RWAs with service and workforce planning. This could be supported through a policy and planning framework.	Refer to Section 3.4 for further detail.
	5	Where appropriate, RWAs should continue to develop tailored workforce solutions for individual communities. Place-based workforce needs assessment and planning should be utilised to account for the specific drivers in each community (e.g. number of different service providers, market maturity, and population size and demographics). This may include: Developing collaborative partnerships with organisations (e.g. local health services, local government agencies, other local health workforce organisations) to design and implement the workforce solution. Identifying where a multi-disciplinary solution could be undertaken to support sustainability of the workforce in the community. Identifying where specialised support services (e.g. tailored case management) can be provided for the health workforce	Refer to Sections 3.1.5, 3.2.5 and 3.4.3 for further detail.

Proposed implementation timeline	#	Recommendation	Relevant Section(s)
		in individual communities to support job satisfaction and retention. Consideration of adjacent or interdependent service workforces (e.g. disability and aged care sectors) when developing the tailored workforce solutions for individual communities, as they are often integrally linked and interdependent on primary health services in rural and remote locations.	
Long term	6	For the program reporting, consider: Transitioning the program reporting to include outcomes-based indicators, to support the RWAs with capturing and reporting on their progress with addressing workforce shortages and maldistribution in regional, rural and remote Australia. A performance framework could support the transition to outcomes-based reporting and ensure consistent reporting by RWAs. Program reporting should align to the program logic (e.g. outputs delivered, outcomes achieved) and support financial data analysis (e.g. unit cost per activity). Implementing a digital platform for reporting. Undertaking national reporting on the outputs and outcomes of the RHWSA program, to provide a summary of the overall impact of the program. The performance framework (referred above) could include information on the national reporting requirements.	Refer to Section 3.1.5 for further detail, including considerations for the future program reporting. The PHN Program Performance and Quality Framework is provided as an example for outcomes-based reporting at an organisational and national level.

1. Introduction

KPMG was commissioned by the Commonwealth Department of Health (the Department) to undertake a review of the Rural Health Workforce Support Activity (RHWSA) program. The review involved evaluating the effectiveness, efficiency, appropriateness and engagement of the RHWSA program. Findings will inform decisions about the future design, funding and implementation of the program beyond June 2021.

1.1.   Structure of this final report

This final report is set out in the sections outlined in Table 2 below.

Table 2: Structure of this final report

Section	Overview
Section 1: Introduction *(current chapter)*	This section provides an overview of the background and context of the RHWSA program and the rural and remote workforce context more broadly. It outlines the key components, objectives and scope of the RHWSA program.
Section 2: Review approach	This section provides information about the approach used for the review, including the scope, objectives and methodology for the review domains.
Section 3: Review findings	This section provides overall findings of appropriateness, effectiveness, efficiency and engagement in relation to the RHWSA program, and, subsequently, presents recommendations for the future design, funding and implementation of the program.
Appendices	Appendices 1 through 9 provide the review requirements and indicators, findings per review question, the literature scan, the stakeholders consulted during the course of the review, the detailed stakeholder consultation questions, a description of the key stakeholders, detailed data limitations, the document register and the reference list.

1.2.   Background and context

Delivering high quality, accessible and sustainable healthcare to geographically dispersed populations presents a unique challenge for the Commonwealth Government. Eighty-six per cent of Australia is classified as 'remote' or 'very remote' (11). For communities living in these areas, equity of access to healthcare services remains a significant issue. This issue is complex and is influenced by a range of factors including labour market dynamics, career opportunities and limitations (including around access to learning and development, caseload exposure and supervision), social and psychological dynamics (including around housing availability, isolation, and spousal opportunities for economic and social participation) and funding and resourcing constraints.

Rural and remote communities experience unique healthcare delivery challenges associated with their geographic location. Health services in these regions often operate out of smaller facilities and have less available infrastructure. These populations also rely more on General Practitioners (GPs) to deliver primary healthcare services, with less access to specialist services (12).

1.3. Key components of the RHWSA program

1.3.1. Context for the program

The RHWSA program is a major source of funding for the Rural Workforce Agencies (RWAs), which are located in each state and the Northern Territory (NT). The RHWSA program provides funding for a range of activities and supports designed to improve the recruitment and retention of the health workforce to rural and remote areas. The RHWSA program sits more broadly within the Health Workforce Program to address a key priority being the delivery of a high quality and well distributed future health workforce. RWAs are the central point of contact for healthcare professionals interested in practising in rural and remote areas. Since the establishment of the RHWSA program, significant work has been undertaken by the seven jurisdictional RWAs to meet the program's objective to "contribute to addressing workforce shortages and maldistribution in regional, rural and remote Australia" (2).

The RHWSA program refreshed the approach to rural health workforce planning in primary and preventive care in Australia through consolidating and rationalising a number of former rural workforce initiatives. The refreshed program focuses on a contemporary and jurisdictional approach to the specific issues and concerns in attracting, retaining, training and supporting the health workforce in regional, rural and remote communities.

The seven jurisdictional RWAs are provided in Table 3 below. There are similarities and differences in the structures of the organisations, which is provided in the Table 3 below.

Table 3: The seven jurisdictional RWAs

#	RWA	Jurisdiction	Not-for-profit, charitable organisation[1]	Primary Health Network (PHN)	Rural Health Outreach Fund (RHOF) fundholder
1	Health Workforce Queensland	Queensland (QLD)	Y	-	-
2	Rural Doctors Workforce Agency	South Australia (SA)	Y	-	Y
3	New South Wales Rural Doctors Network	New South Wales (NSW)	Y	-	Y
4	Rural Workforce Agency Victoria	Victoria (VIC)	Y	-	Y
5	Rural Health West	Western Australia (WA)	Y	-	Y
6	HR+	Tasmania (TAS)	Y	-	-
7	Northern Territory Primary Health Network	NT	Y	Y	-

1.3.2. Objectives for the program

The RHWSA program aims to meet current and future regional, rural and remote community health workforce needs through workforce planning. Acknowledging that the maldistribution of the health workforce has been an ongoing concern for the last few decades, the creation of three program elements sought to drive improved outcomes and better return on investment. These three program elements are:

- **Health Workforce Access:** to improve access and continuity of access to essential primary health care, particularly in priority areas, through jurisdictional workforce assessment process involving health workforce stakeholders.

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[1] All organisations are registered on the Australian Charities and Not-for-profits Commission.

- **Improving Workforce Quality:** to build local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised medical professionals in rural communities.

- **Building A Sustainable Workforce:** to grow the sustainability and supply of the health workforce with a view to strengthening the long term access to appropriately qualified health professionals (1).

Activities in the three program elements are restricted to Modified Monash Model (MM) areas 2 – 7, with the exception of activities that can be undertaken in MM1 for Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations (2). Table 4 below provides the MM categories and inclusions.

Table 4: Modified Monash Model categories and inclusions

MM category	Inclusions
MM1	Metropolitan areas: major cities of Australia, i.e. all areas categorised Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) 1.
MM2	Regional centres: inner and outer regional areas towns with a population greater than 50,000 and within a 20 kilometre (km) road distance of that town. Otherwise categorised as ASGS-RA 2 and 3.
MM3	Large rural towns: inner and outer regional areas specifically, towns with a population between 15,000 and 50,000 and within a 15km road distance of that town. Otherwise categorised as ASGS-RA 2 and 3.
MM4	Medium rural towns: inner and outer regional areas specifically, towns with a population between 15,000 and 50,000 and within a 15km road distance of that town. Otherwise categorised as ASGS-RA 2 and 3.
MM5	Small rural towns: all other inner and outer regional areas not covered in MM 2 – 4. Otherwise categorised as ASGS-RA 2 and 3.
MM6	Remote communities: remote mainland areas and remote islands less than 5km offshore. Otherwise categorised as ASGS-RA 4.
MM7	Very remote communities: very remote areas and all other remote populated island areas more than 5kms offshore. Otherwise categorised as ASGS-RA 5.

Source: (13)

1.3.3. Scope of program services

For each of the three program elements, RWAs are required to undertake a number of activities. This includes establishing a jurisdictional Health Workforce Stakeholder Group (HWSG), developing a Health Workforce Needs Assessment (HWNA) and an Activity Work Plan (AWP), and administering specific programs, including:

- **More Doctors for Rural Australia Program (MDRAP) (formerly the Rural Locum Relief Program):** this program supports doctors working towards joining a college Fellowship Program, by enabling non-vocationally registered doctors to work in rural regions and access Medicare (14).

- **5 Year Overseas Trained Doctor (OTD) Scheme:** this scheme provides incentives to attract appropriately qualified and experienced overseas trained doctors to work in rural locations in areas of need (15).

- **Workforce Incentive Program – Doctor Stream Flexible Payment System (FPS) (formerly the General Practice Rural Incentive Program):** this program provides financial incentives to encourage doctors to deliver services in rural and remote areas (16). The program enables medical practitioners to apply for incentives if they provide eligible non-Medicare Benefits Schedule (MBS) services and / or undertake training under an approved training pathway, which is not reflected in MBS records (17).

Each RWA is required to report against key performance indicators for the program duration to demonstrate action against the key program elements.

Whilst overarching requirements have been in place, the RHWSA program has been relatively decentralised in its governance and approach. This reflects the different organisational history of these entities, and the differing jurisdictional needs, including levels of remoteness, Aboriginal and Torres Strait Islander population density, access to training programs and universities, and the health workforce labour market (including attraction, retention and turnover of the health workforce).

2. Review approach

2.1.   Review overview

A mixed-methods approach was used for the review. This section details the following:

- Review scope and objectives.

- Review methodology.

- Methods of analysis.

- Limitations.

- Data collection methods.

2.2.   Review scope and objectives

The review is focused on the RHWSA program (refer to Section 1), and considers the following two overarching Key Review Questions:

1. Whether the program is currently best meeting Government policy and strategic objectives related to the distribution and retention of health professionals working in rural and remote locations

2. What are preferred future directions for the RHWSA program that promote continuous improvement?

The objective of the review was to evaluate the effectiveness, efficiency, appropriateness and engagement of the RHWSA program. Findings will inform decisions about the future design, funding and implementation of the program beyond June 2021. The four review domains of inquiry are defined as:

- Appropriateness: measuring the extent to which the program addresses an identified need and the program's alignment with government priorities.

- Effectiveness: measuring the extent to which the program is achieving the intended objectives and producing results (activities, outputs and outcomes).

- Efficiency: measuring how well resources are used to produce outputs/ initiatives for the purpose of achieving program objectives.

- Engagement: measuring the extent of stakeholder engagement and input in the achievement of program objectives, and whether duplication and or synergy exists in relation to wider objectives (particularly of the PHNs).

The review considers each of the Key Review Questions and domains of inquiry at four levels:

- The whole of RHWSA program level (national view).

- Individual RWA level (jurisdictional view).

- Across each of the three program elements (Access, Quality and Sustainability) (community level).

- A summary view of how each initiative is contributing to the program elements, including any insights or identified areas for improvement (micro level).

2.3.   Program logic

A program logic was developed to understand the theory of change. A workshop was held with relevant staff from the Department to test and validate the program logic. Figure 1 below illustrates the program logic demonstrating the link between the inputs to the activity and outputs, and the intended short, medium and long-term outcomes.

The program logic is developed in the context of program delivery in regional, rural and remote communities.

Figure 1: Program Logic

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
• Commonwealth Department of Heath • Funding • Rural Workforce Agencies (RWAs) • Health professionals • Other healthcare service providers • Regional, rural and remote communities • Health Workforce Stakeholder Groups (HWSG) • Rural Health Workforce Australia (RHWA)	• Undertake health workforce needs assessment and develop the activity work plan • Establish and provide Secretariat support to the jurisdictional HWSG • Recruitment support to priority needs areas (e.g. grants for relocation) • Providing assistance to service providers, including financial assistance, to source General Practitioner (GP) locums in areas of need • Coordination with existing healthcare services and health professionals to provide services to areas of need • Administer the More Doctors for Rural Australia Program (MDRAP) and the 5-Year Overseas Trained Doctor (OTD) Scheme • Administer and manage the Workforce Incentive Program, Flexible Payment System (FPS) • Subcontract RHWA for national representation and coordination activities • Provide health professionals with access to development opportunities, including through the provision of grants • Develop and implement strategies for safe, culturally sensitive workplaces and services • Develop and implement strategies to improve the jurisdictions' health workforce skills profile, to ensure that organisations have access to the right mix of health professionals by both profession and work type • Provide health professionals access to tools to become vocationally qualified or up-skill to meet a community need • Develop and implement strategies for the retention of the workforce in regional, rural and remote health practices • Provide policy advice on current and emerging issues impacting on sustainability of the workforce • Develop strategies for ensuring continuity of care in rural areas • Develop strategies to direct incoming workforce flows to areas and professions likely to meet future shortages • Promote rural health career opportunities and provide career management support • Provision of grants for health professionals and students to gain exposure to rural health work • Provision of grants to health professionals to improve business practices to ensure long-term sustainability • Provide support services to Bonded Program recipients to prepare them for rural health work and assist them to undertake their return of service • Provide user feedback and input at key stages of the Bonded Program reform implementation process	• Health Workforce Needs Assessment and Activity Work Plan • The jurisdictional HWSG is operating • Health professionals are incentivised to work in rural locations • Health professionals, including GP locums, are placed in areas of need • A visiting health service, hosted and supported by local health organisations • Candidates in the MDRAP and the 5-Year OTD Scheme are placed in areas of need • Support non-vocationally recognised doctors in areas of need who are on the pathway to fellowship • GPs receive funding to provide eligible non-Medicare services that is not reflected in MBS records • RHWA provides national representation, coordination and administration to RWAs • Increase opportunities for health professionals to maintain and improve skills ensuring communities have the skills they need to maintain and enhance their delivery of care • Strategies in place to: • Support workplaces to be safe and culturally sensitive • Identify community need and skill shortages and ensure the right mix of skills in a community • Support retention of the workforce in regional, rural and remote health practices • Support future workforce shortages and continuity of care • Provide examination support, individual learning plans, facilitating workshops, in addition to the provision of grants • RWA provides policy advice (e.g. to the Department of Health) on issues impacting sustainability of the workforce • Health professionals have increased knowledge and awareness of the opportunities to work in regional, rural and remote areas • Health professionals improve business management skills • Bonded participants are placed in areas of need, and are provided with support, given guidance and options for Return of Service obligations • RWAs provide advice on issues impacting implementation of bonded participants	**Short Term Outcomes (less than 12 months)** • Communities can access the right health professional at the right time • Improved timely access to appropriate healthcare • Roles and responsibilities established to deliver health workforce solutions • Short term leave cover is available for health professionals in regional, rural, and remote areas • Improvement in skillset and training in regional, rural, and remote areas • General practice experience in rural and remote communities, including Junior Doctors and locum GPs • Targeted incentives encourage health professionals to work in areas of need • Partnerships and alliances are formed • Provision of timely and accurate information (e.g. to the Department of Health) to support decision making **Medium Term Outcomes (one year to three years)** • Improved quality of healthcare delivered by appropriately qualified health professionals to the community • Improved retention rate of appropriately qualified health professionals in rural, regional and remote areas • Improved cost effectiveness of maintaining an appropriately qualified workforce in areas of need • Improved business viability of regional, rural and remote healthcare services **Long Term Outcomes (after three years)** • Improved continuity and quality of healthcare appropriately delivered to the target community • Building of a sustainable and appropriately qualified health workforce that meets community needs • Health professionals complete the required term of service (5-Year OTD) in a location in areas of need • Retention of medical practitioners in areas of need by providing incentives to continue to work in these areas • Improved rural and remote community health outcomes • Stakeholder groups have a shared vision for the development of a longer-term integrated approach to primary health care workforce planning

Source: KPMG, 2020

2.4.　　Review considerations

The RWAs have a different organisational history and have different jurisdictional needs, including levels of remoteness, Aboriginal and Torres Strait Islander population density, access to training programs and universities, and the health workforce labour market (including attraction, retention and turnover of the health workforce). Given this context, there were a number of challenges that were considered in the review approach. These include:

- Recognising changes that have occurred in the program structure over time in response to key stakeholders (including the RWAs), which may impact on implementation against the original intent and design of the program.

- Quantifying the different base level of rural health workforce access, quality and sustainability in each jurisdiction at the time of program commencement.

- Recognising that different stakeholder perspectives are likely, particularly in relation to review considerations around elements such as the funding proportions of the program, utilisation of resources and level of governance and oversight (for example appropriateness of requirements in the development of the HWNAs).

- Evaluating program delivery across the three elements of the program, noting that there may be areas of interdependency and / or overlap.

- Measuring subjective elements such as the success of stakeholder engagement by the RWAs.

- Taking into account the differing levels of maturity and progress across different jurisdictions, including understanding the nuances in the health workforce context, and reflecting this in any recommendations around program improvement.

- Taking into account that RWAs can also receive funding through State and Territory Governments, meaning that the review needs to clearly distinguish Commonwealth Government funded activity or identify where there have been useful synergies or overlaps across Commonwealth and State and Territory approaches.

2.5.　Review methodology

2.5.1.　　Overview of methodological approach

The review used a mixed-methods approach, and collated data from a range of existing qualitative and quantitative sources.

The approach to evaluating the four domains of appropriateness, effectiveness, efficiency and engagement is outlined in the remainder of this section.

2.5.2.　　Appropriateness analysis

The approach to the appropriateness analysis accounts for the unique challenge of providing sustainable healthcare to regional, rural and remote Australia. Service planning in these areas requires a deep understanding of the complex interface between community need and community size and remoteness.

The appropriateness analysis focuses on:

- Understanding if the program design is informed by a credible and contemporary theory of change and evidence base and understanding if the program is being implemented in line with the design and theory of change.

- Understanding if the current reporting and data collection are appropriate and sufficient to enable progress to be tracked and impact to be measured.

- Understanding how RWAs have implemented the RHWSA program within their local contexts to achieve the aims of the program, and considering if there is sufficient flexibility in the design of the program to enable this to be achieved.

- Identifying if there is any duplication for the RHWSA program with other existing services.

- Considering what changes should be made (if any) to the design of the program moving forward, including if there are any contextual factors which need to be considered in the future design of the program.

2.5.3. Effectiveness analysis

The effectiveness analysis explores the degree to which each of the program components contribute towards achieving the program's objective to *"contribute to addressing workforce shortages and maldistribution in regional, rural and remote Australia"* (2)*.*

The effectiveness analysis focuses on:

- Exploring if the program is demonstrating improvement against its goals.

- Understanding how effectively each of the program elements are meeting their objectives.

- Exploring how effective RWAs have been in implementing the program, and how jurisdictional factors may have impacted this.

- Understanding the facilitators and barriers impacting effectiveness.

- Exploring how the effectiveness of the program can be improved in the future.

2.5.4. Efficiency analysis

The efficiency analysis is from the perspective of the cost of the program to the Department (that is, what the Department funds/pays for services to be delivered) and focuses on:

- The cost to the Department of the RHWSA program.

- Understanding the allocation methodologies for funding to different RWAs and activities, and exploring if the allocation promotes greatest efficiency.

- Understanding the relative cost of each of the three elements in the context of the program objectives.

- Opportunities for the program funding model to improve efficiency.

- Exploring how the efficiency of the program can be improved in the future, including consideration of potential overlaps or synergies with other programs (e.g. PHNs).

2.5.5.   Engagement analysis

The engagement analysis will explore engagement completed by RWAs with stakeholders of the RHWSA program. The engagement analysis focuses on:

- Understanding the engagement completed by RWAs with local communities and the rural health workforce, including:

  - The key factors that may influence this.

  - The strengths and limitations of the current approaches to engagement.

  - How engagement can be strengthened in the future.

- Exploring where there are areas of overlap in stakeholder engagement with PHNs, and how this could be better harnessed or leveraged.
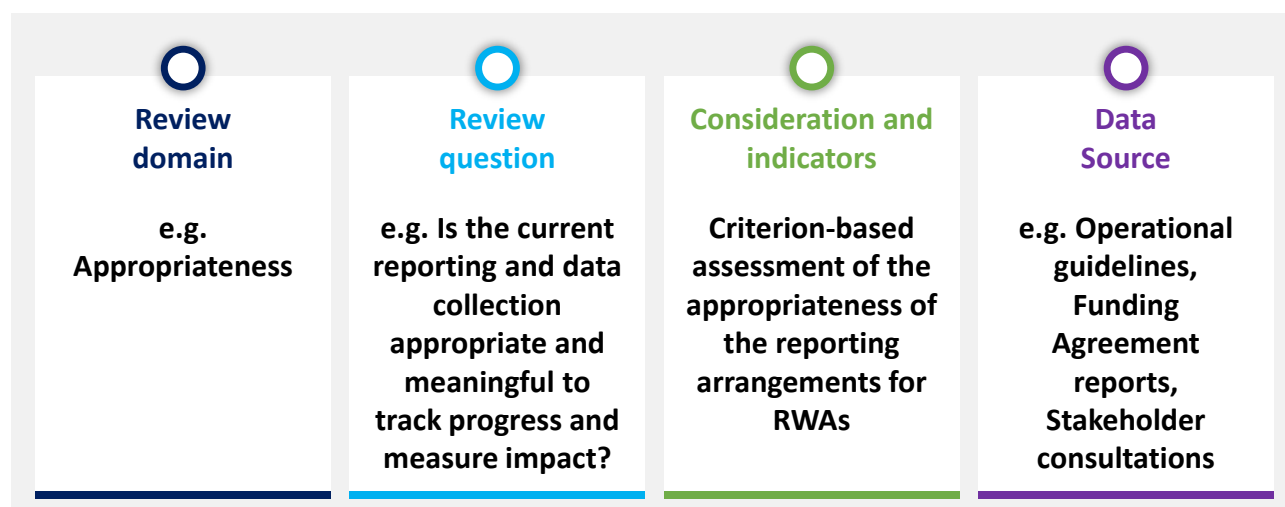
2.5.6.   Indicators

Each of the domains will be explored through the use of a set of qualitative and quantitative indicators. The initial set of indicators and data sources are provided in detail in Appendix 1. Note that the indicators are a mix of:

- **Assessment indicators:** indicators of the extent to which the program activity is meeting the requirement.

- **Contextual indicators**: indicators that provide contextual information that is used to interpret the assessment indicators.

The table in Appendix 1 sets out the areas of inquiry and the preliminary consideration and indicators for the review.

Figure 2: Mapping the review domains against the review questions, key indicators and data sources

Review domain	Review question	Consideration and indicators	Data Source
e.g. Appropriateness	e.g. Is the current reporting and data collection appropriate and meaningful to track progress and measure impact?	Criterion-based assessment of the appropriateness of the reporting arrangements for RWAs	e.g. Operational guidelines, Funding Agreement reports, Stakeholder consultations

Source: KPMG, 2020

2.6. Review methods

2.6.1. Analytical methods

Two broad methods of data analysis were applied, namely: program and financial data analysis. These methods are driven by the four domains of inquiry to understand how the program has been working and to identify any improvement opportunities. A summary of the methods of analysis are provided below.

Program data analysis

Program data was analysed using three types of analysis:

- Descriptive analysis, which was used to generate an understanding of the RHWSA program and its delivery by RWAs.

- Process analysis, which was used to generate an understanding of what the program is doing (i.e. turning inputs into outputs).

- Outcomes analysis, which was used to explore the outcomes being achieved for the Australian community through addressing the maldistribution of the health workforce.

The HWNA Reporting Template and other existing data formed a critical component of this analysis.

Financial data analysis

The approach to the analysis focused on efficiency and cost-effectiveness included:

- Establishment of the operating costs and cost drivers associated with the RHWSA program, by RWA. This was through bringing together service activity data, funding data, supporting documentation and interviews with the RWAs and Commonwealth representatives.

- A key focus was on understanding the apportionment of funding between RWAs, program elements and funding streams.

The detailed data limitations are provided in Appendix 7.

Literature scan

A literature scan has been completed to provide a basis for identifying the program's alignment to contemporary good practice and suitable options to improve outcomes into the future. Through a systematic exploration of the underlying evidence base, this literature scan identifies a range of contemporary practice strategies for attraction, recruitment and retention of rural health professionals across a range of disciplinary background (e.g. Medical, Allied Health, Nursing, Dentistry and Aboriginal and Torres Strait Islander health).

The methodology for conducting the literature scan included a search strategy and a defined scope for the sources considered. The literature scan is provided in Appendix 2, and includes further detail on the scope and method of the literature scan.

Data collection sources and methods

Table 5 below identifies data sources and data collection methods used during the review. Note that the tables in Appendix 1 link the use of these data sources to individual indicators for each of the four domains.

Table 5: Data types and sources for the review

Data type	Source
Operational guidelines	The Department
Documents required under the funding agreement, including: Annual Reports Financial Acquittal Reports Performance Reports HWNAs AWPs	The Department
Annual Information Statements	Australian Charities and Not-for-profits Commission
Other relevant partnerships and collaborations, workforce support and promotion and another relevant information and advice	RWAs and relevant stakeholders
Stakeholder perceptions	Semi-structured stakeholder interviews (discussed further below)

Source: KPMG, 2020

Stakeholder consultation

This section discusses the role of stakeholder consultation in the review approach as a data collection method, including what types of data was collected from whom and the principles that underpinned communication with stakeholders.

Stakeholder consultations were undertaken using a semi-structured interview approach. Table 6 below illustrates the main areas of inquiry for each stakeholder group. The list of stakeholder consultations that were undertaken is provided in Appendix 4. The detailed consultation guides for each stakeholder group is provided in Appendix 5.

Stakeholder consultations were not undertaken with rural health services and professionals, as consultations undertaken with other stakeholder groups identified there would have been less utility for the review due to the low awareness about the RHWSA program. Following discussion with the Department, consultations were not undertaken with State and Territory Departments of Health during the review.

Table 6: Stakeholder consultation approach

Data type	Source
Rural Workforce Agency Network (RWAN) Chair	- Across all domains of inquiry. - Exploring questions on experience and satisfaction with the program. - Understanding views on areas for improvement across all domains. - Exploring the impact on areas of health workforce access, quality and sustainability.
RWAs	- Across all domains of inquiry. - Exploring questions on experience and satisfaction with the program. - Exploring the impact on areas of health workforce access, quality and sustainability. - Exploring jurisdictional considerations.
RHWA	- Across all domains of inquiry. - Exploring questions on experience and satisfaction with the program. - Exploring the impact on areas of health workforce access, quality and sustainability.
Regional Training Organisations (RTOs)	- A focus on effectiveness, appropriateness and engagement domains of inquiry. - Exploring questions on experience and satisfaction with the program. - Exploring the impact on areas of health workforce access, quality and sustainability.
PHNs	- A focus on effectiveness, appropriateness and engagement domains of inquiry. - Exploring questions on experience and satisfaction with the program. - Exploring the impact on areas of health workforce access, quality and sustainability. - Identifying existing linkages and potential crossover in program delivery.
RHOF fundholders	A focus on effectiveness, appropriateness and engagement domains of inquiry.

Data type	Source
	• Exploring questions on appropriateness of the program to rural health workforce needs, including potential gaps in program design, observed impacts on the rural workforce, and opportunities for program improvement.
Specialist Training Pathway Providers	• A focus on effectiveness, appropriateness and engagement domains of inquiry. • Exploring questions on experience and satisfaction with the program. • Exploring the impact on areas of health workforce access, quality and sustainability.
Rural Clinical Schools (RCSs)	• A focus on effectiveness, appropriateness and engagement domains of inquiry. • Exploring questions on experience and satisfaction with the program. • Exploring the impact on areas of health workforce access, quality and sustainability.
Aboriginal and Torres Strait Islander Health State Peak Bodies	• A focus on effectiveness, appropriateness and engagement domains of inquiry. • Exploring questions on the effectiveness of the program in increasing the Indigenous health workforce in rural communities. • Exploring opportunities for improvement in design and implementation.
The Department – Rural Distribution Section	• All domains of inquiry. • Focus on variance from previous program structure and benefits/challenges of each, and perspectives on effectiveness of implementation including variances between RWAs. • Understanding perspectives on governance.

Source: KPMG, 2020

2.6.2.   Limitations and challenges

The known limitations are:

• Representativeness of participants in stakeholder consultations. A range of stakeholders were identified to participate in consultations. In some cases, these stakeholders represent a sample of a broader group. These samples have the potential of being biased and indicative, rather than definitive. Where possible, stakeholders were asked to provide information to support their views, when that information is not already collected from other sources. Additionally, stakeholder consultations were not undertaken with rural health services and professionals and State and Territory Department's of Health.

- Accuracy of existing data sources. The activity and other program data provided by various stakeholders cannot be independently verified. However, an initial sense check of the quality of the data was undertaken to identify outliers which was discussed with the data custodians.

- Data available to explore potential overlaps or synergies with other programs. The data available to inform potential overlaps or synergies with other programs (e.g. the PHNs) was limited to qualitative information obtained from stakeholder interviews and publicly available data.

Additional limitations for the data analysis are provided in Appendix 7.

3. Review findings

The findings of the review of the RHWSA program are presented in this section under the four domains of appropriateness, effectiveness, efficiency and engagement. The methods of analysis used to identify findings are described in Section 2.5 of this report, however where necessary, these have also been described alongside the review findings.

While the scope of this review was limited to the RHWSA program, it is acknowledged that some findings relate and can be attributed to broader rural, regional and remote health workforce challenges and contextual jurisdictional factors. It is important to note the complex and varied stakeholder and system environment within which the RWAs operate and the impact this may have on their effectiveness to drive change.

There are also concurrent activities being undertaken at the same time as the review (e.g. National Medical Workforce Strategy, Evaluation of the Rural Health Multidisciplinary Training Program). Where relevant, outcomes from these activities should be considered in the future design of the RHWSA program.

The key findings and considerations are provided below for each domain. Detailed analysis of all review questions is provided in Appendix 2.

Throughout this report, short examples have been used to highlight issues and themes. These examples are not intended to illustrate best practice.

There are consistent themes across the four domains, with the most relevant of these being stakeholder engagement. These themes are explored individually within the domains to outline the specific findings relevant for each domain.

3.1. Appropriateness

Appropriateness is the extent to which the program addresses an identified need and the program's alignment with Government priorities. This section explores the program need, design and alignment to the evidence base, the key factors that impact on the program and future design considerations. A summary of the findings for the appropriateness domain is provided below.

Summary of appropriateness findings

While there is evidence that the RHWSA program is meeting an identified need, there is a complex ecosystem of stakeholders operating in each jurisdiction to provide support for regional, rural and remote community health workforce needs. A summary of key findings relating to the appropriateness domain is presented below:

- There is some evidence that the program design is informed by a credible evidence base and that the program is being implemented in line with the program design.

- During stakeholder consultations, the RWAs commented that the program design provides the RWAs with a degree of flexibility with their approach in identifying and addressing localised health workforce need. The RWAs have flexibility within each element to deliver eligible activities that best meet the needs of the individual

communities. There are opportunities to adjust the funding model to support RWAs to have more flexibility to achieve the program aims within their local contexts (discussed further in Section 3.3).

- Two RWAs reported a view that there is an opportunity to expand the remit of the program to accommodate the disability and aged care sectors, which are often integrally linked and interdependent on primary health services in rural and remote locations.

- During stakeholder consultations, stakeholders identified the three elements of the RHWSA activity as relevant now and into the future, however they noted that there are challenges in balancing focus and activity across the three elements. Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth area-specific planning to anticipate and address future workforce issues and requirements. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. These include the number of different service providers, market maturity and the population size and demographics.

- There is a complex ecosystem of stakeholders operating in each jurisdiction to provide support for regional, rural and remote community health workforce needs. This can have implications where stakeholders are operating in a duplicative manner, or where there may be competing objectives between different stakeholders.

- The RWAs identified that outcomes-based reporting would better communicate the progress in addressing workforce shortages and maldistribution in regional, rural and remote Australia, and would better align with the three program elements. There is an opportunity to leverage outcomes-based reporting already completed by the RWAs (e.g. reporting to their Board of Directors) for the RHWSA performance reporting.

3.1.1.   Program need

Australia's population is highly urbanised: in 2018-19 capital city growth accounted for 79% of total population growth; comparatively remote and very remote regions experienced population decline (18). As level of remoteness increases, life expectancy decreases. In 2015, the total burden of disease in remote and very remote areas was 1.4 times higher than for those residing in major cities. Additionally, those in rural areas often have more complex health needs due to higher rates of chronic and other health conditions. In particular, Aboriginal and Torres Strait Islander people, who make up a large proportion of populations living in very remote communities, are an 'at risk' population more likely to have poorer health outcomes (12).

With poorer health and greater demand for healthcare services, Australians living in remote and very remote areas experience what has been termed a 'double-edged sword' (19). Additionally, health workforce shortages exist, with a disparity in personnel between metropolitan and rural and remote regions - there is a clear trend of decreasing clinical full-time equivalent health professionals (per 100,000 persons) as remoteness increases (12). Largely, rural and remote healthcare access issues are a result of the persistent problem of health workforce undersupply and maldistribution (8). Traditional training programs and funding mechanisms have led to an uneven distribution of healthcare providers throughout the country (11). Operationally, rural and remote service providers do not experience the same economies of scales as their metropolitan-based counterparts, often experiencing significant administrative burden to meet multiple accreditation, accountability and reporting requirements (12).

Outside of metropolitan centres, access to healthcare remains a significant issue (12). Geographically based disparities in health have been clearly linked to the challenges of providing equitable services to dispersed populations with limited infrastructure and higher service delivery costs (20). A clear need exists to address these ongoing health workforce supply and distribution factors in order to improve health outcomes throughout Australia's rural and remote populations.

3.1.2.   Program design

The RHWSA program is one component of the broader Health Workforce Program, managed by the Department to address health workforce shortages and maldistribution (2). The RWAs administer the program on behalf of the Commonwealth. The program was co-designed by the Department and the RWAs.

The program's objective is to contribute to addressing health workforce shortages and maldistribution in regional, rural and remote Australia.

The expected outcomes of the program are to meet current and future community health workforce needs through workforce planning. The outcomes of the program were to be met by:

- Identification of needs and undertaking activities in three key priority areas of Access, Quality and Sustainability.

- Collaborating with relevant stakeholders, such as PHNs, through the establishment of formal networks of consultation (e.g. HWSG).

- Delivery of programs (e.g. 5 Year OTD).

- National representation of RWAs and their interests, administered through sub-contracting arrangements to RHWA (2).

The program design accounts for variability in jurisdictional priorities. The RWAs can determine the activities to be undertaken to address key priority areas, based on the findings of the local HWNA. The operational guidelines outline eligible activities that can be delivered for each element.

The RWAs, in consultation with the HWSG, also develop a list of eligible medical, nursing and allied health professionals for support under the program, allowing for jurisdictional priorities to be considered in this decision.

Since the establishment of this program in 2017, there has been a shift in the focus of the RWAs with wider inclusion of health professionals, including nursing and allied health in workforce initiatives and programs. The majority of stakeholders identified that this has been a positive shift. Some stakeholders noted that this was still in its infancy.

The majority of stakeholders reported that the three program elements of Access, Quality and Sustainability are appropriate elements for the focus of the program. Stakeholders identified that all three elements were important to meet current and future regional, rural and remote community health workforce needs.

3.1.3.   Program's alignment with evidence base

A literature scan was completed to identify best practice strategies for improving the recruitment and retention of healthcare professionals in rural and remote communities (refer to Appendix 3).

These best practice strategies are grouped across four key domains: education, regulation, financial and personal/professional supports. Whilst there is evidence in support of each strategy in isolation, the literature strongly recommends bundling individual strategies together to form personalised packages of interventions that are flexible and address the unique barriers of the individual context that is being targeted (8; 10; 9; 21; 22; 23).

There are several key programs delivered by the RWAs under the RHWSA program. Each program aligns with an intervention domain identified through this literature scan. This is outlined below:

• 5 Year OTD Scheme – Regulatory.

• MDRAP (formally the RLRP) – Educational.

• Workforce Incentive Program - Doctor Stream FPS (formerly the General Practice Rural Incentive Program) – Financial.

Each jurisdictional RWA has the flexibility to deploy the strategies outlined above to address the specific jurisdictional needs identified in the manner most appropriate to their specific context.

To this end, the program is grounded upon well-established theory linking bundled packages of interventions which utilise a combination of strategies to address the specific jurisdictional challenges, to better recruitment and retention outcomes (8; 10; 9; 21; 22; 23).

3.1.4. Key factors that impact on the program

Place-based planning

Place-based planning was identified by stakeholders consulted as a key variable that positively impacts the program's ability to demonstrate change at a community level. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning.

Place-based planning is occurring in every jurisdiction to some extent. Stakeholders identified there is an opportunity for RWAs to further utilise this approach, to develop tailored workforce solutions for individual communities based on place-based workforce needs assessment and planning.

In the HWNAs, the RWAs documented that a consistent methodology was used by all RWAs to determine relative health workforce needs in communities across Australia (refer to Section A.3 for further detail). RWAs provide strategies and activities for priorities or hot spot towns. This has included broader priority areas such as all Aboriginal Community Controlled Health Services, all mainstream general practices in MM6 and MM7 locations, and support for a regional area. RWAs also identified specific towns where there is an identified need.
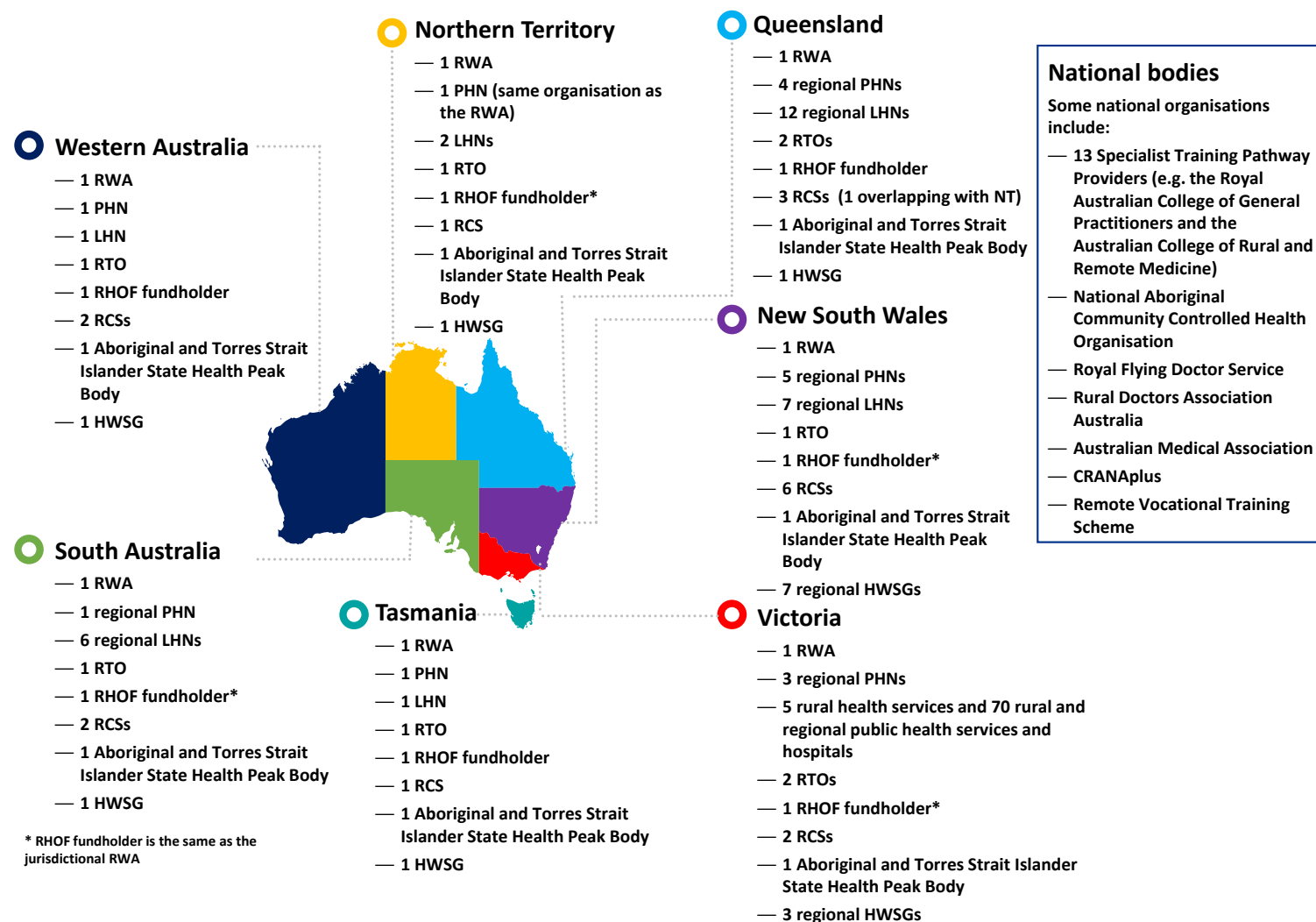
Flexibility

The three program elements provide the RWAs with a degree of flexibility within the program to deliver eligible activities for areas of need, as identified by the HWNA.

During consultations, the RWAs identified that the funding was generally flexible, however the notional splits between program elements and funding streams were unhelpful. This is explored further in Section 3.3.

Policy context at the jurisdictional and national level

There is a complex ecosystem of stakeholders operating in each jurisdiction to provide support for regional, rural and remote community health workforce needs. The stakeholders in each jurisdiction have different resource allocation priorities in relation to rural health workforce models. This can have implications where stakeholders are operating in a duplicative manner, or where there may be competing objectives between different stakeholders. Clarifying each stakeholder's role and remit may assist with demonstrating change at a jurisdictional level. There is also a lack of awareness of the jurisdictional and national priorities for the RHWSA program. Figure 3 below illustrates some of the stakeholders involved in supporting regional, rural and remote community health workforce needs. This includes the RWAs, PHNs, RTOs, Local Health Networks (LHNs), RHOF fundholders, RCSs, Aboriginal and Torres Strait Islander State Health Peak Bodies and national bodies. The number of HWSGs are also reflected on the figure for each jurisdiction. The stakeholder environment is further explored in Section 3.4.

Figure 3: Stakeholders involved in supporting regional, rural and remote community health workforce needs

Northern Territory
— 1 RWA
— 1 PHN (same organisation as the RWA)
— 2 LHNs
— 1 RTO
— 1 RHOF fundholder*
— 1 RCS
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

Queensland
— 1 RWA
— 4 regional PHNs
— 12 regional LHNs
— 2 RTOs
— 1 RHOF fundholder
— 3 RCSs (1 overlapping with NT)
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

National bodies

Some national organisations include:
— 13 Specialist Training Pathway Providers (e.g. the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine)
— National Aboriginal Community Controlled Health Organisation
— Royal Flying Doctor Service
— Rural Doctors Association Australia
— Australian Medical Association
— CRANAplus
— Remote Vocational Training Scheme

Western Australia
— 1 RWA
— 1 PHN
— 1 LHN
— 1 RTO
— 1 RHOF fundholder
— 2 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

New South Wales
— 1 RWA
— 5 regional PHNs
— 7 regional LHNs
— 1 RTO
— 1 RHOF fundholder*
— 6 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 7 regional HWSGs

South Australia
— 1 RWA
— 1 regional PHN
— 6 regional LHNs
— 1 RTO
— 1 RHOF fundholder*
— 2 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

Tasmania
— 1 RWA
— 1 PHN
— 1 LHN
— 1 RTO
— 1 RHOF fundholder
— 1 RCS
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

Victoria
— 1 RWA
— 3 regional PHNs
— 5 rural health services and 70 rural and regional public health services and hospitals
— 2 RTOs
— 1 RHOF fundholder*
— 2 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 3 regional HWSGs

* RHOF fundholder is the same as the jurisdictional RWA

Source: KPMG, 2020

3.1.5. Future design considerations

The following are considerations for the future design of the program.

Place-based planning

Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth area-specific planning to anticipate and address future workforce issues and requirements. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. These include the number of different service providers, market maturity and the population size and demographics.

Findings from the literature scan have identified that place-based approaches can be effective for changing health outcomes or health-related behaviours in target populations. Place-based approaches typically address underlying social determinants associated with poorer health outcomes and can be successful in influencing change in built environments, social cohesion and economic environments within defined geographic locations. Key to the success of place-based approaches is the use of collaborative partnerships between local health services/ providers and relevant local/state/national government agencies to design and implement health programs and services (3).

Program reporting

During stakeholder consultations, the RWAs identified that the program reporting is compliance and outputs focused and does not provide the opportunity for the RWAs to demonstrate the depth of the outcomes that have been achieved. The following are considerations for the program reporting:

- **Outcomes-based reporting:** During stakeholder consultations, the RWAs identified that the reporting is compliance and outputs focused and does not provide the opportunity for the RWAs to demonstrate the depth of the outcomes that have been achieved. RWAs identified that outcomes-based reporting would better communicate the progress in addressing workforce shortages and maldistribution in regional, rural and remote Australia, and to better align with the three program elements. Some RWAs reported that they are required to provide outcomes-based reporting to their Board of Directors. There is an opportunity to leverage outcomes-based reporting already completed by the RWAs (e.g. for their Board of Directors) for the RHWSA performance reporting.

  The literature recommends benchmarking services against desired outcomes postulated during planning to ensure funders can understand to what extent services are achieving positive outcomes for their target population. Care must be taken when designing such frameworks to ensure they are not so onerous, in terms of complexity and time, that they conflict with service delivery (6).

  There are practical challenges associated with moving to outcomes-based reporting. Short-term actionable activity can be undertaken by the Department in ensuring reporting is consistent by the RWAs and providing feedback to RWAs on the quality of the reporting and opportunities for improvement.

There are opportunities to utilise work undertaken by the Department for outcomes-based reporting. One example is the PHN Program Performance and Quality Framework that was implemented by the Department in 2018. It is designed to consider how the activities and functions delivered by PHNs contribute towards achieving the PHN program's objectives. The PHN Program Performance and Quality Framework includes the outcomes to be achieved in the program, drawn from the program logic, and includes indicators to assess individual PHN performance. Additionally, a yearly report is to be prepared for the overall performance of the PHN program, which assesses progress towards achieving the PHN program outcomes. One of the findings from the most recent report was that there are some regions where workforce support is limited and could benefit from a more integrated and planned approach (24).

A performance framework could support the transition to outcomes-based reporting and ensure consistent reporting by RWAs. Additional considerations for outcomes-based reporting are provided below:

- Program reporting should align to the program logic (e.g. outputs delivered, outcomes achieved). Performance indicators should provide accurate insight into the short, medium and long-term effectiveness of the program.

- Program reporting should support financial data analysis (e.g. unit cost per activity).

- Clear guidelines on the reporting requirements should be provided to the RWAs, including information on the purpose of the indicators and how the information will be used.

- Mechanisms are available for the Department to provide feedback to the RWAs on their program reporting and their performance.

- The reporting framework and its indicators should be reviewed and updated as required, to reflect the progress in achieving the program outcomes.

- **Reporting mechanism:** The reporting mechanism is not dynamic. There is an opportunity to implement a digital platform (e.g. web-based portal) to support information, outcomes and risks to be updated efficiently. Considerations for the digital platform could include:

- Having consistent templates and methods for populating the information, so that performance can be consistently assessed and allow for jurisdictional and national analysis.

- Requiring all information to be completed before the reports can be submitted.

- Leveraging existing data collection and analytics capabilities of the RWAs.

- Where possible, incorporating automatic pre-population of the reports to streamline the reporting process.

The Department recently implemented a digital reporting mechanism for the PHN Program, the Primary Health Networks Program Electronic Reporting System (PPERS). It allows PHN users to log in to the PPERS Portal, and to draft, edit and update their reporting information online, and electronic submission and approval processes between PHNs and the Department of Health (25).

- **National reporting:** There is currently no national reporting on the outputs and outcomes of the RHWSA program, by RHWA or by another organisation. Completing national reporting would provide a summary of the overall impact of the program. The performance framework (referred in the outcomes-based reporting section above) could include information on the national reporting requirements.

Consideration of adjacent or interdependent workforces

Two RWAs commented that there is an opportunity for expanding the remit of the program, to accommodate the disability and aged care sectors, which are often integrally linked and interdependent on primary health services in rural and remote locations.

Duplication of activities

Consultations identified that there are duplicate activities being undertaken by different stakeholders (e.g. the role of PHNs in undertaking health workforce support activities) and there is an opportunity to review and consider opportunities for consolidation to support more effective and efficient processes, and reduce duplicative activities being undertaken in the sector, sometimes with differing objectives. Consideration should be provided for opportunities to consolidate processes or activities where appropriate with other stakeholders in the future design of the program. This is explored further in Section 3.4.

Ongoing monitoring and evaluation

The RWAs have flexibility to undertake eligible activities to meet the identified needs in a community. As such, RWAs all undertake different activities across the three program elements. Building the evidence base, through monitoring and evaluation, to assess the design, development and implementation of activities will support identification of what does and does not work, to support continuous improvement of the RHWSA program.

The literature scan identified the need for robust and ongoing data collection, analysis, monitoring and evaluation of all strategies implemented to instigate health workforce improvements in rural, regional and remote settings. The literature scan highlights the importance of implementing evaluation frameworks from the outset when designing programs that aim to support the recruitment and retention of healthcare providers in rural and remote communities, as opposed to completing these retrospectively (8; 10; 9)

3.2. Effectiveness

Effectiveness is the extent to which the program is achieving the intended objectives and producing results (activities, outputs and outcomes). This section explores the needs assessment and planning, the activities undertaken in the program, the key factors that impact on the effectiveness of the program and future design considerations. A summary of the findings for the effectiveness domain are provided below.

Summary of effectiveness findings

The review found some evidence of the effectiveness of the program in contributing towards achieving the RHWSA program objective. A summary of key findings relating to the effectiveness domain is presented below:

- The degree to which an RWA successfully engages and builds relationships with key stakeholders impacts on the overall effectiveness of implementing the program's activities. There are numerous factors that influence this, including the organisational capability to share data and information, a clearly defined organisational remit and responsibilities and the broader state-based vision for the rural health workforce.

- The majority of stakeholders commented that it is challenging to attribute improvements in access, quality and sustainability of the rural primary health workforce to the RHWSA program given the range of activity being completed in the sector to support the rural health workforce. Within each jurisdiction, at least one of the stakeholder groups consulted reported a limited awareness of the role, scope and remit of the RWAs, further impacting the ability to measure the effectiveness the program activities and the impact it is having on the rural health workforce.

- The majority of stakeholders acknowledged that contemporary service delivery models (e.g. telehealth, fly-in-fly-out service delivery) are important considerations in the future to improve rural workforce sustainability and viability. It was broadly acknowledged that these primary health care models will place a greater emphasis on multidisciplinary practice, leveraging off the skills and capabilities of nurses, including nurse practitioners and allied health professionals, to reduce the reliance on, and compliment GPs and other medical professionals.

3.2.1. Needs assessment and planning

The health workforce needs assessment process is critical in identifying areas of need and understanding what support could be provided for specific locations. Most RWAs reported that the HWNA is a useful tool for framing engagement with external stakeholder groups and with providing a nationally consistent approach to localised health workforce planning. The key benefit was identified to be the lens and focus on community needs and challenges. This focus allowed agencies to collaborate to address a common issue rather than focus on pursuing their own organisational agenda. The HWNA template allowed jurisdictional agencies sufficient flexibility to adapt and develop their own methodologies to suit jurisdictional need.

However, in some jurisdictions, these stakeholder groups, particularly the PHNs, commented that as a state-wide mapping activity, the HWNA was too highly aggregated and did not provide detail on the nuances of the local area. There are specific drivers in each community which indicate the need for a more place-based approach to effective

workforce planning. These include the number of different service providers, market maturity and the population size and demographics. Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements.

Effective workforce planning needs to be directly connected to the service model that is appropriate for that area. While workforce availability can alter the choice of service model, a model on which workforce (form) follows the service model (function) is needed to ensure that recruitment is seen in the context of all the local actors and workforce roles. Place-based service planning is undertaken to a degree in each jurisdiction. Stakeholders identified there is an opportunity for RWAs to further utilise this approach, to develop tailored workforce solutions for individual communities based on place-based workforce needs assessment and planning.

3.2.2.   Activities undertaken in the program

The majority of stakeholder groups recognised that three years was a limited period of time for the program to demonstrate change for access, quality and sustainability of the regional, rural and remote health workforce. Some RWAs and jurisdictional stakeholders have noted that short-term improvements have been demonstrated, particularly for workforce access and quality, however this is difficult to solely attribute to the RHWSA program. Majority of stakeholder groups reported limited effectiveness of the program in achieving rural health workforce sustainability since it began in 2017. However, it was acknowledged that this is a longer-term goal for the rural health workforce and there are multiple contributing factors that impact on maintaining a viable rural health workforce model within a community that are outside the scope of the RHWSA program.

RWAs have administered a range of activities including MDRAP, the 5 Year OTD Scheme, the Workforce Incentive Program, FPS and provided grants, scholarships and bursaries. Implementation of these activities has supported the program with achieving the intended objective to "contribute to addressing workforce shortages and maldistribution in regional, rural and remote Australia" (2). Some of the activities include:

- **Recruitment of health professionals:** The RHWSA program resulted in the recruitment of 714 and 659 health professionals to regional, rural and remote Australia in 2017-18 and 2018-19, respectively. The key performance indicator for the recruitment of health professionals does not provide information on the number of health professional recruited compared to the need identified through the period, making it difficult to comment on the effectiveness in meeting the identified need. The reporting also does not consistently detail the communities where health professionals were recruited.

  Figure 4 below provides the number of health professionals recruited per RWA in 2017-18 and 2018-19 by MM. Stakeholder consultations identified that RWAs are increasingly focusing on improving access to health professionals and para-professional roles outside of the medical workforce. In the performance reports, four of the RWAs provided detail of the health professionals recruited, by health profession. In 2017-18 and 2018-19, for the four RWAs, 471 placements were for GPs, and 418 of the placements were for allied health and nursing professionals.

While the number of health professionals recruited into regional, rural and remote Australia are reported every six months in the performance reports, the reporting does not track the longer-term outcomes associated with the placements of individuals in regional, rural and remote communities. The current reporting does not provide any insight regarding the sustainability for health professionals by jurisdiction, community, and MM classification. In moving to outcomes-based reporting, more detail should be provided on health professionals recruited into the communities, the sustainability of the health workforce and the associated health model.

- **Rural health career promotion:** The RWAs undertook a range of activities to promote rural health careers, including facilitating rural exposure for undergraduate students, medical students, junior doctors and GP registrars.

- **GP locum subsidy and support:** The RWAs provided grants for GP locum subsidy and support. In the Access performance reports, NT and WA reported on the number of GP locum days. Overall, NT provided support for 2,360 GP locum days in 2017-18 and 2018-19, and WA 5,677 GP locum days.

- Grants to improve the quality and sustainability of the rural health workforce: This included grants for:

  - Business training.

  - Innovation.

  - Aboriginal cultural safety training.

  - Continuing Professional Development (CPD) grants (e.g. for attendance at workshops, exam preparation).

  - Upskilling grants.

  - Aboriginal student support grants.

  - Pre-exam support for International Medical Graduates (IMGs).

Some RWAs reported that some activities have been less effective with improving the access, quality and sustainability for the primary and preventive health workforce. One example was grants and scholarships, where the initial design of the program required over 50% of funding to be expended on grants and incentives. The RWAs welcomed a decrease in the level of funding required to be allocated to this funding stream to enable more funding to be allocated to other activities to meet the identified areas of need. This is explored further in Section 3.3.2.

Some RWAs and PHNs identified that the provision of broader support and social services for an individual's partner and family are additional activities that can enhance the effectiveness of the RWA program in attracting and retaining a rural primary health workforce. Additionally, through the literature scan, it was identified that investment in infrastructure that improves the living and working conditions for a health worker's family (e.g. appropriate schooling opportunities for children and spousal employment opportunities) may positively influence distributional issues (8; 9). Specifically, it was identified that the opposite (i.e. poor living conditions and inadequate medical and schooling facilities) was a significant disincentive to the uptake of work in rural and remote communities (21; 9).

The literature scan identified that of all strategies reviewed, the strongest evidence of the impact of education on ameliorating the geographical maldistribution of doctors came from the 'integrated rural medical workforce pipeline'

approach (8). This approach targets key points throughout the medical workforce pipeline and considers each component in the context of how it may contribute to increasing non-metropolitan practice and the retention of doctors in rural and remote regions (8). During consultations, stakeholders reported that the ongoing fragmentation of postgraduate medical pathways requires RWAs to put in additional effort to retain people for regional, rural and remote locations who have relocated to metropolitan locations. This can work against the integrity of the 'integrated rural medical workforce pipeline' approach.

Figure 4: Number of health professionals recruited in 2017-18 and 2018-19 per Rural Workforce Agency by Modified Monash Model area
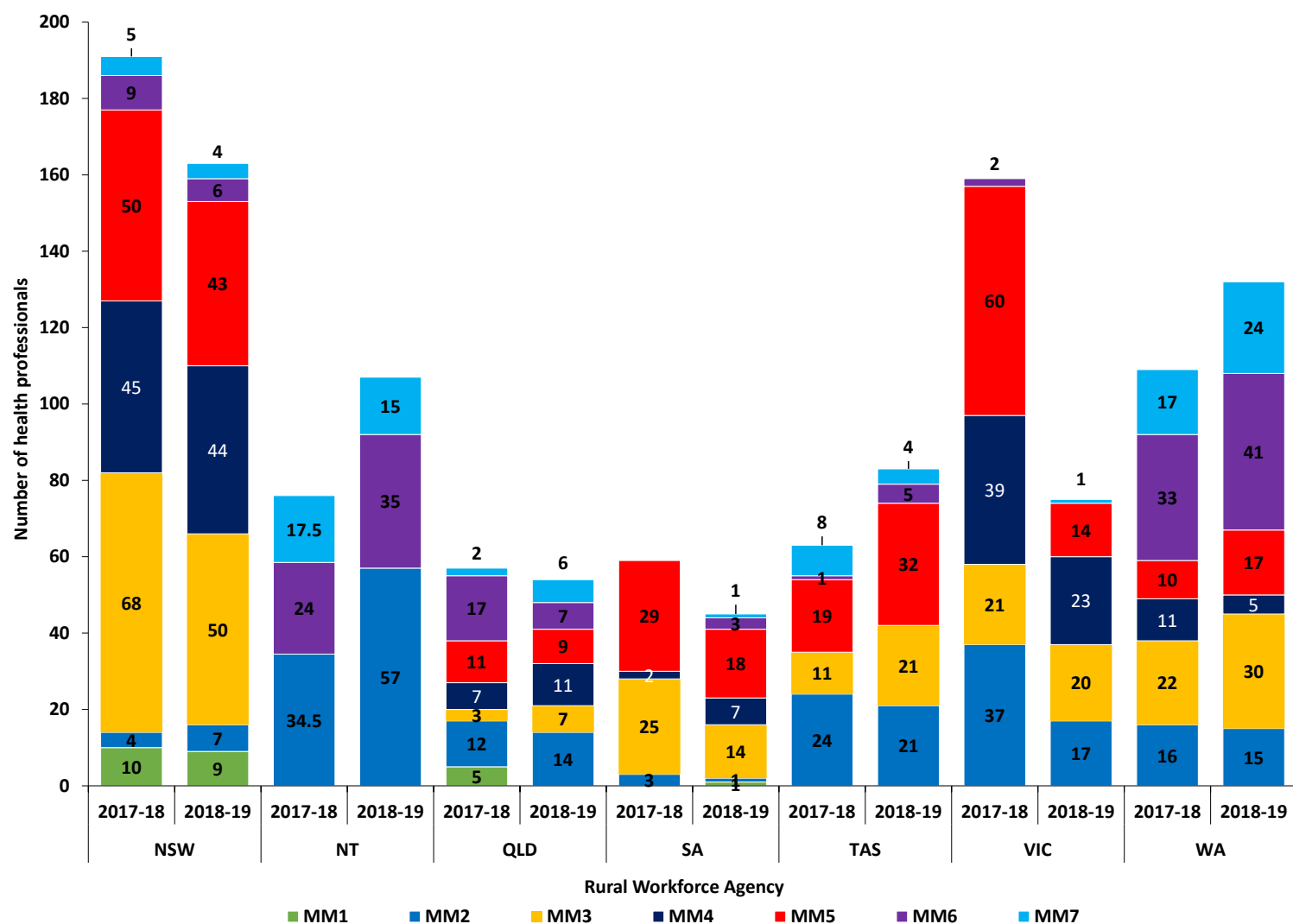
Source: Commonwealth Department of Health, analysed by KPMG

3.2.3. Rural Health Workforce Australia

The RWAs are required to sub-contract RHWA to provide national representation and coordination activities. The RWAs reported limited evidence on the effectiveness of the national representation and coordination activities in improving the access, quality and sustainability for the primary and preventive health workforce in regional, rural and remote Australia.

Considerations for national representation

There is an opportunity to clarify the roles and responsibilities of RHWA with specific respect to stakeholder engagement, reporting and program delivery, or to consider opportunities to support more effective national representation of the program.

Considerations for strengthening national representation of the program include:

- Supporting a level of synergy nationally between the RWAs.

- Preventing duplication of effort with other stakeholders (e.g. Specialist Training Pathway Providers).

- Increasing stakeholder awareness of the RHWSA program and the activities undertaken by RWAs.

- Promoting innovation within the RHWSA program.

- Supporting reallocation of resources to areas of need between jurisdictions.

- Undertaking national reporting of the outputs and outcomes of the RHWSA program.

The strengths and challenges for RHWA or RWAN providing national representation are provided below. An alternative body could also be considered to provide national representation for the RHWSA program.

RHWA

Under this model, RHWA continues to provide national representation and coordination activities for the RHWSA program. There are opportunities to clarify the funding, roles and responsibilities of RHWA with specific respect to stakeholder engagement, reporting and program delivery.

The strengths and challenges of this model are outlined below

Strengths

- RHWA is an independent body (separate from the RWAs), which reduces any potential or perceived conflicts of interest.

- As the model and process continues as it currently stands, there is no requirement to change internal departmental processes or funding agreements with RWAs. However, there are opportunities to review the funding and contractual arrangements when clarifying the roles and responsibilities of RHWA with specific respect to stakeholder engagement, reporting and program delivery.

- As RHWA is an independent body, the organisation is removed from the day-to-day operations of the RWAs in delivering the RHWSA program.

RWAN

Under this model, RWAN would provide national representation and coordination activities for the RHWSA program.

The strengths and challenges of this model are outlined below.

Strengths

- RWAN has representation from all RWAs, who can provide input to support national representation for the RHWSA program. This enables RWAN to leverage insights and learnings from the RWAs when developing and implementing activities at a national level.

- There is an opportunity for RWAN to serve as a touchpoint for the RHWSA program for national stakeholder groups.

Challenges

- The RWAN Chair is a representative from one RWA. This may create actual or perceived conflicts of interest for national representation of the program. This could be mitigated through program guidelines which outline the decision-making process for RWAN for national representation and coordination activities.

- More capacity may be required within RWAN to provide the national representation and coordination activities for the program, which may include hiring additional staff to deliver this activity.

3.2.4.   Key factors that impact on the effectiveness of the program

Stakeholder engagement

The degree to which an RWA successfully engages and builds relationships with key stakeholders impacts on the overall effectiveness of implementing the program's activities.

Case Study 1 below provides an example of a jurisdiction that has successfully integrated and coordinated an approach to rural primary health workforce planning, assessment and implementation of activities.

Further detail on stakeholder engagement is provided in Section 3.4.

Case Study 1: Partnerships and place-based planning in the Western NSW region

The Western NSW Primary Health Workforce Planning Project (the Project) was established in 2017, driven by unique challenges associated with health workforce planning in the Western NSW region. The Project was led by a partnership of four organisations: the NSW Rural Doctors Network, the Western NSW PHN, Western NSW Local Health District (LHD), Far West NSW LHD and the Bila Muuji Aboriginal Corporation Health Service recognising that a collaborative approach was required to form a deep understanding of the specific workforce issues facing the region and to better identify the key areas for action that would have the greatest impact (26).

The partnership, led by the NSW RDN, developed a tailored *Primary Health Workforce Planning Framework* and associated *2030 Western NSW Primary Health Workforce Priority Actions*, which brought together regional stakeholders united under a common vision to develop a longer term, integrated approach to primary health care workforce planning. Broad stakeholder engagement was critical to the process and included over 40 organisations involved in primary healthcare delivery across the Western NSW region. The Planning Framework articulates six priority action areas: recruitment, retention, addressing need, strong partnerships, professional development and training and strengthened coordination. Within each are key actions and strategies that are prioritised over a three-year implementation period, with "wave one" commencing in 2018-19 (26). The Project is an example of a place-based approach to rural health workforce planning and delivering tailored workforce strategies for a community.

Key enablers have been identified that have led to success of the Project, including:

- **Meaningful consultation and planning with a long-term lens:** The Workforce Plan and Priority Actions were developed with close consultation with regional stakeholders and primary health organisations. This ensured the local challenges and needs were accurately identified and the resulting action statements and strategies were focused to address the most important issues and tailored to the specific context of the Western NSW community. A three-year lens to the process facilitated the shift towards identifying proactive and sustainable strategies for the region, breaking the cycle of siloed, short-term responses from individual agencies (26).

- **Partnerships and collaboration:** The five organisations have made a commitment to collectively deliver on the strategies within the Workforce and Priority Action Plan. The partnership has been sustained through formal and informal mechanisms, such as (26):

  - Actively investigating opportunities to integrate primary health care workforce initiatives across agencies, particularly in areas where duplication may occur. For example, co-funding the creation of a Western NSW Primary Health Care Careers Platform, to centralise and coordinate health professional recruitment across partner organisations. Other identified opportunities for co-delivering workforce support activities include tailored continuing professional development and training.

  - Creating a Partnership Coordinator workforce role to administer agreements and governance arrangements between the partnership to formalise and sustain the commitment across the organisations.

  - Identifying accountability and responsibilities for delivering on the Workforce Plan, as outlined within the Stakeholder Report. A priority activity was to establish systems to track, monitor and report on progress, actions and achievements of the partnership to ensure collective progress on implementation is occurring.

- **Sharing knowledge, information and data:** The agencies are seeking to establish processes to link relevant health data, coordinate the health needs assessment processes and actively map existing workforce

support activities of stakeholders. This will inform and support future collaboration, reduce duplication and siloed activity and facilitate further integration of primary health care workforce programs (26).

The Western NSW Partnership has equipped key stakeholders with a shared understanding of the challenges, necessary tools and potential solutions to enable and drive sustainable future rural health workforce strategies, actions and services to address issues in the region and break reactive, siloed workforce planning and initiatives (26). Whilst the approach is tailored to the Western NSW region, the enablers of success can be taken forward and utilised in other regional, rural and remote areas, and demonstrates what can be achieved within a community.

Underlying system complexity and structure within which the RWA operates

The complexity of the health system is a factor that can impact on the RWA to effectively plan, assess and deliver rural health workforce activities. As discussed in Section 3.1.4, the complexity of the health workforce ecosystem can be attributed to the number of health workforce organisations, the organisational structure and governance arrangements, and the capability of leadership. This impacts on the ability to engage and navigate the stakeholder environment.

All stakeholder groups commented broadly on the long-term and complex challenges associated with rural health workforce planning across Australia, and the large number of programs implemented by a range of organisations to address these issues. Stakeholders commented that it is challenging to attribute improvements in access, quality and sustainability of the rural primary health workforce given these contextual factors. Within each jurisdiction, at least one of the stakeholder groups consulted reported a limited awareness of the role, scope and remit of the RWAs, further impacting the ability to measure the effectiveness the program activities and the impact it is having for the rural health workforce.

The following areas of duplication or overlap were identified during the stakeholder consultations:

- **State and Territory Governments:** The RWAs and State and Territory Governments both participate in crisis and short-term workforce initiatives through establishing locum placement opportunities for health professionals in areas of high need. RWAs identified long standing locum arrangements, particularly for GPs delivered by the State and Territory Governments reduce the effectiveness of the RWA to embed a long term sustainable health workforce model of care in a community, as locum positions provide services to a significant portion of the local community and reduce the need for full time primary health professionals within the region.

- **RHOF fundholders**: During consultations, RHOF fundholders reported a level of duplication in providing allied health outreach services to remote locations, which is also an activity delivered by the RWAs.

- **PHNs:** As provided in Section 1.3.2, RWAs are restricted to delivering activities for the three program elements in MM 2 - 7, except activities can be undertaken in MM1 for Aboriginal Community Controlled Health Organisations. Currently 17 PHN boundaries align and / or overlap with the MM 2 – 7 regions in which the RWAs operate within (4). In establishing the PHNs, the Australian Government identified seven priority areas to guide their work, including; mental health, Aboriginal and Torres Strait Islander health,

population health, digital health, health workforce, aged care, and alcohol and other drugs (5). The outcomes of the workforce priority area for the PHN program are:

- Local workforce has suitable cultural and clinical skills to address health needs of PHN region.

- PHNs support general practices and other health care providers to provide quality care to patients.

- People are able to access a high quality, culturally safe and appropriately training workforce (24).

There are a number of workforce indicators, such as 'Integrated Team Care improved the cultural competency of mainstream primary health care services' and 'Rate of general practice accreditation' (24).

Consultation with the RWAs and PHNs identified areas of duplication and overlap may occur where the 17 PHNs and the RWAs are both delivering rural health workforce activities within the same region. While the RHWSA program guidelines acknowledge the need for collaboration with the PHN through representation on the HWSG, there is a greater need for a more formalised partnership arrangement in the future, and to further differentiate the specific role and responsibility each organisation has in regards to workforce planning in regions where both are operating.

Noting a limitation that only three Aboriginal and Torres Strait Islander State Peak Bodies completed a stakeholder consultation, the consultations did not identify duplication in services provided in the RHWSA program in MM1.

Clarity of the roles, responsibilities and remit of key stakeholders within the system is important to reduce the risk of duplication across agencies and support a cohesive and coordinated approach to providing support to the regional, rural and remote health workforce. It was consistently identified throughout consultation that the RWAs should aim to collaborate and coordinate processes and activities with stakeholders across the continuum of the health workforce pipeline. This includes the following:

- RHOF fundholders.

- RCSs.

- PHNs.

- State and Territory Governments.

The mechanisms through which the RWAs can facilitate collaboration with stakeholders includes coordinating processes, information and data sharing, and establishing formalised agreements and partnerships.

In the future design of the program, there is an opportunity to review linkages or synergies with other Commonwealth funded programs and clarify the roles and responsibilities of different organisations operating in the rural health workforce sector to support ongoing collaboration.

3.2.5.   Future design considerations

This review has identified several opportunities to improve the effectiveness of the program. These include:

- **Flexible workforce models, multidisciplinary teams:** The majority of stakeholders acknowledged that contemporary service delivery models (e.g. telehealth, fly-in-fly-out service delivery) are important considerations in the future to improve rural workforce sustainability and viability. It was generally acknowledged that these primary health care models will place a greater emphasis on multidisciplinary practice, leveraging off the skills and capabilities of nurses, including nurse practitioners, and allied health professionals to reduce the reliance on, and compliment GPs and other medical professionals. Strategies that support the growth of a diversified health workforce (e.g. dentists and allied health professionals) and enhance the scope of appropriately qualified clinicians (e.g. nurse practitioners) were identified in the underlying literature as crucial for improving the supply of health workers in rural and remote areas (19; 9; 10). Additionally, to meet the ever-growing and complex demands of an evolving healthcare sector, this growth needs to be accompanied by holistic, flexible workforce models, particularly those that promote the use of multidisciplinary teams of healthcare professionals (19; 8).

- **Place based workforce planning:** A greater emphasis on the Sustainability program element and promoting a shift towards place-based approaches to workforce planning, assessment and activities determined by localised community need. This is explored in further detail in Section 3.1.5.

- **Clarifying roles and responsibilities:** There is an opportunity to clarify the roles and responsibilities of RHWA with specific respect to stakeholder engagement, reporting and program delivery, or to consider opportunities to support more effective national representation of the program. The role of RHWA is explored further in Section 3.4.2.

Improving awareness of the RHWSA program will assist the capacity to measure effectiveness of the program in meetings the objectives. Additionally, transitioning to outcomes-based reporting for the RHWSA program (as described in Section 3.1.5) would also build further evidence based on which interventions assist most in sustaining workers in rural and remote communities.

3.3. Efficiency

The efficiency domain focused on measuring how well resources are used to produce outputs/initiatives for the purpose of achieving program objectives. The efficiency analysis is from the perspective of the cost of the program to the Department (that is, what the Department funds/pays for services to be delivered). This section explores the cost of the program, allocation of funding to RWAs and program elements, RWA expenditure and future design considerations. A summary of the findings for the efficiency domain are provided below.

Summary of efficiency findings

Limitations with the available data impacted on the ability for analysis of unit cost per program activity, limiting the ability to comment on whether there was efficient use of resources to produce outputs/initiatives in the program. The analysis focused on the funding arrangements for the RWAs, program elements and the funding streams, and perspectives from stakeholder interviews.

A summary of key findings related to the efficiency domain is presented below:

- During consultations, most RWAs communicated that the notional splits between program elements and funding streams were unhelpful. Some RWAs commented that having more flexibility to move funding between program elements and program streams would support the delivery of the program in a manner that more directly aligns with the identified needs in their jurisdiction. A revised funding arrangement could also support discretionary and innovative solutions.

- There are opportunities to coordinate processes with other stakeholders to achieve efficiencies in the program and reduce duplication with other stakeholders.

3.3.1. Cost of the program

The total funding provided by the Department to the RWAs during the RHWSA program, from 2016-17 to 2019-20, was $80,104,785.40 (GST excl.).

The funding provided to each RWA during the RHWSA program is provided in Figure 5 below. NSW received the most funding ($15,166,612) followed by QLD ($13,996,478), with TAS receiving the least amount of funding ($4,909,248).

Figure 5: Total funding provided to each RWA for the RHWSA program, between 2016-17 and 2019-20[2]
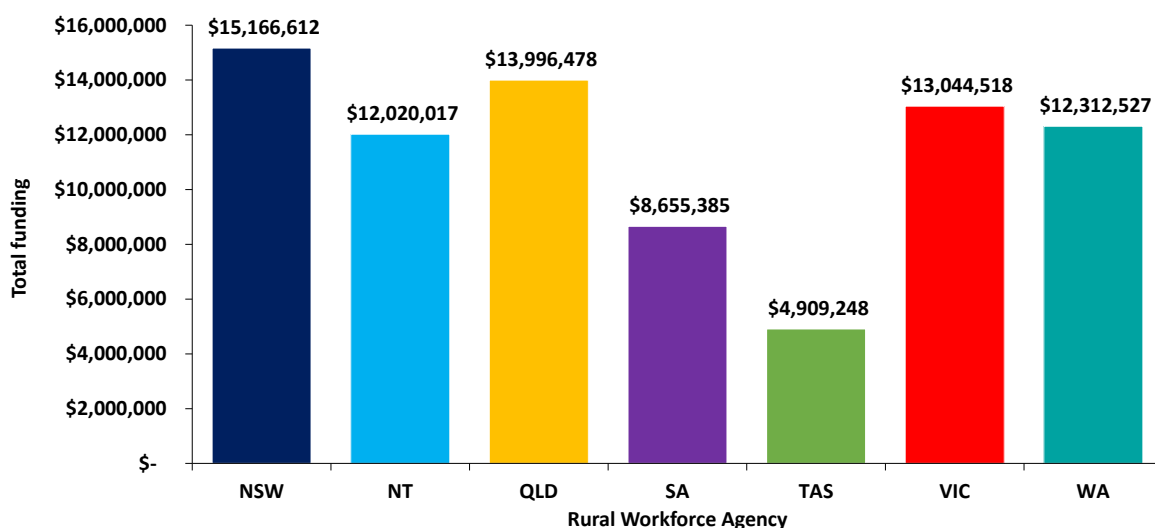
Source: Commonwealth Department of Health, analysed by KPMG

3.3.2. Allocation of funding

Allocation of funds to each RWA

The Department advised that the allocation of funds to each RWA was informed by the following factors:

- MM.

- Aboriginal and Torres Strait Islander population.

- Population over the age of 65.

- Socio-Economic Indexes for Areas (SEIFA) decile.

Allocation of funds to each program element

Funding is allocated to each element, with Access allocated 40% of total funding and Quality and Sustainability each allocated 30% of total funding for each RWA. The overall funding provided to each element in the program is provided in Table 7 below.

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[2] Figures are GST exclusive.

Table 7: Total funding provided for each program element in the RHWSA program, from 2016-17 to 2019-20

Program element	Total funding provided to the RWAs, from 2016-17 to 2019-20 ($)
Access	32,041,919.96
Quality	24,031,432.72
Sustainability	24,031,432.72
Total funding	**80,104,785.40**

Source: Commonwealth Department of Health, analysed by KPMG

Allocation of funds to the funding streams

At the beginning of the program, the allocations per funding stream were defined in the Standard Funding Agreement Schedule between the Department and each RWA as:

- Grants and Incentives: must not be less than 50 per cent of a Grant applicant's total budget for the program.

- Operational Funds: must not exceed 15 per cent of a Grant applicant's total budget for the program.

- Program Delivery: must not exceed 35 per cent of a Grant applicant's total budget for the program.

Following feedback and consultation between the Department and the RWAs, the funding stream allocations were revised to reduce the funding allocated to the Grants and Incentives funding stream. The Department advised that the funding stream amendments were approved on 1 April 2019. A Deed of Variation with the RWAs formalised this in 2020, where the ratios for the funding streams changed to:

- Grants and Incentives: must be more than 20 per cent of a Grant applicant's total budget for the program.

- Operational Funds: must not exceed 15 per cent of a Grant applicant's total budget for the program.

- Program Delivery: must not exceed 65 per cent of a Grant applicant's total budget for the program.

Allocation of funds to RHWA

As discussed in Section 3.2, the RWAs are required to sub-contract RHWA to provide national representation, coordination and administration for the RWAs. RWAs are required to provide at least 2% of funding from each element toward funding national representation and coordination, which is allocated to the Program Delivery funding stream.

Movement of funds between elements and streams

The RWAs may request from the Department approval to move funds between the elements or between funding streams, with supporting evidence that illustrates that it will improve outcomes for the jurisdiction.

Written agreement from the Department is required for funds to move between funding streams, and a Deed of Variation to the Funding Agreement is required for funds to move between elements (2).

3.3.3. RWA expenditure

Costs incurred by RWAs in delivering the program

The cost incurred by the RWAs in delivering the program was analysed for 2018-19, to understand variability between the funding received and the expenditure for the year[3]. Table 8 below provides the total income and expenditure to deliver the program for 2018-19. The total income for 2018-19 includes unspent funds from the prior year, funds brought forward, other income, and interest received on grant funds. The difference between income and expenditure varied between the RWAs. One RWA (TAS) had greater expenditure than total income for 2018-19. The largest underspend was NT ($1,131,089, 23% unspent funds) and SA ($588,207, 17% unspent funds).

Table 8: Total income and expenditure for 2018-19 by RWA

RWA	Total income for 2018-19 ($)[4]	Expenditure for 2018-19 ($)	Difference ($)	Difference (%)
NSW	5,496,811	5,421,811	75,000	- 1%
NT	4,944,020	3,812,931	1,131,089	- 23%
QLD	4,981,887	4,981,887	0	0%
SA	3,374,561	2,786,354	588,207	- 17%
TAS	1,736,111	1,766,625	(30,514)	+ 2%
VIC	4,779,421	4,598,196	181,225	- 4%
WA	4,110,886	4,019,353	91,533	- 2%

Source: Commonwealth Department of Health, analysed by KPMG

Proportion of RWA costs for the program elements

The costs incurred by the RWAs in delivering the program was analysed per element. Table 9 below provides the difference in total income and expenditure for each element in 2018-19. A positive value indicates that the RWAs had more income than expenditure for that period. During 2018-19, no RWA had a greater expenditure for the Sustainability element than income for the period. TAS was the only RWA that had greater expenditure than income in 2017-18, for the Access element ($30,205) and Sustainability element ($615). Overall, the

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[3] Financial reporting information for 2017-18 was not available for all RWAs.
[4] Includes unspent funds from prior year, funds brought forward, other income, and interest received on grant funds.

Sustainability element had the largest underspend ($1,048,169) followed by Access ($767,466) and Quality ($220,924).

Table 9: Difference in total income and expenditure for each element, in 2018-19

RWA	Access ($)	Quality ($)	Sustainability ($)
NSW	30,000	22,500	22,500
NT	440,564	112,395	578,130
QLD	-	-	-
SA	231,866	2,852	353,489
TAS	- 30,205	- 615	306
VIC	87,898	21,694	71,632
WA	7,323	62,098	22,112
Total	**767,466**	**220,924**	**1,048,169**

Source: Commonwealth Department of Health, analysed by KPMG

Level of funding for the RHWSA program

There is insufficient data to comment on whether the level of funding is appropriate for the RWAs to deliver the RHWSA program. The allocation of funding for each RWA should be reviewed before the commencement of the next funding agreement. One RWA commented that they would appreciate increased transparency with how the funding envelope is calculated and distributed for the RWAs.

3.3.4.   Future design considerations

During consultations, most RWAs communicated that the notional splits between program elements and funding streams were unhelpful and may not support responding to the identified need in the communities. Some RWAs commented that having more flexibility to move funding between program elements and program streams would support the delivery of the program in a manner that more directly aligns with the identified needs in their jurisdiction. A revised funding arrangement could also support discretionary and innovative solutions. Some views from the consultations are provided below:

- One RWA commented that overlapping the program element funding allocations with the funding stream allocations was difficult.

- One RWA commented that it is difficult to be innovative with the current funding model, as there are various 'buckets' of funding that they are required to deliver activities within.

- One RWA commented that following co-designing a workforce solution with stakeholders, they would need to retrofit the solution within the funding 'buckets'.

- One RWA commented that it is difficult to allocate time used for collaboration within the funding streams.

- Two RWAs commented that the requirement to use unspent funds from the prior year within the same program element is restrictive, and suggested that it would be beneficial to be able to use these funds within any of the program elements.

- One RWA commented that under the current funding arrangement, there is limited opportunity to support investments in infrastructure projects (e.g. telehealth).

- One RWA suggested that if the funding allocations remain, including bands (e.g. plus or minus 5% of the funding allocation) would be beneficial.

There is an opportunity to consider revising the funding model to be more flexible, to support the RWAs in delivering the program to meet the identified needs in their jurisdiction.

Alternative funding models

KPMG has identified three alternative funding models for the Department to consider for the RHWSA program. These options are based on findings from the review.

Under each of these models, it is crucial that the definitions of each cost category are clear, consistent, documented and well understood by all stakeholders. Further, it is essential that these costs can be easily reported against and analysed.

For the purposes of analysing the strengths and challenges of the alternative funding models, the three models below consider the allocation of funding to the program elements and funding streams together. These are:

- Model 1: Maintain the status quo

- Model 2: Soften the allocation requirements for funding streams and program elements

- Model 3: Remove the allocation requirements for funding streams and program elements.

A combination of these models could be considered for the future funding model for the RHWSA program (e.g. the allocation of funds to the program elements could be considered through Model 2, and the allocation of funds to the funding streams could be considered through Model 3).

Additionally, one option is presented (Option 1: Implement an innovation funding pool) which could be implemented alongside any of the models below.

Model 1: Maintain the status quo

Under this funding model, the Department continues the current method of allocating funding to the RWAs. This involves continuing to allocate funding to each program element and funding stream.

The strengths and challenges of this model are outlined below.

- As the funding model and process continues as it currently stands, there is no requirement to change internal departmental processes or funding agreements with RWAs.

Challenges

- The funding model has constraints on how the RWAs can use the funding, due to the allocation of funding to program elements and funding streams. This may limit RWAs in undertaking activities that meet an identified need in a community.

- It is difficult to move funding between program elements (requires a Deed of Variation). Written agreement from the Department is required to move funds between funding streams.

- The funding model may not support RWAs developing and implementing discretionary and innovative solutions to meet an identified community need. This may include limiting collaboration and undertaking co-design with stakeholders.

Model 2: Soften allocation requirements for funding streams and program elements

Under this model, the Department continues to have certain contractual requirements for funding allocations to funding streams and program elements, however these requirements are softened to provide more flexibility to RWAs with implementing the program. For example, the funding requirements for the program elements could include:

- A base level for funding allocated to each program element (e.g. at least 20% of funding must be allocated for each program element, providing the RWAs with flexibility for how the remaining 40% of funding can be allocated); or

- Bands for allocation of funds to each program element (e.g. between 20% – 40% of funding is to be allocated for each program element).

The strengths and challenges of this model are outlined below.

Strengths

- This option supports the funding being used in line with the objectives of the Commonwealth and the RHWSA program, and maintains a level of consistency with how the RWAs will use the funds within the program.

- This option provides greater flexibility for RWAs to use funding to meet identified needs in communities.

Challenges

- This may increase the administrative burden for the RWAs, if they are required to provide more evidence of how they have used the funds to meet the objectives of the program.

- The administrative burden for the Department may increase, as more scrutiny may be required to ensure the funds are used in line with the objectives of the program.

- The funding model has some constraint on how the RWAs can use the funding, due to the required allocation of funds to the program elements and / or funding streams. This may have limitations for the RWAs in undertaking activities to meet the identified needs in a community.

- The funding model may not support RWAs developing and implementing innovative solutions. This may include limiting collaboration and undertaking co-design with stakeholders.

Model 3: Remove allocation requirements for program elements and funding streams

Under this funding model, the Department would remove the contractual requirements for funds to be allocated to program elements and funding streams. This model would require that all funds are used to meet the objectives of the program, however the funding model will not provide a requirement for the level of funding to be used for each program element or each funding stream.

The strengths and challenges of this model are outlined below.

Strengths

- This option supports the funding being used in line with the objectives of the Commonwealth and the RHWSA program.

- This option provides greater flexibility for RWAs to use funding to meet identified needs in the communities. This option also allows for variation in the use of funding through the lifecycle of the program (e.g. greater focus on sustainability in later funding years).

Challenges

- This may increase the administrative burden for the RWAs, if they are required to provide more evidence of how they have used the funds to meet the objectives of the program.

- The administrative burden for the Department may increase, as more scrutiny is required to ensure the funds are used in line with the objectives of the program.

- The funding model may not support RWAs developing and implementing innovative solutions. This may include limiting collaboration and undertaking co-design with stakeholders.

Option 1: Implement an innovation funding pool

This option can be combined with any of the models outlined above. This option would involve implementing an innovation funding pool, to support discretionary and innovative solutions. All RWAs would be able to apply for funding from the innovation funding pool, which would be administered by the Department.

The strengths and challenges of including this option in the funding model are outlined below.

Strengths

- It supports the RWAs with developing and implementing discretionary and innovative solutions. This would support RWAs with continuing to develop tailored workforce solutions for individual communities.

- All RWAs can apply for funding from the innovation funding pool.

- This will increase the administration burden for the RWAs, as they would be required to apply for funding for their discretionary or innovative solution.

- This will increase the administrative burden for the Department, as the Department will need to review and approve applications for funding from the innovation funding pool. The Department would need to develop guidelines to support selecting the applications for approval, and to ensure the fair and equitable distribution of funding.

3.4. Engagement

Engagement measures the extent of stakeholder engagement and input in the achievement of program objectives, and whether duplication and / or synergy exists in relation to wider objectives (particularly of the PHNs). This section explores the approach to stakeholder engagement in the program, key factors that impact on stakeholder engagement and future design considerations. The summary of findings for the engagement domain are provided below.

Summary of engagement findings

The review found that the level stakeholder engagement completed by each RWA varies in delivery of the program. A summary of key findings related to the engagement domain is presented below:

- The stakeholder engagement completed by each RWA varies and can be linked to the complexity of the stakeholder environment (e.g. number of PHNs), organisational structure (e.g. the Northern Territory Primary Health Network is both the PHN and the RWA), and individual relationships.

- During consultations, it was identified that while the HWSG provides a positive platform to bring stakeholders together to support the development of the HWNA, some stakeholders noted they had no involvement with the HWSG in either the development of the HWNA and / or the AWP.

- The awareness of the role of the RWAs is low among some stakeholder groups at a jurisdictional and national level. There is also a lack of clarity regarding the roles and responsibilities of different stakeholders, often with competing objectives.

- Some stakeholders (e.g. Specialist Training Pathway Providers) identified that there would be benefits with having a clear contact for the program nationally.

- The RWAN provides a forum for the RWAs to discuss the program and provides a single point of contact for the Department. RWAs commented that RWAN is an effective means for RWAs to connect with each other and present a unified voice nationally as needed.

- Some stakeholders reported a view that the role of RHWA is unclear and there was a view that the functions could be better fulfilled by the individual RWAs. There is an opportunity to clarify the roles and responsibilities of RHWA, or consider opportunities to support more effective national representation of the program.

3.4.1. Approach to stakeholder engagement

The stakeholder engagement completed by each RWA varies and can be linked to the complexity of the stakeholder environment (e.g. number of PHNs), organisational structure (e.g. the Northern Territory Primary Health Network is both the PHN and the RWA), and individual relationships. RWAs' approach with completing stakeholder engagement in the program is explored for the local community, rural health workforce and other organisations through the HWSG.

Local community

Community engagement is identified as a key data source for informing the HWNA planning process in the RHWSA program's operational guidelines. These guidelines stipulate community consultation as essential for obtaining information about perceived local community need, insights into the experiences of patients, consumers and carers and their views on improvements in the delivery of local primary health services (2).

The review found that most RWAs have some touchpoints with local communities through the following means:

- Survey distribution.

- Consultations with local council, local government and local mayors.

- Local community advisory groups.

- Newsletters and annual report distribution.

- Social media activities.

- Community events e.g. local high school career expos or family days.

Through consultations, it was identified that the nature of the RWAs' engagement with local communities was either in response to a local workforce crisis (e.g. GP retirement / close of business) or for strategic forward planning purposes. These were delivered by the RWAs through the following mechanisms:

- **Community collaboration:** RWAs sought to work collaboratively with the community, and other local health workforce stakeholders (e.g. PHNs) to understand the local needs and skills-mix required to replace the existing health care provider, and then determine who could be recruited to provide this service. For example, in one jurisdiction, local clinicians identified community access to general practice services was a significant, ongoing issue. A working group was convened by the RWA including representatives from local councils, local health districts, PHNs and Aboriginal Community Controlled Health Services (ACCHS) to understand the underlying issues. It was identified that GPs in this town were not effectively collaborating with the local health districts, which was not supporting health workforce recruitment and retention. A collaborative approach was undertaken to address the regulated systems and competitive challenges preventing a stable health workforce. The RWA advised that one outcome from this working group was increased engagement between the local community and incoming health professionals through events such as a health professional networking evening. This was identified as key to breaking practitioner isolation.

- **Community consultation**: Only one RWA identified meeting with community for proactive workforce planning purposes. Community feedback surveys analysed by the RWAs as part of these consultations moved beyond the medical workforce and identified a market gap around the need for nursing and allied programs similar to the John Flynn Placement Program. The outcomes of these consultations saw the establishment of a three-year program providing medical, nursing and allied health students an opportunity to experience comprehensive clinical practice in rural and remote communities. This program

is now delivered collaboratively between the jurisdictional RWA and relevant University Department of Rural Health.

Rural Health Workforce

The RHWSA operational guidelines stipulate that the perspective of health professionals, providers and funders are equally as important for informing needs assessment, and the views of these groups may differ considerably to those of the local community (2). Consultation with the rural health workforce is outlined as another key activity for the identification of health service issues and needs (2).

The review found that jurisdictional RWAs directly engage with rural health services and professionals through the following mechanisms:

- Boutique GP practice support services including practice manager support programs.

- Collaboration with GP registrars (identified as the future workforce.

- Engagement with health student bodies through scholarship provision and partnerships with student clubs.

- Supporting the provision of health workforce to local health services.

- Personalised touchpoints where possible.

Engagement with rural health professionals, especially the private rural and remote GP and allied health sector, was identified to be a challenge for most RWAs. Consultations identified this cohort was typically hard to engage due to the competing demands of clinical service delivery and business operations. RWAs developed some strategies to supplement engagement with this sector through other means, including:

- Engaging with the GPs / allied health specialists who are employed through the government and university sectors (i.e. salaried / contractual positions).

- Leveraging pre-existing networks that include representation from this sector (e.g. the PHN clinical councils may have representatives from private GPs and allied health service providers).

An example for engaging with the rural health workforce was provided by one RWA in the delivery of practice management support. The RWA identified practice managers as an underlying driver for a successful health service. In response to an identified need, the RWA recruited a practice manager to identify the common issues facing practice managers and understand what was needed to support workforce planning. Utilising a combination of grants, the RWA funded a network of professional practice managers to undertake a specially designed practice management diploma. The RWA identified this to be one of their most successful approaches for engaging with local health workforces and services and highlighted key outcomes to be increased connectivity and reduced isolation in this workforce cohort.

Role of the HWSG

Several key external rural health workforce organisations support the delivery of the RHWSA program. RWAs engage with these stakeholders through various mechanisms, most frequently through their involvement on

the jurisdictional HWSG. RWAs are responsible for the convening and ongoing administration of the HWSGs, which are to include membership from RTOs, PHNs, RHOF fundholders, Specialist Training Pathway Providers, RCSs, Regional Training Hubs, State Health Departments and Aboriginal and Torres Strait Islander Health State Peak Bodies (2).

A detailed description of the key stakeholders is provided in Appendix 6, including a description of their role in supporting the delivery of the program.

Several stakeholders described RWAs as willing collaborators capable of pulling relevant agencies together through the HWSG to solve local health workforce issues. This was achieved through the following mechanisms:

- Regular engagement which led to meaningful and productive conversations.

- Formalised mechanisms such as Memorandums of Understanding, formal partnership agreements, data sharing agreements and / or advisory groups.

- Acknowledgement of a shared commitment to improving rural and remote health outcomes.

- More informal, close working relationships built on trusting and respectful personal associations with long-standing executive teams.

- Seemingly genuine efforts to address identified need.

Despite this, some stakeholders had no involvement or limited involvement in the HWSG, in either the development of the HWNA and / or the AWP. Additionally, some of the stakeholders outlined in the operational guidelines noted during interviews that they had no involvement in the HWSGs (e.g. Specialist Training Pathway Provider). For these stakeholders, the value of the HWSG as a forum for engagement was not as clear. This occurred due to the following circumstances:

- **Limited knowledge of the scope and remit of the RWAs:** Some stakeholders reported it was unclear where RWAs fit within the broader health workforce stakeholder environment.

- **Varied appetite of external agencies to participate in HWSG:** Stakeholder participation is dependent on leadership and interagency relationships. For example, in one jurisdiction, it was noted that although one stakeholder group was invited to participate in the HWSG, they advised they did not want to be involved in this forum.

- **Lack of a clear direction**: Some stakeholders reported the HWSG was simply an exercise in sense checking the findings of the HWNA and no new information about local health workforce issues were uncovered. Additionally, no new, innovative strategies and solutions were offered during the HWSG to address workforce concerns. To some stakeholders the HWSG lacked a clear direction in terms of actions and it was not obvious how their engagement in this forum translated to improvements in health workforce access, quality and sustainability in their jurisdictions.

## 3.4.2. Key factors that impact on stakeholder engagement

Several key factors influence how RWAs engage with local communities, the rural health workforce and other agencies in the healthcare sector. These factors either strengthen or limit the capacity of RWAs to meaningfully interact with the varied stakeholders and synergistically address activities stipulated in the operational guidelines. These key factors are considered below including a description of the various strengths and / or challenges associated with each factor.

The complex stakeholder environment

The varied simplicity or complexity of the health ecosystem in which an RWA operates was identified during consultations as one of the key factors influencing their capacity to engage with their stakeholders. Figure 6 below provides an illustration of some rural and regional stakeholder organisations (regional PHNs, RTOs, regional LHNs and RCSs) involved in the RHWSA program. For comparative purposes, VIC is not included on the figure below. VIC has a different structure when compared to LHNs in other jurisdictions, involving five rural health regions, and 70 rural and regional public health services and hospitals (27).

As illustrated below in Figure 6, each jurisdiction has a different environment in which to operate, involving varying numbers of rural and regional organisations. When considering the four stakeholder groups provided in the figure, QLD has the largest number of organisations (21) followed by NSW (19), SA (10), WA (five), NT (five) and TAS (four).

Figure 6: The number of regional PHNs, RTOs, regional LHNs and RCSs operating in each jurisdiction
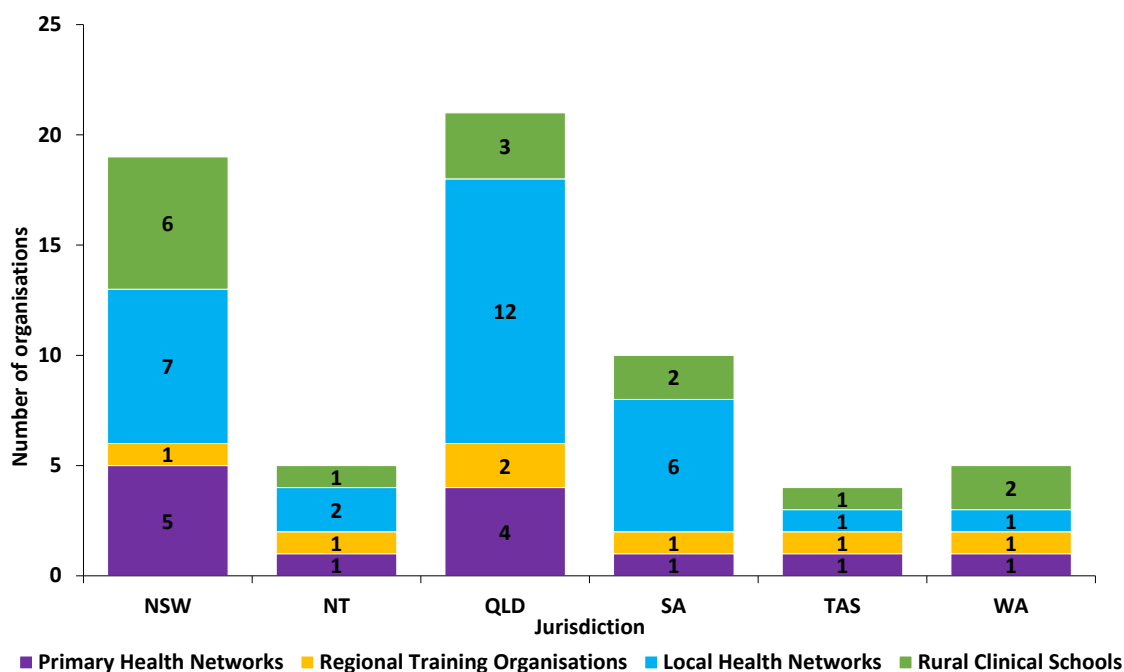
Source: Data from multiple sources (28) (29) (30) (31) (32) (33) (34) (35) (36), analysed by KPMG

Some observations of RWAs operating in these differing environments on stakeholder engagement include:

- **Stronger engagement in simpler health ecosystems**: Jurisdictions with simpler health ecosystems were able to engage more seamlessly through a singular HWSG with all key jurisdictional stakeholders around the table. The key factors facilitating stronger engagement in these smaller jurisdictions was the relative simplicity of their health ecosystems and the ability to more easily develop effective working relationships across agencies due to the lower volume of stakeholders to engage with.

  For example, in the NT, the RWA operates in a unique environment, operating as an embedded branch within the PHN. It is identified as a distinct and important function through unique branding and a separate subcommittee who oversee the work of the RWA. Stakeholder consultations reported that the NT PHN model was effective within this particular jurisdiction, given its unique contextual elements in terms of geographic area, population spread and primary healthcare service delivery model. Elements of this structure also enable the RWA to more easily deliver services collaboratively with the PHN through seamless joint planning initiatives which identify alignment between overlapping objectives and opportunities to either implement activities in synergy or prevent duplication. Information and data sharing is also more streamlined and easier to access.

- **A modified approach to the HWNA and / or HWSG:** For jurisdictions with a complex ecosystem of health stakeholders, some RWAs convened multiple, regional HWSGs. Others modified their HWNA approach to distribute a state-wide needs analysis complemented with regional breakdowns. Some stakeholders in these jurisdictions acknowledged that such collaborative engagement strategies led to productive activity execution that was seen to develop real and tangible progress towards addressing the three program elements.

- **Ineffective engagement without stakeholder synchronisation:** A majority of stakeholders acknowledged the wider health workforce ecosystem was complex with lots of moving parts. Most stakeholders highlighted synchronisation throughout the complex ecosystem of stakeholders was considered vital for effective engagement. For some stakeholders in jurisdictions where this synergy was lacking, engagement was identified as ineffective or even, non-existent.

- **Successful engagement was person-driven:** Engagement with external organisations across all jurisdictions (both complex and simple) was deemed by some stakeholders to be successful from effective leadership and long-standing relationships and less a consequence of the structural arrangements in place through the RHWSA program. Additionally, most stakeholders identified a need for greater coordination and leadership within this system with a more cohesive engagement strategy that crosses agency boundaries and clearly stipulates the roles and responsibilities of each stakeholder group within the broader ecosystem.

Awareness of the roles of the RWAs

A majority of stakeholders recognised that greater understanding between the RWAs and external stakeholders of the organisational roles and responsibilities led to expanded opportunity for collaboration. Key to this successful engagement was:

- A clear breakdown of roles and responsibilities between agencies.

- Identification of where there was overlapping priorities and scope for collaborative service delivery activities to meet common objectives.

Most stakeholders identified that opportunities exist for more cohesive interagency engagement approaches between RWAs and their various external stakeholder groups. Case Study 2 below describes the co-designed and collaborative approach taken by Rural Health West (RHW) and WA Primary Health Alliance (WAPHA) in the delivery of a GP practice support service known as Practice Assist.

Conversely, among some stakeholder groups the awareness of the role of the RWAs is low and this was identified as a key barrier to successful interagency collaboration. This occurred due to the following circumstances:

- **Lack of clarity regarding roles and responsibilities of different stakeholders**: Some stakeholders identified the purpose and objective of the RWAs are not as visible to key external stakeholders compared to other external agencies (e.g. LHDs and PHNs).

- **Differing organisational focus:** Whilst RWAs deliver programs across the continuum of the health workforce recruitment and retention pipeline, external stakeholders may only intersect with the RWAs at one point on this continuum. Some stakeholders identified indirect engagement only as a natural fallout from the execution of their own business strategies and functions. For example, there was recognition from most RTOs that their engagement with RWAs was largely through the lens of career pathway services. Although RTOs were aware the RWAs delivered other services beyond this scope, they had little knowledge or oversight of these activities.

There is opportunity for the RWAs to consider more strategic engagement through clear marketing and communication activities. Additionally, clarifying the roles and responsibilities of the RWAs and other key stakeholders may improve integrated collaboration between agencies.

Case Study 2: A co-designed and collaborative approach in the delivery of a general practice support service

RHW and WAPHA have a shared focus on assisting primary healthcare service providers, principals, managers and administrators to develop viable, sustainable businesses through capacity building and quality enhancement activities (37). In 2016, RHW, in collaboration with WAPHA, undertook a feasibility study to identify effective ways to collaborate in the delivery of a comprehensive, state-wide general practice support service.

The following common service delivery goals were identified:

- Addressing the barriers that prevent access to quality and coordinated primary health care.

- Improving retention rates for the health workforce throughout rural and remote WA.

- Building sustainable partnerships across the health and social care systems.

- Embracing and supporting innovative models of health care delivery.

- Adopting contemporary and flexible business strategies that are sustainable and support their vision (37).

Additionally, through online surveys targeted at general practices, principals, administrators and managers, the feasibility study identified the following top five needs of general practices:

1. Fact sheets and training on new initiatives.

2. CPD opportunities for non-clinical staff.

3. Information on government initiatives.

4. Support with utilising the MBS.

5. Using practice data for continuous quality improvement (38).

As a result, *Practice Assist* was established to provide free advice, support, resources and education to general practices to enhance their sustainability, viability and to improve patient outcomes by alleviating the administrative burden on healthcare professionals (37).

Through this joint initiative and in response to the needs identified in the feasibility study, *Practice Assist* provides the following services free of charge to general practices throughout WA:

- A toll-free help desk – 1800 2 ASSIST – which can provide a quick response to most common general practice queries.

- A dedicated website containing over 180 practice resources, such as fact sheets and templates.

- Educational webinars, networking events and regional workshops.

- A fortnightly practice newsletter, Practice Connect, with over 1,700 subscribers.

- The provision of in-practice support including training delivered by Primary Health Liaisons (37; 38).

The role of national agencies (e.g. the Department, RHWA, RWAN Chair and Specialist Training Pathway Providers)

Overall, the RWAs highlighted a positive, productive relationship with the Department. Additionally, some RWAs acknowledged this relationship was built through the collaborative RHWSA program design process with the Department. Some RWAs explained the new RHWSA program was seen as a significant shift in focus which would require an appropriate adjustment period to fully understand the implications and respond to the refreshed RHWSA program. These RWAs expressed they felt appropriately consulted and supported by the Department throughout this change process.

Additionally, the RWAN Chair described their role as fit for purpose in the sense that they were able to provide a nationally consistent voice if necessary, without limiting the ability of individual RWAs to highlight jurisdictional nuances when needed.

No evidence was provided during stakeholder consultations that the RWAN Chair and RHWA engage with local communities, rather their engagement focused on the other peak national agencies (e.g. the Services for Australian Rural and Remote Allied Health, Indigenous Allied Health Australia). Despite this, it was identified through consultations with Specialist Training Pathway Providers that there does not seem to be a clear contact for the program nationally.

There is an opportunity to clarify the roles and responsibilities of RWAN and / or RHWA with specific respect to stakeholder engagement, reporting and program delivery, or consider opportunities to support more efficient and effective national representation of the program.

3.4.3.   Future design considerations

There are several key areas where it was identified that stakeholder engagement of the RWAs could be strengthened in the future. The areas are considered below, with relation to engagement with the local community and engagement with broader stakeholders in delivering the program.

In local community

- **RWAs provide increased wrap around support to newly placed, rural and regional health workers**: Some stakeholders identified that RWAs could work more closely with local community and other local health workforce organisations to engage with newly placed health workers through the delivery of specialised support services. The provision of wrap around services that provide holistic, welcome and ongoing support packages, including tailored case management and psychosocial strategies when necessary, is one approach identified in the underlying literature as key for addressing job dissatisfaction and isolation (39; 8; 10).

- **RWAs work to establish local networks of healthcare professionals across rural, regional and remote communities:** Some stakeholders highlighted that RWAs should play a role in addressing feelings of isolation and connection amongst remote and regionally based healthcare professionals through formalised networking arrangements. It was acknowledged that these groups should be extended to include nursing, allied health and any other paraprofessionals. Through the establishment of a formalised network of health professionals, RWAs may further increase touchpoints with local community, in particular with individual health workforce professionals who attend these forums. The formation of professional associations or networks provides opportunities for continuous professional stimulation and support. This was found to encourage rural practice and has been linked to increased rural health workforce retention (21; 39; 9; 10).

Across the broader rural health workforce

- **Consider opportunities for the RWAs to establish strategic vision / priorities with their jurisdictional stakeholders and delineating the roles and responsibilities of the stakeholders to achieve this vision**: Most stakeholders alluded to the substantial number of agencies with similar objectives unknowingly undertaking similar health workforce activities as the RWAs. Various stakeholders indicated they did not

have clarity on the specific remit of the RWAs and thus had no knowledge of the potential for overlapping objectives and activities. Most stakeholders conveyed that when they are expected to engage with each other to support the planning and delivery of activities within the RHWSA program, the roles and responsibilities of each key stakeholder should be clearly delineated. Clarity in remit and scope of each stakeholder and their responsibility within the program may support more efficient engagement, identify potential areas of overlap in objectives and define opportunities for more streamlined collaboration in service delivery.

- **Consider opportunities for the RWAs to increase their engagement with stakeholders in the implementation of workforce activities**: Whilst most stakeholders largely identified the HWSG as a positive forum to be engaged with, a key criticism was outlined by some stakeholders around the forum's lack of clear direction in terms of actions for stakeholders involved. A few stakeholder consultations identified this forum was viewed as simply a sense checking exercise for stakeholders to validate and endorse the HWNA with no tangible actions to then address the identified need. The Department advised that following feedback from stakeholders, the HWSG members are to 'support' the HWNA and AWP, rather than 'endorse' the documents.

  There is scope for RWAs to better leverage this forum and identify key activities that can be delivered in collaboration with other key stakeholders to address needs and issues identified through the HWNA process. Additionally, the HWSG can be utilised to explore innovative solutions that draw on the various resources, skills and knowledge of all agencies involved.

- **Consider opportunities for the RWAs to coordinate the needs assessment process with the other jurisdictional stakeholders and align with the planning cycle of PHNs for services and workforce planning:** There is an opportunity for the development of a framework or set of guidelines, which details the specific requirements characterising an 'integrated' approach to long-term, primary healthcare workforce planning. This can be aligned to the planning cycles of other jurisdictional stakeholders, for example the PHNs, for service and workforce planning. In turn, jurisdictional stakeholders can know what is to be expected in terms of activities and outputs through their involvement in the RHWSA program workforce planning processes. The Department has a key role in setting expectations around the linkage between the role of PHNs and RWAs with service and workforce planning. This could be supported through a policy and planning framework.

- **Clarify the roles and responsibilities of RWAN and / or RHWA in stakeholder engagement activities:** Some stakeholders identified that the roles of RHWA and RWAN were unclear with respect to stakeholder engagement. There is opportunity to clarify the roles and responsibilities of RWAN and / or RHWA with specific respect to stakeholder engagement, reporting and program delivery, or consider opportunities to support more efficient and effective national representation of the program.

3.5. Conclusion

The RHWSA program is contributing to addressing health workforce shortages and maldistribution in regional, rural and remote Australia. The review has found that there are a number of opportunities to improve the appropriateness, effectiveness, efficiency and engagement of the RHWSA program, to ensure that it is operating appropriately, effectively and efficiently in meeting the needs of the community.

The following recommendations are provided for the RHWSA program in Table 10 below. The link between recommendations and findings from the review are also provided in Table 10 below.

The proposed implementation timeline is provided below for the recommendations, as short term (less than one year), medium term (one to three years) and long term (greater than three years). The recommendations that are medium to long term are identified to require more effort or coordination with stakeholders to support successful implementation. There are aspects of some medium to long term recommendations that may require less effort to implement which can be achieved within a shorter timeframe than listed.

Table 10: Recommendations for the RHWSA program

Proposed implementation timeline	*#*	*Recommendation*	*Relevant Section(s)*
Short term	1	Clarify the roles and responsibilities of RWAN and / or RHWA with specific respect to stakeholder engagement, reporting and program delivery, or consider opportunities to support more efficient and effective national representation of the program. This should include providing a clear contact for stakeholders nationally.	Refer to Sections 3.2.3 and 3.4 for further detail.
	2	Develop a Monitoring and Evaluation Framework for the RHWSA program to support continuous improvement of the program at a jurisdictional and national level.	Refer to Section 3.1.5 for further detail.
	3	Consider revising the funding model to be more flexible, to support the RWAs in delivering the program to meet the identified needs in their jurisdiction. This may include: • Establishing an innovation funding pool, whereby RWAs can submit a proposal to the Department for funding specific activities (e.g. collaborative activities). • Allowing for additional flexibility with moving funds between the program elements and / or the funding streams.	Refer to Section 3.3.4 for strengths and challenges of different options for the future funding model.

Proposed implementation timeline	#	Recommendation	Relevant Section(s)
Medium term	4	Consider opportunities for the RWAs to: • Coordinate the dissemination of the information and data for the various needs assessments across stakeholder groups. This should inform the development and implementation of particular health workforce activities. This could include formalised mechanisms such as Memorandums of Understanding, formal partnership agreements or data sharing arrangements. • Clarify the planning cycle with PHNs for service and workforce planning. The Department has a key role in setting expectations around the linkage between the role of PHNs and RWAs with service and workforce planning. This could be supported through a policy and planning framework.	Refer to Section 3.4 for further detail.
	5	Where appropriate, RWAs should continue to develop tailored workforce solutions for individual communities. Place-based workforce needs assessment and planning should be utilised to account for the specific drivers in each community (e.g. number of different service providers, market maturity, and population size and demographics). This may include: • Developing collaborative partnerships with organisations (e.g. local health services, local government agencies, other local health workforce organisations) to design and implement the workforce solution. • Identifying where a multi-disciplinary solution could be undertaken to support sustainability of the workforce in the community. • Identifying where specialised support services (e.g. tailored case management) can be provided for the health workforce in individual communities to support job satisfaction and retention. • Consideration of adjacent or interdependent service workforces (e.g. disability and aged care sectors) when	Refer to Sections 3.1.5, 3.2.5 and 3.4.3 for further detail.

Proposed implementation timeline	#	Recommendation	Relevant Section(s)
		developing the tailored workforce solutions for individual communities, as they are often integrally linked and interdependent on primary health services in rural and remote locations.	
Long term	6	For the program reporting, consider: • Transitioning the program reporting to include outcomes-based indicators, to support the RWAs with capturing and reporting on their progress with addressing workforce shortages and maldistribution in regional, rural and remote Australia. A performance framework could support the transition to outcomes-based reporting and ensure consistent reporting by RWAs. Program reporting should align to the program logic (e.g. outputs delivered, outcomes achieved) and support financial data analysis (e.g. unit cost per activity). • Implementing a digital platform for reporting. • Undertaking national reporting on the outputs and outcomes of the RHWSA program, to provide a summary of the overall impact of the program. The performance framework (referred above) could include information on the national reporting requirements.	Refer to Section 3.1.5 for further detail, including considerations for the future program reporting. The PHN Program Performance and Quality Framework is provided as an example for outcomes-based reporting at an organisational and national level.

Appendix 1: Review requirements and indicators (detailed)

Table 11: Review requirements, considerations and indicators, and data sources for each domain of inquiry

Domain	Number	Review questions	Considerations and indicators	Data sources
Appropriateness	1	Is the program design informed by a credible and contemporary theory of change?	• Alignment with evidence base / strength of evidence.	• Operational guidelines • Stakeholder consultations
	2	Is the program being implemented in line with the design and theory of change (program fidelity)?	• Documentation of policy and supportive materials including models, inputs, consultation processes and administrative processes. • Criterion-based assessment of the extent to which the policy and processes are consistent with program requirements.	• Operational guidelines • Stakeholder consultations
	3	Is the current reporting and data collection appropriate and meaningful to track progress and measure impact? Is there overlap with the reporting required for the three elements?	• Criterion-based assessment of the appropriateness of the reporting arrangements for RWAs.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	4	What are the key variables which may be positively or negatively impacting the program's ability to demonstrate change at a 1) micro	• As rated / reported by RWAs, as evidenced by examples of responsive actions / failure to respond.	• Operational guidelines • Stakeholder consultations

Domain	Number	Review questions	Considerations and indicators	Data sources
		activity level, 2) community level, 3) jurisdictional level and 4) national level?		
	5	How satisfied are stakeholders with 1) the design of the program 2) the administration of the program by the Department 3) the implementation of the program by the RWAs?	• Alignment with evidence base / strength of evidence (perception of stakeholders).	• Operational guidelines • Stakeholder consultations
	6	Do RWAs have enough flexibility to achieve the program aims within their local contexts?	• As rated / reported by RWAs, as evidenced by examples of responsive actions / failure to respond.	• Operational guidelines • Stakeholder consultations
	7	Are there contemporary contextual factors which need to be considered in the future design of the program (e.g. large scale reforms impacting the rural health workforce)?	• Evidence that activities are planned in coordination with other service providers. This requires analysis of largely qualitative information about different programs that exist in each of the regions and where there is overlap in service delivery with other types of similar programs. • Variation in the application of RHWSA guidelines across RWAs, including needs assessment approach.	• Operational guidelines • Stakeholder consultations

Domain	Number	Review questions	Considerations and indicators	Data sources
	8	What changes, if any, should be made to the design of the program going forward?	• Based on findings from previous review questions and indicators.	• Operational guidelines • Stakeholder consultations
Effectiveness	9	Is the program demonstrating improvement against its goals to improve workforce access, quality and sustainability for the primary and preventive health workforce?	• Alignment with evidence base / strength of evidence.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	10	How effectively are each of the program elements meeting their objectives? How does this compare and / or intersect with other elements?	• Alignment with evidence base / strength of evidence, by program element.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	11	How effective are the RWAs in their role of implementing the program? What jurisdictional factors may be positively or negatively impacting on the RWAs' ability to implement their program of work?	• Extent to which activities have been implemented. • Alignment with operational guidelines.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations

Domain	Number	Review questions	Considerations and indicators	Data sources
	12	What are the facilitators and barriers impacting effectiveness at a 1) micro, 2) community, 3) jurisdictional and 4) national level?	• Alignment with evidence base / strength of evidence.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	13	How can the effectiveness of the program be improved into the future?	• Alignment with evidence base / strength of evidence.	• Operational guidelines • Stakeholder consultations
Efficiency	14	What is the cost of the program, by program element and by RWA?	• Historical funding allocation (program and jurisdictional level).	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	15	How is funding allocated to different RWAs and activities? What may influence this (e.g. level of need, remoteness, complexity)?	• Proportion of funding allocated to each program activity and RWA.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	16	What is the relative cost of each of the three elements of the program?	• Unit cost by program activity.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations

Domain	Number	Review questions	Considerations and indicators	Data sources
	17	What, if any, changes should be made to the funding model for the program?	This requires descriptive analysis encompassing: • How funding is allocated and utilised, including matching identified priority activities with demand. • The effectiveness and efficiency of funding utilisation at the program level, and RWA level. This will need to consider the characteristics and complexity of the different program activities and regions and the extent to which funding has been used flexibly to accommodate differences in context and circumstance. • Opportunities to improve the efficiency of the RHWSA program and funding model. This may include consideration for potential cost savings associated with changes to program delivery arrangements and service delivery models.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations
	18	How can the efficiency of the program be improved in the future (e.g. are there potential overlaps or synergies with other rural workforce programs funded through State and Territory or other sources (including PHNs))?	This requires descriptive analysis encompassing: • Interaction with similar programs (i.e. opportunities to leverage existing funding, infrastructure and	• Operational guidelines • Funding Agreement reports • Stakeholder consultations

Domain	Number	Review questions	Considerations and indicators	Data sources
			supports from other programs to achieve desired outcomes). • This will also build on considerations and analysis undertaken in previous review questions (efficiency and effectiveness).	
Engagement	19	How do each of the RWAs currently engage 1) local communities and 2) the rural health workforce? What are the key factors that may influence this?	• Criterion-based assessment of the extent to which RWAs engage with key stakeholder and working groups. • Number of stakeholder groups involved in program design and delivery. • Partner satisfaction. • Stakeholder awareness of RHWSA.	• Operational guidelines • Funding Agreement reports • Stakeholder consultations • Relevant documentation and collateral
	20	What are the strengths and limitations of the current approaches to engagement?	• Alignment with evidence base / strength of evidence.	• Operational guidelines • Stakeholder consultations
	21	Are there areas of overlap in stakeholder engagement with other Commonwealth funded	• Alignment with evidence base / strength of evidence.	• Operational guidelines • Stakeholder consultations

Domain	Number	Review questions	Considerations and indicators	Data sources
		activities that could be better harnessed or leveraged?		
	22	How can engagement be strengthened in the future?	• Alignment with evidence base / strength of evidence.	• Relevant documentation and collateral

Source: KPMG, 2020

Appendix 2: Findings per review question

The findings for each review question are presented in this section under the four domains of appropriateness, effectiveness, efficiency and engagement.

There are consistent themes across the four domains, with the most relevant of these being stakeholder engagement. These themes are explored individually within the domains to outline the specific findings relevant for each review question.

A. Appropriateness

Appropriateness is the extent to which the program addresses an identified need and the program's alignment with Government priorities. The appropriateness domain is examined through eight questions, which are discussed individually in this section.

A.1 Is the program design informed by a credible and contemporary theory of change?

This question is answered based on the following approach:

- Examination of the RHWSA program design considering contemporary good practice in improving the rural health workforce.

- Identification of stakeholders' views on the design of the program.

Program need

Australia's population is highly urbanised: in 2018-19, capital city growth accounted for 79% of total population growth, and comparatively remote and very remote regions experienced population decline (18). As level of remoteness increases, life expectancy decreases. In 2015, the total burden of disease in remote and very remote areas was 1.4 times higher than those residing in major cities. Additionally, those in rural areas often have more complex health needs due to higher rates of chronic and other health conditions. In particular, Aboriginal and Torres Strait Islander people, who make up a large proportion of populations living in very remote communities, are an 'at risk' population more likely to have poorer health outcomes (12).

With poorer health and greater demand for healthcare services, Australians living in remote and very remote areas experience what has been termed a 'double-edged sword' (19). Additionally, health workforce shortages exist, with a disparity in personnel between metropolitan and rural and remote regions - there is a clear trend of decreasing clinical full-time equivalent health professionals (per 100,000 persons) as remoteness increases (12). Largely, rural and remote healthcare access issues are a result of the persistent problem of health workforce undersupply and maldistribution (8). Traditional training programs and funding mechanisms have led to an uneven distribution of healthcare providers throughout the country (11). Operationally, rural and remote service providers do not experience the same economies of scales as their metropolitan-based counterparts, often experiencing significant administrative burden to meet multiple accreditation, accountability and reporting requirements (12).

Outside of metropolitan centres, access to healthcare remains a significant issue (12). Geographically based disparities in health have been clearly linked to the challenges of providing equitable services to dispersed populations with limited infrastructure and higher service delivery costs (20). A clear need exists to address these ongoing health workforce supply and distribution factors in order to improve health outcomes throughout Australia's rural and remote populations.

Overview of the program design

The RHWSA program is one component of the broader Health Workforce Program, managed by the Department to address health workforce shortages and maldistribution (2). The RWAs administer the program on behalf of the Commonwealth. The program was co-designed by the Department and the RWAs.

The program's objective is to contribute to addressing health workforce shortages and maldistribution in regional, rural and remote Australia.

The expected outcomes of the program are to meet current and future community health workforce needs through workforce planning. The outcomes of the program were to be met by:

- Identification of needs and undertaking activities in three key priority areas of Access, Quality and Sustainability.

- Collaborating with relevant stakeholders, such as PHNs, through the establishment of formal networks of consultation (e.g. HWSG).

- Delivery of programs (e.g. 5 Year OTD).

- National representation of RWAs and their interests, administered through sub-contracting arrangements to RHWA (2).

The program design accounts for variability in jurisdictional priorities. The RWAs can determine the activities to be undertaken to address key priority areas, based on the findings of the local HWNA. The Operational Guidelines outline eligible activities that can be delivered for each element.

The RWAs, in consultation with the HWSG, also develop a list of eligible medical, nursing and allied health professionals for support under the program, allowing for jurisdictional priorities to be considered in this decision.

Since the establishment of this program in 2017, there has been a shift in the focus of the RWAs with wider inclusion of health professionals including nursing and allied health in workforce initiatives and programs. The majority of stakeholders identified that this has been a positive shift. Some stakeholders noted that this was still in its infancy.

The objective of the program is considered below, followed by the key components of the program design.

Objective of the program

As the objective of the program is to contribute to addressing health workforce shortages and maldistribution in regional, rural and remote Australia, it is important to understand the breadth of other strategies, initiatives and programs that operate alongside the RHWSA program, implemented both nationally and by the various States and Territories. Relevant Commonwealth, State / Territory and other rural health and workforce development strategies

and programs have been summarised below in Table 12. This table draws on previous review findings, evidence and literature (35; 40; 41).

It was identified through stakeholder consultations that key stakeholder groups were aware of the broader policy context in which the RHWSA program had been developed. Stakeholders recognised that the RHWSA program had been constructed to align with broader initiatives, including the National Medical Workforce Strategy, the RHMT program and activities of the National Rural Health Commissioner.

Table 12: The RHWSA program in context with national, State and other strategies and programs

-	National	State	Other
Strategies	• National Medical Workforce Strategy • Stronger Rural Health Strategy • National Rural Generalist Pathway • National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023 • International Recruitment Strategy	• SA Rural Health Workforce Strategy • NSW Health Professionals Workforce Plan 2012 – 2022 • NT Health Workforce Strategy 2019 – 2022 • Sustainable Health Review (WA) • Strategic Framework for Health Services 2012- 2018 (TAS) • Advancing Rural and Remote Service Delivery through Workforce: A strategy for Queensland 2017- 2020 • People in Health strategy (VIC)	• National Regional, Rural and Remote Education Strategy

Programs	• RHWSA program
	
	  - RLRP and MDRAP
	
	  - 5 Year OTD
	
	  - Workforce Incentive Program – Doctor Stream: FPS
	
	  - Grants & Scholarships
	
	• John Flynn Placement Program
	
	• PHNs
	
	• Workforce Incentive Program
		Each jurisdiction has various rural health workforce programs that align with the RHWSA program and other Commonwealth rural health workforce programs. Some commonalities exist with respect to jurisdictional health workforce programs including:
		
		• Implementation of various integrated education and training programs that leverage the following jurisdictional infrastructure:
		
		  - Rural Generalist training programs for medicine, nursing and allied health (in some jurisdictions)
			• Regional university centres
			
			• Regional study hubs

-	National	State	Other
	• Rural Health Multidisciplinary Training Program • Australian General Practice Training program - Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) - Rural Procedural Grants Program • Specialist Training Program (STP) • Remote Vocational Training Scheme • Rural Health Continuing Education Sub Program • Rural Locum Assistance Program - Nursing and Allied Health Rural Locum Scheme - Rural Obstetric and Anaesthetic Locum Scheme - Rural Locum Education Assistance Program • Aboriginal and Torres Strait Islander Health Workforce - Health Scholarships specifically for Aboriginal and Torres Strait Islander Health Workforce - Aboriginal and Torres Strait Islander Health Curriculum Framework	- RTOs - University Departments of Rural Health - RCSs - Regional Training Hubs • Various scholarships and subsidies programs • Capacity building programs that enhance workforce capability through advanced practice scope • Design and development of innovative, flexible & sustainable rural health workforce models that align to the needs of the community • Programs that support multidisciplinary approaches to care • Data system programs to capture and monitor real-time health workforce information. These health workforce programs are typically delivered by jurisdictional Local Hospital Networks, jurisdictional rural health outreach programs/services, local PHNs and various other local health services.	

-	National	State	Other
	• Royal Flying Doctor Service program • RHOF • Various Scholarship schemes and Bonded Medical Placement Scheme • Rural Pharmacy Workforce Program • Rural Pharmacy Scholarship Scheme		

Source: Information from multiple sources (35; 40; 41)

Program elements

The majority of stakeholders reported that the three program elements of Access, Quality and Sustainability are appropriate elements for the focus of the program. Stakeholders identified that all three elements were important to meet current and future regional, rural and remote community health workforce needs.

When considering whether the design of the program elements is appropriate for meeting the program's objective, it is important to understand the literature which pinpoints the unique contextual factors influencing workforce distribution and retention in rural and remote communities. The literature scan, included as Appendix 3, provided an in-depth exploration of the rural health workforce context including the identification of those factors influencing distribution and retention. Briefly, this is discussed here in the context of the three program elements: Access, Quality and Sustainability.

Access

In Australia, health workforce shortages exist with a clear disparity in personnel between metropolitan and rural and remote regions - there is a clear trend of decreasing clinical full-time equivalent health professionals (per 100,000 persons) as remoteness increases. Additionally, Aboriginal and Torres Strait Islander people make up a large proportion of populations living in very remote communities. Aboriginal and Torres Strait Islanders are an 'at-risk' population more likely to have poorer health outcomes due to higher rates of chronic and other conditions compared to non-Indigenous Australians (12). Largely, healthcare access issues are a result of the persistent problem of health workforce undersupply and maldistribution (8). There is a clear need to address rural and remote community access to essential primary healthcare services. Considering these underlying factors, there is some evidence that the Access element is an appropriate priority area for addressing the program's objective.

Quality

Traditionally, health service delivery models have been developed in the context of metropolitan settings specifically to meet the healthcare needs of larger Australian cities (11). Subsequently, when translated to rural and remote communities, there is a discrepancy between the service models and models of care utilised and the unique healthcare service needs of those communities. Additionally, traditional metropolitan-based training programs and funding mechanisms have led to an uneven distribution of health care providers throughout the country (11). Due to these underlying factors, the capability of the local health workforce is diminished, and there is a clear need to address the quality of this workforce to ensure it is 'fit for purpose' that is "ensuring communities can access the right health professionals at the right time" (2). To this end, there is some evidence that the Quality element is an appropriate priority area for addressing the program's objective.

Sustainability

Operationally, rural and remote service providers do not experience the same economies of scales as their metropolitan-based counterparts, often experiencing significant administrative burden to meet multiple accreditation, accountability and reporting requirements (12). Health services in these regions are very different to their metropolitan counterparts often operating out of smaller facilities, delivering a broader range of services to more

dispersed populations with less infrastructure and with limited access to specialist services (11). It is clear that Australian rural and remote healthcare service providers face additional barriers to maintain viability and continue delivering healthcare services within their communities; as such, there is some evidence that the Sustainability element is an appropriate priority area for addressing the program's objective.

Collaborating with relevant stakeholders

There is some evidence, such as through the interactions on the HWSG, that the RHWSA program stewards (i.e. the RWAs) have oversight of other activities funded in the education and training space including activities of RCSs, the Specialist Training Program (STP), the Australian General Practice Training Program and the Remote Vocational Training Scheme. To this end, there appear to be some structures in place, such as the HWSG, within the RHWSA program that seek to bring together education and training pipeline initiatives in an integrated way, however this is not formalised. The broader evidence base supports this integrated approach as best practice for improving the recruitment and retention of the rural and remote health workforce.

Delivery of programs

There are several key programs delivered under the RHWSA program. These are discussed below in relation to the underlying evidence base. These programs include:

- 5 Year OTD Scheme.

- MDRAP (formally the RLRP).

- Workforce Incentive Program – Doctor Stream FPS (formerly the General Practice Rural Incentive Program.

The 5 Year OTD Scheme

The 5 Year OTD scheme provides additional assistance and incentives to attract OTDs to regional, rural and remote locations that are typically underserved and hard to recruit regions (42). Since 2010, OTDs are limited to where they can work through Medicare Provider Number restrictions for a period of up to 10 years depending on the level of remoteness of their primary location of practice (42). Through participating in the 5 Year OTD scheme, OTDs are eligible for a time reduction in the 10-year moratorium on provider number restrictions (42).

This contractual arrangement falls in the broader literature as one type of regulatory lever for influencing the recruitment and retention of health workers in rural and remote communities (10; 9). No evidence in the literature indicated such strategies improved long-term rural workforce retention, and Russell et al (2016) reported that GPs trained overseas had a 45% increased risk of leaving a rural community compared to an Australian-trained GP (43; 21; 10; 23). Additionally, these strategies have been criticised for increasing turnover in health centres, subsequently reducing continuity and quality of care (9). Such policies may even be detrimental, potentially reducing the incentive to improve working conditions, build educational capacity or possibly even alienate professionals from rural and remote work, thus becoming counterproductive (10; 21).

IMGs still substantially continue to underpin Australia's rural and remote medical service capacity and it is worth considering how current contractual approaches might be best combined with other types of incentives to support

this crucial demographic of health workers (44). When utilising contractual approaches, they should be complemented with wrap-around professional and personal supports allowing IMGs to acclimatise to the Australian rural and remote health system (44). Parallel efforts should be put in place to improve the living and working conditions in these communities to support retention of IMGs at the conclusion of their contracted period by making these regions enjoyable places in which to live and work (44).

MDRAP (formally the RLRP)

RWAs administer several programs and activities that fit within the broader literature as various types of education strategy used to influence rural and remote health workforce distribution. MDRAP (formally the RLRP) is another key program funded under the RHWSA program. MDRAP supports non-vocationally recognised doctors to gain general practice experience in rural and remote communities prior to commencing a general practice fellowship (45). As key components of the MDRAP, participants must: undertake a certain number of supervised hours dependent on prior experience, complete foundation GP training modules provided through RACGP and ACRRM, undertake a certain amount of relevant professional development hours and demonstrated evidence of application towards the fellowship pathway (45).

Workforce Incentive Program – Doctor Stream FPS

Another key program funded under the RHWSA program is the administration of the Workforce Incentive Program – Doctor Stream FPS. Specifically, this stream of incentive payment aims to encourage medical practitioners to practice in regional, rural and remote communities through the provision of financial incentives (16; 17). Under this program, incentive payments are dependent on time-served and geographic location, meaning the focus is placed on retention (i.e. greater payment for greater time served) (16; 17). The literature supporting this approach is mixed, where there is evidence highlighting the program's effectiveness for improving the retention of healthcare professionals in rural and remote communities, it has also been criticised for being potentially wasteful through focusing on healthcare professionals already willing to stay in these regions, regardless of government intervention (23; 10).

Overarchingly, the broader evidence base supports the deployment of financial incentives as an effective retention strategy for rural and remote healthcare professionals; however, there is scope to consider a better practice approach which may focus on bundling these incentives with other supports and determining the right kind of incentive mix that will attract newer healthcare providers to these regions.

The programs delivered under the RHWSA program largely align the with evidence base and are best practice although there is room for improvement. To this end, there is evidence that they are appropriate for achieving the throughputs of improved recruitment and retention.

National representation

There was a clear view from stakeholder consultations that the health workforce space was complex. There is acknowledgment through the program's objective statement that the RHWSA program is only one program "contributing to" addressing health workforce shortages and maldistribution, which indicates this program is considered as one component within a broader picture. Stakeholders noted the importance of having clear direction

and oversight of both the national and jurisdictional health workforce space. Having national representation supports a clearer view of what RWAs are trying to achieve and what their role is within the broader picture. To this end, national representation is considered to be an appropriate component of the program's design.

Summary

There is some evidence to demonstrate that the RHWSA program design is informed by a credible evidence base and aligns with perspectives provided in the stakeholder consultations. The underlying literature recommends some better practice approaches that may strengthen current arrangements to better deliver on these outcomes. These are explored in the following sections.

A.2 Is the program being implemented in line with the design and theory of change (program fidelity)?

The desktop review of program documents (e.g. HWNA, AWP and performance reports) identified that the program is being implemented by the RWAs in line with the program design, which focuses on identifying needs and undertaking activities in the three program elements, completing stakeholder consultation (e.g. through the HWSG), delivering programs (e.g. 5 Year OTD) through the RHWSA program, and sub-contracting RHWA to provide national representation.

As described in Section A.1, the program design provides the RWAs with a degree of flexibility with their approach in identifying and addressing localised health workforce need. During stakeholder consultations, stakeholders identified the three program elements of the RHWSA activity as relevant now and into the future, however they noted that there are challenges in balancing focus and activity across the three elements. Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. These include the number of different service providers, market maturity and the population size and demographics.

A.3 Is the current reporting and data collection appropriate and meaningful to track progress and measure impact? Is there overlap with the reporting required for the three elements?

RWAs are required to develop a number of reports annually during the program, including the HWNA, AWP, performance reports for the three elements and annual financial reports. Figure 7 below illustrates the yearly reporting requirements in the program and provides a description of the reports.

In addition to the yearly reporting requirements, RWAs develop additional documents during the program and are required to provide reporting at the completion of the program, as outlined in Table 13 below.

This section further explores the HWNA, AWP and performance reports required in the program, along with the mechanism for reporting.

Health Workforce Needs Assessment

The RWAs are required to develop a HWNA every year, which is endorsed by the HWSG and approved by the Department. The HWNA includes a description of the services provided by the RWA, a description of the process to develop the HWNA, data needs and gaps, and outcomes of the assessment. The RWAs have provided different levels of information within the templates.

Approach to developing the HWNA

To minimise duplication, the HWNA is completed using existing data and evidence, where possible. The assessments incorporate local and national health data, service needs and available service provisions, consider clinical and community consultation, and market analysis. Some RWAs also highlighted in their HWNA that they engaged or partnered with other stakeholders to complete the needs analysis, including rural local health districts and universities (2).

The RWAs developed the HWNA each year with a focus on a different group of health professionals relevant to their jurisdictional priorities. All RWAs focused the first year on GPs, with some also focusing on other health practitioners, including Aboriginal Health Practitioners and Remote Area Nurses. This was expanded in the following years to include additional health professionals, such as allied health.

The process to develop the HWNA involved a number of different data sources, including qualitative (e.g. surveys, expert reference groups, community engagement, meetings) and quantitative inputs (e.g. remoteness, age, GP workforce), and validation with the HWSG.

In the HWNAs, the RWAs documented that a consistent methodology was used by all RWAs to determine relative health workforce needs in communities across Australia. This included consideration of the following data:

- Statistical Areas Level 2 aggregation for demographic data. This generally represents a population of 3,000 to 25,000 persons, and the purpose is to represent a community that socially and economically interacts together (46).

- Remoteness, by MM.

- SEIFA. This ranks areas in Australia according to relative socio-economic advantage and disadvantage (47).

- Population numbers.

- Workforce population (e.g. full-time equivalent GP workforce).

- Priority communities (e.g. high Indigenous population).

- Any other likely or known significant impacts for the jurisdiction.

Limitations of the approach

Some of the limitations of the approach reported by the RWAs in the HWNA included:

- It was hard to take into account other factors such as visiting workforce (e.g. locums), prevalence of disease or service demand.

- There was limited access to accurate data, particularly for allied health data and national data sets for the primary health care workforce.

- Some areas did not have data available to be included in the ranking process, so further consultation was required to identify workforce needs.

- One RWA reported that the Aboriginal weighting for the national HWNA framework skewed data for regions without a significant Aboriginal population.

Some RWAs commented that there are additional considerations for small communities, where a small change can have a significant impact, and there are some groups (e.g. Aboriginal Medical Services) where priorities change quickly. Ongoing monitoring of the workforce situation was highlighted to ensure they are able to respond to changing needs.

In the 2017-18 HWNA, one RWA commented that several agencies were all completing health workforce needs analyses separately (e.g. RTOs and PHNs), creating duplicate effort and causing confusion among service providers. The RWA identified this as an area to work on with the other organisations. This was also identified during the stakeholder consultations and is explored further in the engagement domain of inquiry.

Opportunities for improvement

As described in Section A.2, some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements. There is an opportunity for RWAs to develop place-based workforce needs assessment and planning, which can be reported to the Department through the HWNA. This will assist with tracking progress and measuring impact of the program.

Activity Work Plan

The RWAs complete an AWP for each element every year. The AWPs document the tasks, output(s), deliverable(s), performance measure(s), expected expenditure per funding stream, and the timeline for completion of the task.

There was variability in the level of detail provided in the AWPs, and some RWAs reported on duplicate information in the Access, Quality and Sustainability performance reports.

During consultations, it was identified that the AWP could also include the ability for an RWA to reflect and identify areas for improvement, which is currently limited.

Performance Reports

A Performance Report Assessment Template was provided by the Department to the RWAs to complete the performance reporting. The performance reports for each element include activity performance indicators as defined

in the contract with each RWA, progress against activities, issue resolution, funding for the financial year and expenditure to date, risks (RWA risks and program risks) and opportunities.

The desktop review identified that the activity performance indicators were reported on differently by the RWAs, which impacted on the analysis and comparability of some of the indicators across the RWAs. There was also variability in the level of detail provided in the performance reports, and some RWAs reported on duplicate information in the Access, Quality and Sustainability performance reports.

During stakeholder consultations, the RWAs identified that the reporting is compliance and outputs-focused and does not provide the opportunity for the RWAs to demonstrate the depth of the outcomes that have been achieved. RWAs identified that outcomes-based reporting would better communicate the progress in addressing workforce shortages and maldistribution in regional, rural and remote Australia, and would better align with the three program elements.

The literature recommends benchmarking services against desired outcomes postulated during planning to ensure funders can understand to what extent services are achieving positive outcomes for their target population. Care must be taken when designing such frameworks to ensure they are not so onerous, in terms of complexity and time, that they conflict with service delivery. The literature identifies that these types of reporting tools, when correctly applied, can be used by providers as a real-time, strategic resource supporting the ongoing delivery and adjustment of health services (6).

Some RWAs reported that they are required to provide outcomes-based reporting to their Board of Directors. There is an opportunity to leverage outcomes-based reporting already completed by the RWAs (e.g. for their Board of Directors) for the RHWSA performance reporting.

Reporting mechanism

The RWAs provide the program reporting to the Department by pre-determined dates, as provided in Figure 7. The reporting mechanism is not dynamic. There is an opportunity to implement a digital platform (e.g. web-based portal) to support information, outcomes and risks to be updated efficiently.

National reporting on the RHWSA program

There is currently no national reporting on the outputs and outcomes of the RHWSA program, by RHWA or by another organisation. Completing national reporting would provide a summary of the overall impact of the program.

Figure 7: Summary of RWAs yearly reporting requirements to the Department

Document Type	Description	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Health Workforce Needs Assessment (HWNA) – all elements	Developed by RWAs to outline the jurisdictional needs identified over the three program elements. The needs analysis considers health workforce data, information from surveys, and findings from stakeholder group members and communications from the Department and other jurisdictional stakeholders. It also includes a list of all eligible professionals within jurisdictional RWAs for the program.		● 28th Feb										
Activity Work Plan (AWP)	Each RWA submits a yearly AWP across all three program elements. This document outlines the strategy and approach to addressing the jurisdictional needs identified in the HWNA (the first AWP developed in 2017-18 was completed prior to the HWNA being provided to the Department). This includes specific plans for delivery, a timetable for estimated delivery dates, estimated expenditure and performance measures.							● 31st Jul					
Performance Reports – Access	Twice yearly, each RWA submits a performance report against the Access program element. Reporting occurs against pre-determined performance indicators to demonstrate core organisational performance and local organisational performance. The reports should outline the extent to which the aim of the program element has been met and any problems or delays encountered to date. The reports also include the total funding allocated for the financial year and the expenditure to date.	● 31st Jan								● 30th Sep			
Performance Reports – Quality	Twice yearly, each RWA submits a performance report against the Quality program element. Reporting requirements are the same as those outlined above in the Access performance report.	● 31st Jan								● 30th Sep			
Performance Reports – Sustainability	Twice yearly, each RWA submits a performance report against the Sustainability program element. Reporting requirements are the same as those outlined above in the Access performance report.	● 31st Jan								● 30th Sep			
Annual Financial Report	Income and expenditure statement for the financial year.						● 30th Jun						

Key: ● Report Submission Date

Source: Commonwealth Department of Health, analysed by KPMG

Table 13: Additional documents developed by the RWAs during and at the end of the program

Time Period	Document Type	Description
Additional documents developed during the program	**HWSG – Terms of Reference**	Document outlining purpose, objectives and various roles and responsibilities of the HWSG and its constituent members. The Terms of Reference should also define the group's governance context including authority and accountability and define the guiding principles.
	RWA Hotspot List	List of jurisdictional RWAs hotspot locations. The needs analysis assessment helps to identify the hotspot locations.
	Needs Analysis Assessment	This report summarises the HWNA outlining progress against milestones / deliverables in the funding agreement for departmental reporting and approval. This was completed for 2018-19 and was due at the same time as the HWNA.
Documents required post RHWSA program completion	**Final Report**	Final Report for the entire project period was required by 30 September 2020. It must contain the following: • A summary of the Performance Reports provided to date including an update of the Activity not yet reported on including. • A discussion of any issues, problems or delays that organisations experienced in performance of the Activity and an explanation of how the organisation dealt with those issues, problems and delays. • A copy of all Activity Material that the Department requests be provided to it as part of this Final Report.
	Audited Financial Report	An audited financial statement for the entire project period was required by 30 September 2020. This must occur across all three program elements.

Source: Commonwealth Department of Health, analysed by KPMG

A.4 What are the key variables which may be positively or negatively impacting the programs ability to demonstrate change at a 1) micro activity level, 2) community level, 3) jurisdictional level and 4) national level?

The key variables that may be positively or negatively impacting the programs ability to demonstrate change were identified during stakeholder consultations.

Micro activity level

The three program elements provide the RWAs with a degree of flexibility within the program to deliver eligible activities for areas of need, as identified by the HWNA.

During consultations, the RWAs identified that the funding was generally flexible, however the notional splits between program elements and funding streams were unhelpful. This may impact negatively on the activities that the RWAs can implement, whereby the activities undertaken are not the most appropriate to meet the identified need. This is explored further in the efficiency domain of inquiry.

Community level

Place-based planning was identified by stakeholders consulted as a key variable that positively impacts the program's ability to demonstrate change at a community level. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. Place-based planning is occurring in every jurisdiction to some extent. Stakeholders identified there is an opportunity for RWAs to further utilise this approach, to develop tailored workforce solutions for individual communities based on place-based workforce needs assessment and planning.

For example, one RWA demonstrated collaboration with multiple stakeholder groups, such as the PHN, RHOF Fundholder and various non-government organisations, to identify local community need and coordinate initiatives to address local workforce issues. The RWA has established formal processes to collaborate with the PHN, such as memorandums of understanding, developing data sharing protocols between agencies and undertaking mutually involved planning and assessment processes. Coordinated workforce initiatives include a joint strategy for Aboriginal and Torres Strait Islander health workforce and to fund community level activities.

There is an opportunity for RWAs to develop tailored workforce solutions for individual communities based on place-based workforce needs assessment and planning.

The following variables were identified to negatively impact the program's ability to demonstrate change at a community level:

- Lack of stakeholder engagement with communities.

- Issues in the local community that are outside of the control of the RHWSA program (e.g. safety issues within a community).

- Lack of awareness of the program or the role of the RWAs, whereby individuals or organisations in a community do not know who to contact to request support.

- Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements.

Jurisdictional level

The following variables were identified to positively impact the program's ability to demonstrate change at a jurisdictional level:

- The HWSG was identified by a number of stakeholders as a positive forum to bring stakeholders together. This is explored further in the engagement domain of inquiry.

- Some RWAs provided examples where sustained engagement with stakeholders in the jurisdiction has led to more effective workforce planning and implementation of solutions on a jurisdictional level. This is explored further in the engagement domain of inquiry.

The following variables were identified during consultations that may negatively impact on the program's ability to demonstrate change at a jurisdictional level:

- There is a complex ecosystem of stakeholders operating in each jurisdiction to provide support for regional, rural and remote community health workforce needs. The stakeholders in each jurisdiction have different resource allocation priorities in relation to rural health workforce models. This can have implications where stakeholders are operating in a duplicative manner, or where there may be competing objectives between different stakeholders. Clarifying each stakeholder's role and remit may assist with demonstrating change at a jurisdictional level. Figure 8 below illustrates some of the stakeholders involved in supporting regional, rural and remote community health workforce needs. This includes the RWAs, PHNs, RTOs, LHNs, RHOF fundholders, RCSs, Aboriginal and Torres Strait Islander State Health Peak Bodies and national bodies. The number of HWSGs are also reflected in the figure for each jurisdiction. The stakeholder environment is further explored in the engagement domain of inquiry.

- Some stakeholders do not have awareness of the role of the RWA in their jurisdiction or of the RHWSA program. This limits the ability for stakeholders to reach out to the RWA to inform them of areas where support is needed within the jurisdiction. This also limits the ability for stakeholders to comment on whether the program has demonstrated change in their jurisdiction.
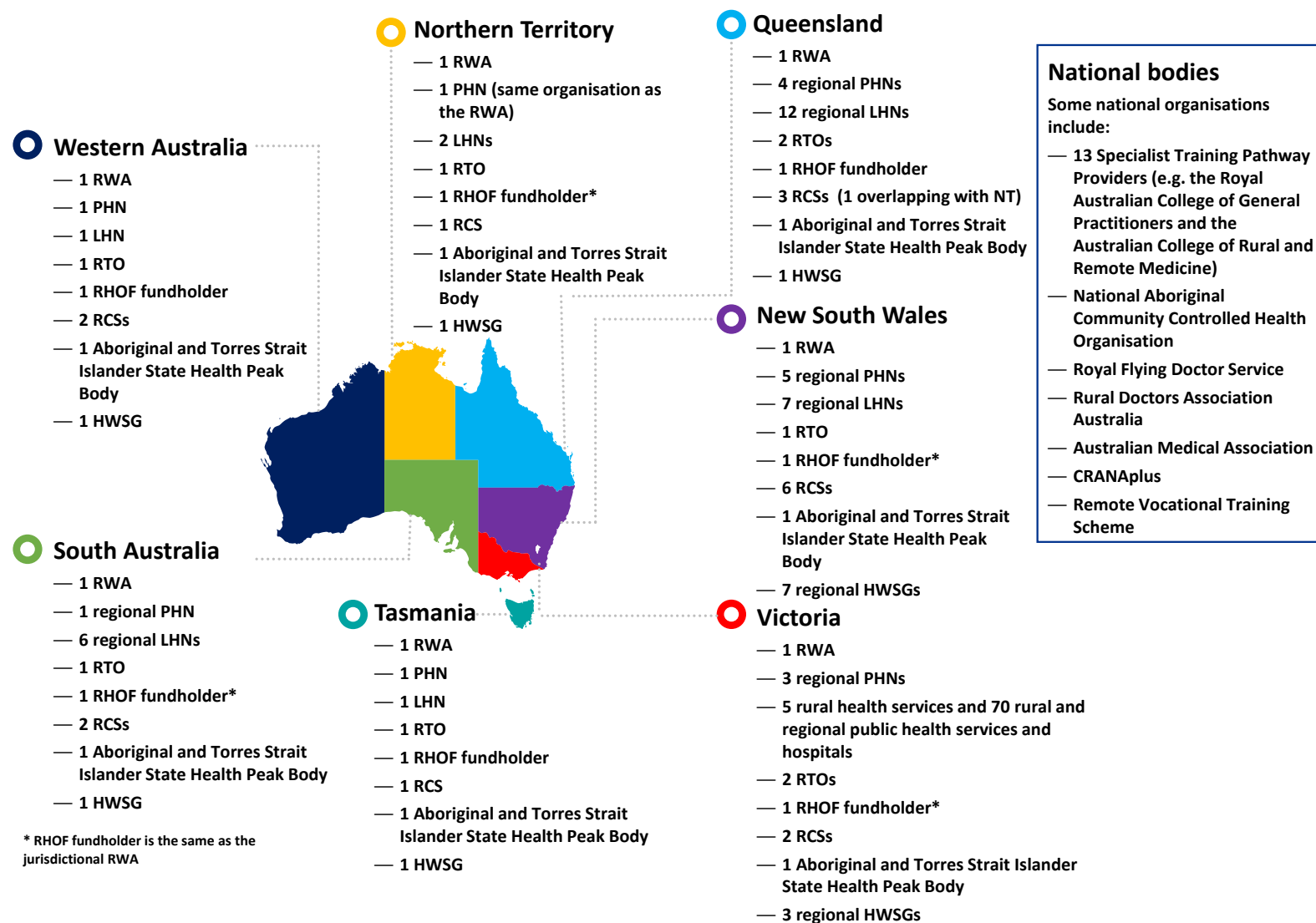
National level

The RWAs identified that the RWAN provided a positive platform to discuss the RHWSA program.

The following variables were identified during consultations that may negatively impact on the program's ability to demonstrate change at a national level:

- Lack of awareness of the national priorities for the RHWSA program.

- National peak bodies and organisations may not have awareness of how to engage with RWAN to discuss health workforce planning and initiatives.

- The RWAs reported a view that the role of RHWA is unclear in supporting delivery of the program.

- As described in Section A.3, there is currently no reporting on the outcomes of the program at a national level, limiting the ability to demonstrate change at a national level.

Figure 8: Stakeholders involved in supporting regional, rural and remote community health workforce needs

Western Australia
— 1 RWA
— 1 PHN
— 1 LHN
— 1 RTO
— 1 RHOF fundholder
— 2 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

South Australia
— 1 RWA
— 1 regional PHN
— 6 regional LHNs
— 1 RTO
— 1 RHOF fundholder*
— 2 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

* RHOF fundholder is the same as the jurisdictional RWA

Northern Territory
— 1 RWA
— 1 PHN (same organisation as the RWA)
— 2 LHNs
— 1 RTO
— 1 RHOF fundholder*
— 1 RCS
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

Tasmania
— 1 RWA
— 1 PHN
— 1 LHN
— 1 RTO
— 1 RHOF fundholder
— 1 RCS
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

Queensland
— 1 RWA
— 4 regional PHNs
— 12 regional LHNs
— 2 RTOs
— 1 RHOF fundholder
— 3 RCSs (1 overlapping with NT)
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 1 HWSG

New South Wales
— 1 RWA
— 5 regional PHNs
— 7 regional LHNs
— 1 RTO
— 1 RHOF fundholder*
— 6 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 7 regional HWSGs

Victoria
— 1 RWA
— 3 regional PHNs
— 5 rural health services and 70 rural and regional public health services and hospitals
— 2 RTOs
— 1 RHOF fundholder*
— 2 RCSs
— 1 Aboriginal and Torres Strait Islander State Health Peak Body
— 3 regional HWSGs

National bodies
Some national organisations include:

— **13 Specialist Training Pathway Providers (e.g. the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine)**
— **National Aboriginal Community Controlled Health Organisation**
— **Royal Flying Doctor Service**
— **Rural Doctors Association Australia**
— **Australian Medical Association**
— **CRANAplus**
— **Remote Vocational Training Scheme**

Source: KPMG, 2020

A.5 How satisfied are stakeholders with 1) the design of the program 2) the administration of the program by the Department 3) the implementation of the program by the RWAs?

The views provided below were obtained through stakeholder consultations with a broad range of stakeholders.

Design of the program

Excluding the RWAs, most stakeholders consulted were not aware of the full remit of the RHWSA program or did not have awareness of the role of the RWAs in delivering the program. Where stakeholders had awareness of the program, they generally provided the view that the three elements were the appropriate focus for the program.

Where stakeholders had involvement with the HWSG, it was generally described as a positive platform to bring stakeholders together to support the development of the HWNA. Some stakeholders noted they had no involvement with the HWSG in either the development of the HWNA and / or the AWP.

Some stakeholders commented more broadly about the large number of programs implemented to provide support to the rural, regional and remote health workforce, and that the RHWSA program was just one program of many. The scope of rural health workforce is expansive; from high school and tertiary education, to supporting junior and senior health professionals and addressing succession planning and future sustainability of the workforce. Multiple agencies are involved in the sector across the entirety of the rural health workforce pipeline.

Administration of the program by the Department

Overall, the RWAs reported a positive relationship with the Department in administering the program. The Department joins the RWAN meetings every month, which was seen a positive engagement with the RWAs, and provided a platform for the Department and the RWAs to communicate with each other on a regular basis.

Implementation of the program by the RWAs

Where the stakeholders had engagement with the RWAs in delivering the program, the experience was viewed as generally being positive. Stakeholder engagement in each jurisdiction varied. Some stakeholders noted that there is an opportunity to increase involvement and collaboration with the HWSG, and also increase engagement with stakeholders in the implementation of workforce activities. Refer to the engagement domain of inquiry for further detail.

A.6 Do RWAs have enough flexibility to achieve the program aims within their local contexts?

During stakeholder consultations, the RWAs commented that the program design provides the RWAs with a degree of flexibility with their approach in identifying and addressing localised health workforce need. The RWAs have flexibility within each element to deliver eligible activities that best meet the needs of the individual communities.

There are opportunities to adjust the funding model to support RWAs to have more flexibility to achieve the program aims within their local contexts. This is explored further in the efficiency domain of inquiry.

A.7 Are there contemporary contextual factors which need to be considered in the future design of the program (e.g. large scale reforms impacting the rural health workforce)?

There were a number of contemporary contextual factors identified during consultations that could be considered in the future design of the program. They are explored individually below.

Focus on telehealth

With the advent of COVID-19, there has been a shift towards providing telehealth in Australia. There is an opportunity for the future design of the program to consider how the RWAs can best support rural, regional and remote communities with utilising telehealth in their model of care. One RWA commented that there are limited opportunities to support investments for telehealth infrastructure in the current program and that this should be a consideration moving forward.

Consideration of adjacent or interdependent workforces

Two RWAs commented that there is an opportunity for expanding the remit of the program, to accommodate the disability and aged care sectors, which are often integrally linked and interdependent on primary health services in rural and remote locations. Any future reforms in the disability and aged care sectors should be reviewed with regards to the future design of the program.

Breadth of rural health workforce strategies and programs

During consultations, stakeholders noted that the RHWSA program is one program of many that support addressing workforce shortages and maldistribution in regional, rural and remote Australia.

Consultations identified that there are duplicate activities being undertaken (e.g. the role of PHNs in undertaking health workforce support activities) and there is an opportunity to review and consider opportunities for consolidation to support more effective and efficient processes, and reduce duplicative activities being undertaken in the sector, sometimes with differing objectives. Consideration should be provided for opportunities to consolidate processes or activities, where appropriate, with other stakeholders in the future design of the program.

A.8 What changes, if any, should be made to the design of the program going forward?

The following are considerations for the future design of the program.

Place-based planning

Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. These include the number of different service providers, market maturity and the population size and demographics.

Findings from the literature scan have identified that place-based approaches can be effective for changing health outcomes or health-related behaviours in target populations. Place-based approaches typically address underlying

social determinants associated with poorer health outcomes and can be successful in influencing change in built environments, social cohesion and economic environments within defined geographic locations. Key to the success of place-based approaches is the use of collaborative partnerships between local health services / providers and relevant local / state / national government agencies to design and implement health programs and services (3).

Program reporting

During stakeholder consultations, the RWAs identified that the program reporting is compliance and outputs-focused and does not provide the opportunity for the RWAs to demonstrate the depth of the outcomes that have been achieved. The following are considerations for the program reporting:

- **Outcomes-based reporting:** During stakeholder consultations, the RWAs identified that the reporting is compliance and outputs-focused and does not provide the opportunity for the RWAs to demonstrate the depth of the outcomes that have been achieved. RWAs identified that outcomes-based reporting would better communicate the progress in addressing workforce shortages and maldistribution in regional, rural and remote Australia, and would better align with the three program elements. Some RWAs reported that they are required to provide outcomes-based reporting to their Board of Directors. There is an opportunity to leverage outcomes-based reporting already completed by the RWAs (e.g. for their Board of Directors) for the RHWSA performance reporting.

  The literature recommends benchmarking services against desired outcomes postulated during planning to ensure funders can understand to what extent services are achieving positive outcomes for their target population. Care must be taken when designing such frameworks to ensure they are not so onerous, in terms of complexity and time, that they conflict with service delivery (6).

  There are practical challenges associated with moving to outcomes-based reporting. Short-term, actionable activity can be undertaken by the Department in ensuring reporting is consistent by the RWAs and providing feedback to RWAs on the quality of the reporting and opportunities for improvement.

  The Department has made some progress in moving to outcomes-based reporting. One example is the PHN Program Performance and Quality Framework that was implemented by the Department in 2018. It is designed to consider how the activities and functions delivered by PHNs contribute towards achieving the PHN program's objectives. The PHN Program Performance and Quality Framework includes the outcomes to be achieved in the program, drawn from the program logic, and includes indicators to assess individual PHN performance. Additionally, a yearly report is to be prepared for the overall performance of the PHN program, which assesses progress towards achieving the PHN program outcomes. One of the findings from the most recent report was that there are some regions where workforce support is limited and could benefit from a more integrated and planned approach (24).

- **Reporting mechanism:** The reporting mechanism is not dynamic. There is an opportunity to implement a digital platform (e.g. web-based portal) to support information, outcomes and risks to be updated efficiently.

The Department recently implemented a digital reporting mechanism for the PHN Program, the PPERS. It allows PHN users to log in to the PPERS Portal, and to draft, edit and update their reporting information online, and electronic submission and approval processes between PHNs and the Department of Health (25).

- **National reporting:** There is currently no national reporting on the outputs and outcomes of the RHWSA program, by RHWA or by another organisation. Completing national reporting would provide a summary of the overall impact of the program.

Consideration of adjacent or interdependent workforces

Two RWAs commented that there is an opportunity for expanding the remit of the program, to accommodate the disability and aged care sectors, which are often integrally linked and interdependent on primary health services in rural and remote locations.

Duplication of activities

Consultations identified that there are duplicate activities being undertaken by different stakeholders (e.g. the role of PHNs in undertaking health workforce support activities) and there is an opportunity to review and consider opportunities for consolidation to support more effective and efficient processes, and reduce duplicative activities being undertaken in the sector, sometimes with differing objectives. Consideration should be provided for opportunities to consolidate processes or activities, where appropriate, with other stakeholders in the future design of the program. This is explored further in the engagement domain of inquiry.

Ongoing monitoring and evaluation

The RWAs have flexibility to undertake eligible activities to meet the identified needs in a community. As such, RWAs all undertake different activities across the three program elements. Building the evidence base, through monitoring and evaluation, to assess the design, development and implementation of activities will support identification of what does and does not work, to support continuous improvement of the RHWSA program.

The literature scan identified the need for robust and ongoing data collection, analysis, monitoring and evaluation of all strategies implemented to instigate health workforce improvements in rural, regional and remote settings. The literature scan highlights the importance of implementing evaluation frameworks from the outset when designing programs that aim to support the recruitment and retention of healthcare providers in rural and remote communities, as opposed to completing these retrospectively (8; 10; 9).

B. Effectiveness

Effectiveness is the extent to which the program is achieving the intended objectives and producing results (activities, outputs and outcomes). There are five questions considered in the effectiveness domain, which are discussed individually in this section.

B.1 Is the program demonstrating improvement against its goals to improve workforce access, quality and sustainability for the primary and preventive health workforce?

The majority of stakeholders recognised that three years was a limited period of time for a program to demonstrate change over the three program elements. Some RWAs and jurisdictional stakeholders have noted that short-term improvements have been demonstrated, particularly for workforce access and quality; however, this is difficult to solely attribute to the RHWSA program.

RWAs have administered a range of activities including MDRAP, the 5 Year OTD Scheme, the Workforce Incentive Program, FPS and provided grants, scholarships and bursaries. Implementation of these activities has supported the program with achieving the intended objective to "*contribute to addressing workforce shortages and maldistribution in regional, rural and remote Australia"* (2).

Some RWAs reported that some activities have been less effective with improving the access, quality and sustainability for the primary and preventive health workforce. One example was grants and scholarships, where the initial design of the program required over 50% of funding to be expended on grants and incentives. RWAs welcomed a decrease in the level of funding required to be allocated to this funding stream to enable more funding to be allocated to other activities to meet the identified areas of need. This is explored further in the efficiency domain of inquiry.

All stakeholder groups commented broadly on the long-term and complex challenges associated with rural health workforce planning across Australia, and the large number of programs implemented by a range of organisations to address these issues. Stakeholders commented that it is challenging to attribute improvements in access, quality and sustainability of the rural primary health workforce given these contextual factors. Within each jurisdiction, at least one of the stakeholder groups consulted reported a limited awareness of the role, scope and remit of the RWAs, further impacting the ability to measure the effectiveness of the program activities and the impact it is having for the rural health workforce.

B.2 How effectively are each of the program elements meeting their objectives? How does this compare and / or intersect with other elements?

This question is answered based on the following approach:

- Examination of how effectively each program element has met its objectives.

- Examination of the interaction of the three program elements.

Access

The objective of the Access element is on improving access and continuity of access to essential primary health care for communities most in need. Eligible activities within this element include:

- The provision of recruitment support to priority areas of need, including grants to health professionals to encourage relocation to rural Australia.

- Providing assistance, including financial, to sourcing GP locums for areas of need.

- Coordination with existing health professionals and organisations to provide services to areas of need identified by the HWSG and / or the Department, including grants to support the provision of outreach services (2).

The first two activities are analysed individually below, with the third activity analysed at the end of this section.

Provision of recruitment support

The RHWSA program resulted in the recruitment of 714 and 659 health professionals to rural Australia in 2017-18 and 2018-19, respectively. In 2017-18, the largest number of health professionals were recruited into MM5 (179), whereas in 2018-19, the largest number of health professionals were recruited into MM3 (142). In both periods, the smallest number of health professionals were recruited into MM1, followed by MM7. The number and proportion of professionals recruited into each MM is provided in Table 14 below.

Figure 9 illustrates the total number of professionals recruited and the distribution by MM for each RWA in 2017-18 and 2018-19. Four RWAs recruited less health professionals in 2018-19 than in 2017-18, with the largest decrease experienced by VIC, decreasing from 159 health professionals recruited in 2017-18 to 75 recruited in 2018-19. Three RWAs recruited more health professionals in 2018-19 than in 2017-18, with NT experiencing the largest increase, from 76 recruited in 2017-18 to 107 in 2018-19. The key performance indicator for the recruitment of health professionals does not provide information on the number of health professionals recruited compared to the need identified through the period, making it difficult to comment on the effectiveness in meeting the identified need. The reporting also does not consistently detail the communities where health professionals were recruited.

Table 14: The number and proportion of health professionals recruited in 2017-18 and 2018-19 per MM

MM	2017-18 Number of Professionals	2017-18 Percentage of Total	2018-19 Number of Professionals	2018-19 Percentage of Total
MM1	15	2%	10	2%
MM2	130.5	18%	132	20%
MM3	150	21%	142	22%
MM4	104	15%	90	14%

MM	2017-18 Number of Professionals	2017-18 Percentage of Total	2018-19 Number of Professionals	2018-19 Percentage of Total
MM5	179	25%	133	20%
MM6	86	12%	97	15%
MM7	49.5	7%	55	8%
Total	**714**	-	**659**	-

Source: Commonwealth Department of Health, analysed by KPMG

Figure 9: Number of health professionals recruited in 2017-18 and 2018-19 per RWA by MM
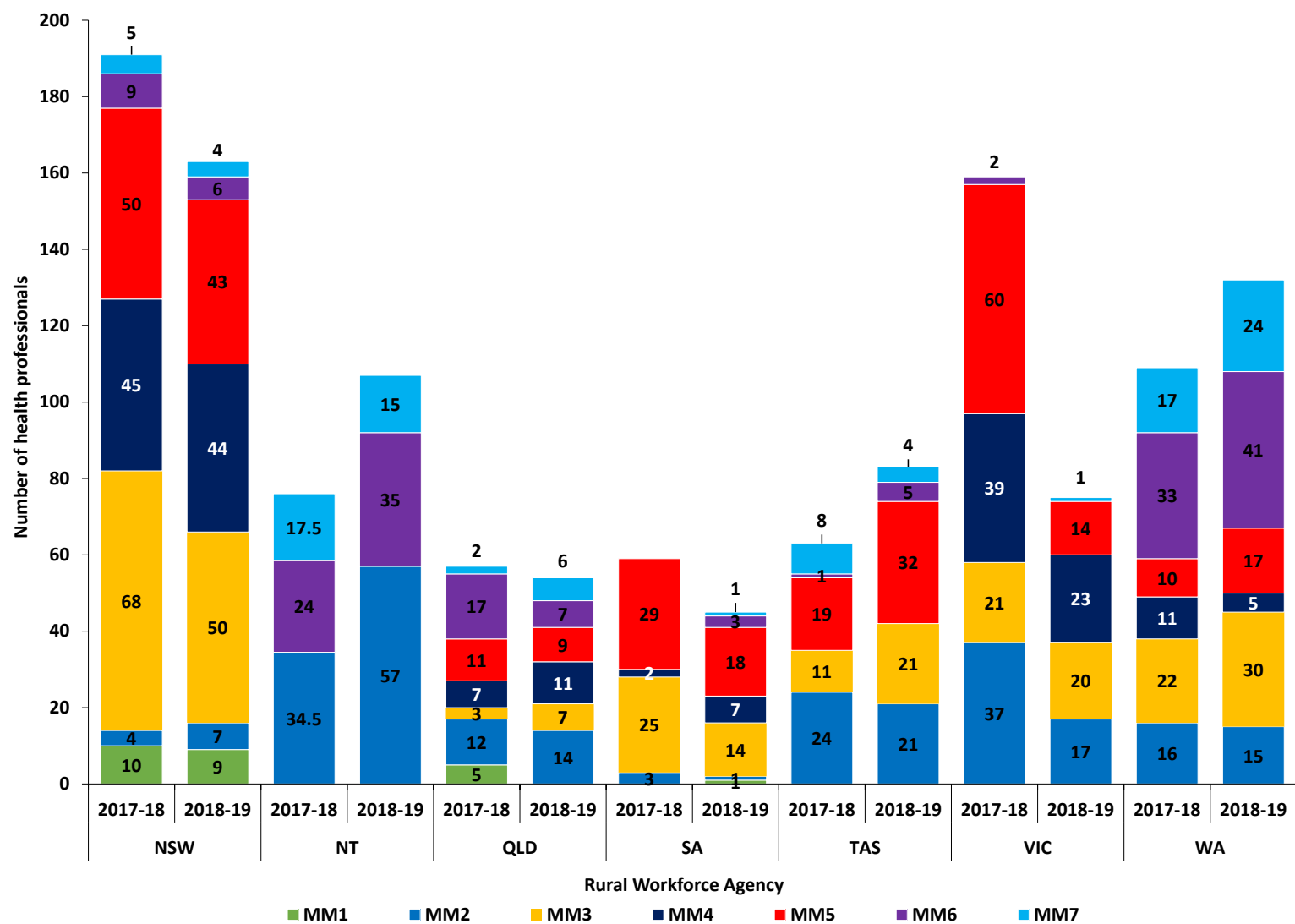
Source: Commonwealth Department of Health, analysed by KPMG

Stakeholder consultations identified that RWAs are increasingly focusing on improving access to health professionals and para-professional roles outside of the medical workforce. In the performance reports, four of the RWAs provided a breakdown of the health professionals recruited, by health profession. For the four RWAs, overall, 471 of the placements were for GPs, and 418 of the placements were for allied health and nursing professionals. A summary is provided in Table 15 below.

Table 15: Health professionals recruited in 2017-18 and 2018-19

-	NT 2017-18	NT 2018-19	QLD 2017-18	QLD 2018-19	NSW 2017-18[5]	NSW 2018-19[6]	WA 2017-18	WA 2018-19
GPs	16	22	33	33	152	142	42	31
Allied health	60	85	17	12	39	21	67	101[7]
Nursing			7	9				
Total	**76**	**107**	**57**	**54**	**191**	**163**	**109**	**132**
ACCHS placements[8]	-	-	10	3	10	9	-	-

Source: Commonwealth Department of Health, analysed by KPMG

While the number of health professionals recruited into regional, rural and remote Australia are reported every six months in the performance reports, the reporting does not track the longer-term outcomes associated with the placements of individuals in regional, rural and remote communities. The current reporting does not provide any insight regarding the sustainability for health professionals by jurisdiction, community, and MM classification. In moving to outcomes-based reporting, more detail should be provided on health professionals recruited into the communities, the sustainability of the health workforce and the associated health model.

In the performance reports, the RWAs provided detail of the types of grants provided in the Access element. The grants were reported differently by the RWAs, with some RWAs providing specific details of the number of each type of grant provided and the associated expenditure (or committed funds), and other RWAs providing an approximate value of expenditure. The grants varied in name, but included grants for:

- Relocation support (including rental and travel assistance).

- Orientation.

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[5] In the performance reports, the term 'medical' professionals was used. For the purposes of the analysis, this is assumed to mean GPs.

[6] In the performance reports, the term 'medical' professionals was used. For the purposes of the analysis, this is assumed to mean GPs.

[7] This includes dental and midwifery.

[8] The ACCHS placements are included for the RWAs that provided this in the reporting, either through explicitly stating this, or by reporting that health professionals were recruited in MM1. This may not capture all ACCHS placements for the RWAs.

- GP locum subsidy and support.

- Specialist recruitment grants.

- Supervision costs.

- CPD.

- Registration and settlement assistance.

In 2017-18, three grant recipients were reported to have left rural work within 12 months of receiving the grant, one each in NT, QLD and WA. There was an increase in the number reported in 2018-19, with five in NT, two in SA and one in VIC. A reason was only provided for one health professional that left rural work within 12 months, which related to the health professional relocating to an area that was not eligible for the support package. For NT, all health professionals who left had received the Health Professional Support Grant, which is primarily used to assist with relocation costs, and were in the following locations MM2 (four health professionals), MM6 (one health professional) and MM7 (one health professional).

Support for GP locums

As described above, the RWAs provided grants for GP locum subsidy and support. In the Access performance reports, NT and WA reported on the number of GP locum days. Overall, NT provided support for 2,360 GP locum days in 2017-18 and 2018-19, and WA 5,677 GP locum days. Further detail of the GP locum days per MM is provided in Table 16 below.

Table 16: Number of GP locum days for NT and WA, for 2017-18 and 2018-19

MM	NT 2017-18	NT 2018-19	WA 2017-18	WA 2018-19
MM2	74	91	143	65
MM3	0	0	237	292
MM4	0	0	35	37
MM5	0	0	399	279
MM6	260	484	1,232	790
MM7	234	1,217	972	1,196
Total	**568**	**1,792**	**3,018**	**2,659**

Source: Commonwealth Department of Health, analysed by KPMG

Perspectives from stakeholder consultations

During stakeholder consultations, RWAs described their efforts of engaging with medical students, and maintaining that relationship throughout medical school and as a junior doctor, leading to a greater likelihood of an individual practicing as a rural clinician.

Quality

The objective of the Quality element is on growing a quality workforce by building local health workforce capability with a view to ensuring communities can access the right health professional at the right time. Eligible activities within this element include:

- Working with health professionals and organisations to provide communities with access to the right mix of health professionals by both profession and by work type.

- Working with health professionals to become vocationally qualified or upskill to meet community need.

- Working with other stakeholder groups, particularly those in the HWSG, to:

  - Improve the jurisdictional health workforce skills profile.

  - Develop retention strategies for health professionals.

  - Develop strategies for safe, culturally sensitive workplaces and services.

- Provision of grants to health professionals to access CPD opportunities (including courses), access professionally development opportunities outside of formally provided courses and to make their practice safe, culturally sensitive workplaces for both practitioners and patients (2).

Working with health professionals and stakeholder groups

During consultations, RWAs, RCSs and Specialist Training Colleges discussed that the provision of medical training, continuing professional development and education bursaries and scholarships are an effective mechanism to maintaining and improving the capability of the medical workforce within the RWA's jurisdiction. During consultations, these stakeholders noted that workshops were tailored to specific community need.

Postgraduate Fellowship programs were also viewed as effective in generating pipeline medical professionals, however it was considered that they are not always feasible to be implemented widely as Fellowship programs require appropriately trained senior clinicians.

Provision of grants

In the performance reports, the RWAs provided detail of the types of grants provided in the Quality element. The grants are reported differently by the RWAs, with some RWAs providing specific details of the number of each type of grant provided and the associated expenditure (or committed funds), and other RWAs providing an approximate value of expenditure. The grants varied in name, but included grants for:

- CPD grants (e.g. for attendance at workshops, exam preparation).

- Upskilling grants.

- Aboriginal student support grants.

- Pre-exam support for IMGs.

- Locum support (e.g. bonus paid to top up salaries, subsidise travel).

- Support for cultural responsiveness training (reported by one RWA).

Four RWAs reported that no grant recipients left rural work within 12 months of receiving a grant. One RWA (WA) reported that this activity performance indicator was not applicable for locum services. In 2018-19, VIC reported that four grant recipients left work 12 months after receiving a grant.[9] QLD reported that two grant recipients in 2017-18 and 2018-19 left rural work within 12 months of receiving a grant, with both recipients in 2017-18 taking up placements in other States, and both recipients in 2018-19 receiving Fellowship and moving to metropolitan areas.

Sustainability

The focus of the Sustainability element is future workforce planning, by growing the sustainability and supply of the health workforce, to strengthen the long-term access to appropriately qualified health professionals. Eligible activities in this element include:

- Providing policy advice on current and emerging issues impacting the sustainability of the health workforce.

- In conjunction with other health workforce stakeholders, including members of the HWSG:

  - Monitor the stability of the health workforce and develop strategies for ensuring continuity of care in rural areas.

  - Develop strategies to direct incoming workforce flows to areas and professions likely to meet future shortages.

- Develop and implement strategies to encourage interest in rural health careers.

- Increase business management skills of rural general practices.

- Provision of grants to:

  - Students and health professionals to gain exposure to rural health work.

  - Health professionals to improve business practices to ensure long-term sustainability.

- Provide outreach and support services to health professionals with Return of Service obligations in order to prepare them for rural health work, and facilitate placement in rural areas (2).

Perspectives from the stakeholder consultations are provided below, along with further detail on the provision of grants and the provision of outreach and support services to health professionals with Return of Service obligations.

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[9] The information for VIC for July – December 2017 was not available for the analysis.

Perspectives from the stakeholder consultations

The majority of stakeholder groups reported limited effectiveness of the program in achieving rural health workforce sustainability since it began in 2017. However, it was acknowledged that this is a longer-term goal for the rural health workforce and there are multiple contributing factors that impact on maintaining a viable rural health workforce model within a community that are outside the scope of the RHWSA program.

Provision of grants

In the performance reports, the RWAs provided detail of the types of grants provided in the Sustainability element. The grants are reported differently by the RWAs, with some RWAs providing specific details of the number of each type of grant provided and the associated expenditure (or committed funds), and other RWAs providing an approximate value of expenditure. The grants varied in name, but included grants for:

- Facilitating rural exposure for undergraduate students, medical students, junior doctors and GP registrars.

- Attending conferences or industry events (e.g. for practice managers and receptionists).

- Rural health careers promotions.

- Business training.

- Support practice staff at Aboriginal Medical Services to complete their Diplomas of Practice Management.

- Innovation.

- Aboriginal cultural safety training.

All RWAs either stated that it was too early to report on the number of recipients provided practice sustainability grants who ceased work within 12 months of receiving a grant, or the RWA provided a response of zero.

Return of Service obligations

In the performance reports, there was variability in how the RWAs reported on the number of health professionals with Return of Service obligations and the support provided to them. Support provided to the health professionals with Return of Service obligations included:

- Orientations for newly-recruited GPs and allied health professionals commencing work in rural and remote areas.

- Clinical placement grants.

- Workshops for Bonded Medical Students that provide information about training pathways and opportunities in rural locations.

Interaction between the program elements

As provided in Section A.1, many stakeholders identified the three elements of the program as relevant now and into the future, and some stakeholders also commented that there is a strong connection between the three elements. Some RWAs commented that the three elements provided a positive focus and natural prioritisation for the programs they delivered given the complex and vast challenges associated with rural health workforce.

Each RWA was to implement and facilitate a HWSG during the program. The effectiveness of the HWSG is explored in B.3 below.

The RWAs are also required to sub-contract RHWA to provide national representation and coordination activities. The RWAs reported limited evidence on the effectiveness of the national representation and coordination activities in improving the access, quality and sustainability for the primary and preventive health workforce.

B.3 How effective are the RWAs in their role of implementing the program? What jurisdictional factors may be positively or negatively impacting on the RWAs ability to implement their program of work?

The degree to which an RWA successfully engages and builds relationships with key stakeholders impacts on the overall effectiveness of implementing the programs activities.

There are different approaches and contextual factors that underpin RWAs' relative effectiveness in implementing the program; these jurisdictional factors are discussed in greater detail below. As outlined in Section B.2, stakeholder consultation largely identified aspects of each program element that all RWAs are effective in implementing, mostly within education, training and providing financial incentives.

Jurisdictional factors that impact on the ability for an RWA to effectively implement their program of work are explored below.

Stakeholder involvement in the HWSG

The HWSG is required to endorse the HWNA and AWP for each element. As described in the program elements above, the RWAs are to work with other health workforce stakeholders, including members of the HWSG, to implement a number of the activities. During consultations, stakeholders reported mixed feedback regarding the effectiveness of the HWSG and the HWNA. Some RWAs and PHNs reported the needs assessment process and the HWSG as effective mechanisms to identify priority areas and immediate, short-term workforce shortages, and the representation of key stakeholders led to meaningful and appropriate solutions being identified and implemented. However, some stakeholders noted they had no involvement with the HWSG in either the development of the HWNA and / or the AWP. There is an opportunity to increase engagement of stakeholders in the implementation of workforce activities.

As described in Section A.7, there is also an opportunity to enhance the effectiveness of the needs assessment process through integration and coordination of planning processes with other key agencies such as the PHN. Data and knowledge sharing will facilitate a more holistic view of the challenges communities face, and more readily identify appropriate workforce policies, initiatives and activities to address the need.

In some instances, the objectives and activities of other agencies, including State and Territory Governments, negatively impact the sustainability of new and developing primary health practices implemented and supported by the RWA.

Underlying system complexity and structure within which the RWA operates

It was acknowledged that the complexity of the health system is a key contributor to jurisdictional differences in the ability of the RWA to effectively plan, assess and deliver rural health workforce activities. As discussed in Section A.4, the complexity of the health workforce ecosystem can be attributed to the number of health workforce organisations, the organisational structure and governance arrangements, and the capability of leadership. In turn, this impacts on the ability to engage and navigate the stakeholder environment, and be aware of the roles, responsibilities and remit of all key stakeholders within the system.

The following areas of duplication or overlap were identified during the stakeholder consultations:

- **State and Territory Governments:** The RWAs and State and Territory Governments both participate in crisis and short-term workforce initiatives through establishing locum placement opportunities for health professionals in areas of high need. RWAs identified long standing locum arrangements, particularly for GPs delivered by the State and Territory Governments reduce the effectiveness of the RWA to embed a long term sustainable health workforce model of care in a community, as locum positions provide services to a significant portion of the local community and reduce the need for full time primary health professionals within the region.

- **RHOF fundholders:** During consultations, RHOF fundholders reported a level of duplication in providing allied health outreach services to remote locations, which is also an activity delivered by the RWAs.

- **PHNs:** As provided in Section 1.3.2, RWAs are restricted to delivering activities for the three program elements in MM 2 - 7, except activities can be undertaken in MM1 for Aboriginal Community Controlled Health Organisations. Currently 17 PHN boundaries align and / or overlap with the MM 2 – 7 regions in which the RWAs operate within (4). In establishing the PHNs, the Australian Government identified seven priority areas to guide their work, including; mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged care, and alcohol and other drugs (5). The outcomes of the workforce priority area for the PHN program are:

  - Local workforce has suitable cultural and clinical skills to address health needs of PHN region.

  - PHNs support general practices and other health care providers to provide quality care to patients.

  - People are able to access a high quality, culturally safe and appropriately training workforce (24).

  There are also a number of workforce indicators, such as 'Integrated Team Care improved the cultural competency of mainstream primary health care services' and 'Rate of general practice accreditation' (24).

  Consultation with the RWAs and PHNs identified areas of duplication and overlap may occur where the 17 PHNs and the RWAs are both delivering rural health workforce activities within the same region. While the RHWSA program guidelines acknowledge the need for collaboration with the PHN through representation on the HWSG, there is a greater need for a more formalised partnership arrangement in the future, and to further differentiate the specific role and responsibility each organisation has in regards to workforce planning in regions where both are operating.

Noting a limitation that only three Aboriginal and Torres Strait Islander State Peak Bodies completed a stakeholder consultation, the consultations did not identify duplication in services provided in the RHWSA program in MM1.

Clarity of the roles, responsibilities and remit of key stakeholders within the system is important to reduce the risk of duplication across agencies and support a cohesive and coordinated approach to providing support to the regional, rural and remote health workforce. It was consistently identified throughout consultation that the RWAs should aim to collaborate and coordinate processes and activities with stakeholders across the continuum of the health workforce pipeline. This includes the following:

- RHOF fundholders.

- RCSs.

- PHNs.

- State and Territory Governments.

The mechanisms through which the RWAs can facilitate collaboration with stakeholders includes coordinating processes, information and data sharing, and establishing formalised agreements and partnerships.

In the future design of the program, there is an opportunity to review linkages or synergies with other Commonwealth funded programs and clarify the roles and responsibilities of different organisations operating in the rural health workforce sector to support ongoing collaboration.

B.4 What are the facilitators and barriers impacting effectiveness at a 1) micro, 2) community, 3) jurisdictional and 4) national level?

Micro level

At a micro level, the review identified two key facilitators that impact positively on the effectiveness of the program. These include:

- As outlined within Section B.2, a focus on continuing professional education, training and development are important in ensuring the local primary health workforce obtain and maintain the relevant skills and knowledge to provide safe, effective, high quality primary health care.

- Some PHNs and RWAs identified that the provision of broader support and social services for an individual's partner and family are additional activities that can enhance the effectiveness of the RWA program in attracting and retaining a rural primary health workforce. Additionally, through the literature scan, it was identified that investment in infrastructure that improves the living and working conditions for a health worker's family (e.g. appropriate schooling opportunities for children and spousal employment opportunities) may positively influence distributional issues (8; 9). Specifically, it was identified that the opposite (i.e. poor living conditions and inadequate medical and schooling facilities) was a significant disincentive to the uptake of work in rural and remote communities (21; 9).

Conversely, as identified within Section B.2, a limited capability for junior medical officers to undertake postgraduate rural generalist training through a Fellowship given the lack of suitably qualified senior clinicians to provide oversight and supervision is a barrier for the RWA.

The literature scan identified that, of all strategies reviewed, the strongest evidence of the impact of education on ameliorating the geographical maldistribution of doctors came from the 'integrated rural medical workforce pipeline' approach (8). This approach targets key points throughout the medical workforce pipeline and considers each component in the context of how it may contribute to increasing non-metropolitan practice and the retention of doctors in rural and remote regions (8). During consultations, stakeholders reported that the ongoing fragmentation of postgraduate medical pathways requires RWAs to put in additional effort to regain people for regional, rural and remote locations who have relocated to metropolitan locations. This can work against the integrity of the 'integrated rural medical workforce pipeline' approach.

Community level

The health workforce needs assessment process is critical in identifying areas of need and understanding what support could be provided for specific locations. Most RWAs reported that the HWNA is a useful tool for framing engagement with external stakeholder groups and with providing a nationally consistent approach to localised health workforce planning. The key benefit was identified to be the lens and focus on community needs and challenges. This focus allowed agencies to collaborate to address a common issue rather than focus on pursuing their own organisational agenda. The HWNA template allowed jurisdictional agencies sufficient flexibility to adapt and develop their own methodologies to suit jurisdictional need. However, in some jurisdictions, some stakeholder groups commented that as a state-wide mapping activity, the HWNA was too highly aggregated and did not provide detail on the nuances of the local area. There are specific drivers in each community which indicate the need for a more place-based approach to effective workforce planning. These include the number of different service providers, market maturity and the population size and demographics. Some stakeholders reported a view that RWAs are overly focussed on immediate workforce shortages and there is a need to shift towards focusing on sustainability and undertaking in-depth, area-specific planning to anticipate and address future workforce issues and requirements.

Effective workforce planning needs to be directly connected to the service model that is appropriate for that area. While workforce availability can alter the choice of service model, a model on which workforce (form) follows the service model (function) is needed to ensure that recruitment is seen in the context of all the local actors and workforce roles. Place-based service planning is undertaken to a degree in each jurisdiction. Stakeholders identified there is an opportunity for RWAs to further utilise this approach, to develop tailored workforce solutions for individual communities based on place-based workforce needs assessment and planning.

Across the community, a key barrier includes the multiple needs assessment processes that occur across multiple organisations, including RWAs, PHNs, GP training organisations and State and Territory Governments. The engagement domain of inquiry discusses this concept in greater detail, however it is important to note that these multiple needs assessment processes, often pursuing different agendas, and utilising various data collection methods and / or analysis, result in duplication and a lack of an integrated, coordinated approach to rural primary health

workforce planning, assessment and implementation of activities. This impacts on the effectiveness of the RWA implementing the program. The Western NSW Case Study (refer to Case Study 1) is an example of a jurisdiction that has demonstrated this. The partnership, led by the NSW RDN, developed a tailored *Primary Health Workforce Planning Framework* and associated *2030 Western NSW Primary Health Workforce Priority Actions*, which brought together regional stakeholders united under a common vision to develop a longer-term, integrated approach to primary health care workforce planning. These were developed with close and authentic consultation with primary health workforce agencies across the region and ensured the local challenges and need were accurately identified, and that the resulting action statements and strategies are focused to address the most important issues, tailored to the specific context of the Western NSW community. A three-year lense to the process facilitated the shift towards identifying proactive and sustainable strategies for the region, breaking the cycle of siloed, short-term responses from individual agencies. Further, greater transparency regarding the remit and focus of the RWAs and other agencies (PHNs in particular) was identified as a key avenue for supporting a more streamlined, collaborative approach to needs assessment and workforce planning.

Jurisdictional level

Section B.3 outlines in detail two jurisdictional factors that impact the effectiveness of the RWA. Briefly, these include:

- The underlying system complexity and structure within which the RWA operates.

- State and Territory Government rural health and workforce policy.

National level

At a national level, the allocation of funding between program elements can impact on the ability of an RWA to support innovative activities within a local region. Stakeholder consultation identified this impacted on an RWA's capacity to fund or co-fund activities with other agencies, such as the PHN, and limited the agility of the agency to quickly adapt to changing community need or environment. This is explored in further detail in the efficiency domain of inquiry.

B.5 How can the effectiveness of the program be improved into the future?

This review has identified several opportunities to improve the effectiveness of the program, including:

- **Flexible workforce models, multidisciplinary teams:** The majority of stakeholders acknowledged that contemporary service delivery models (e.g. telehealth, fly-in-fly-out service delivery) are important considerations in the future to improve rural workforce sustainability and viability. It was generally acknowledged that these primary health care models will place a greater emphasis on multidisciplinary practice, leveraging off the skills and capabilities of nurses, including nurse practitioners, and allied health professionals to reduce the reliance on, and compliment, GPs and other medical professionals. Strategies that support the growth of a diversified health workforce (e.g. dentists and allied health professionals) and enhance the scope of appropriately qualified clinicians (e.g. nurse practitioners) were identified in the underlying literature as crucial for improving the supply of health workers in rural and remote areas (19; 9; 10). Additionally, to meet the ever-growing and complex

demands of an evolving healthcare sector, this growth needs to be accompanied by holistic, flexible workforce models, particularly those that promote the use of multidisciplinary teams of healthcare professionals (19; 8).

- **Place based workforce planning:** A greater emphasis on the Sustainability program element and promoting a shift towards place-based approaches to workforce planning, assessment and activities determined by localised community need. This is explored in further detail in Section A.8.

- **Clarifying roles and responsibilities:** There is an opportunity to clarify the roles and responsibilities of RHWA with specific respect to stakeholder engagement, reporting and program delivery, or to consider opportunities to support more effective national representation of the program. The role of RHWA is explored further in Section A.8.

Improving awareness of the RHWSA program will assist the capacity to measure effectiveness of the program in meeting the objectives. Additionally, transitioning to outcomes-based reporting for the RHWSA program (as described in Section A.8) would also build further an evidence base on which interventions assist the most in sustaining workers in rural and remote communities.

C. Efficiency

The efficiency domain focused on measuring how well resources are used to produce outputs/initiatives for the purpose of achieving program objectives. The efficiency analysis is from the perspective of the cost of the program to the Department (that is, what the Department funds/pays for services to be delivered). There are five questions considered in the efficiency domain, which are discussed individually in this section.

C.1 What is the cost of the program, by program element and by RWA?

The cost of the program is analysed from the perspective of the Department. The cost of the program is first considered by RWA and then by program element.

Cost of the program by RWA

The Standard Funding Schedule Agreements between the Department and the individual RWAs were analysed to determine the funding provided by the Department to the RWAs. The total funding provided to the RWAs during the RHWSA program, from 2016-17 to 2019-20, was $80,104,785.40 (GST excl.).

The funding provided to each RWA during the RHWSA program is provided in Figure 10 below. NSW received the most funding ($15,166,612) followed by QLD ($13,996,478), with TAS receiving the least amount of funding ($4,909,248).

Figure 10: Total funding provided to each RWA for the RHWSA program, between 2016-17 and 2019-20
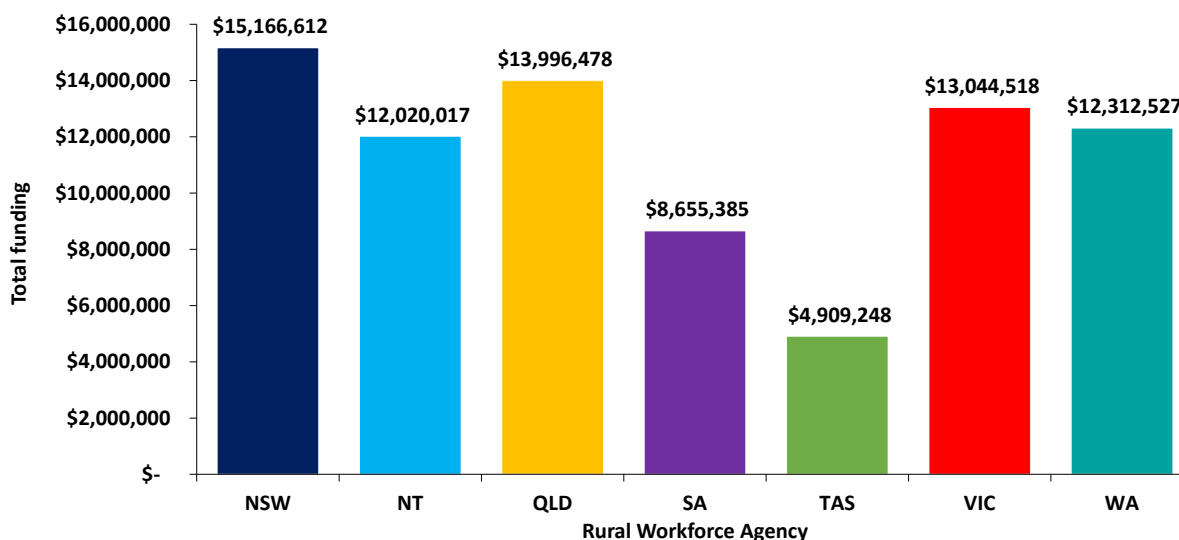
Source: Commonwealth Department of Health, analysed by KPMG

In 2016-17, the RWAs received a total of $1,850,191.81 (GST excl.) funding, with the distribution of funding provided in Figure 11. This payment was made on execution of the funding agreement in June 2017.

Figure 11: Total funding provided to each RWA in 2016-17[10]
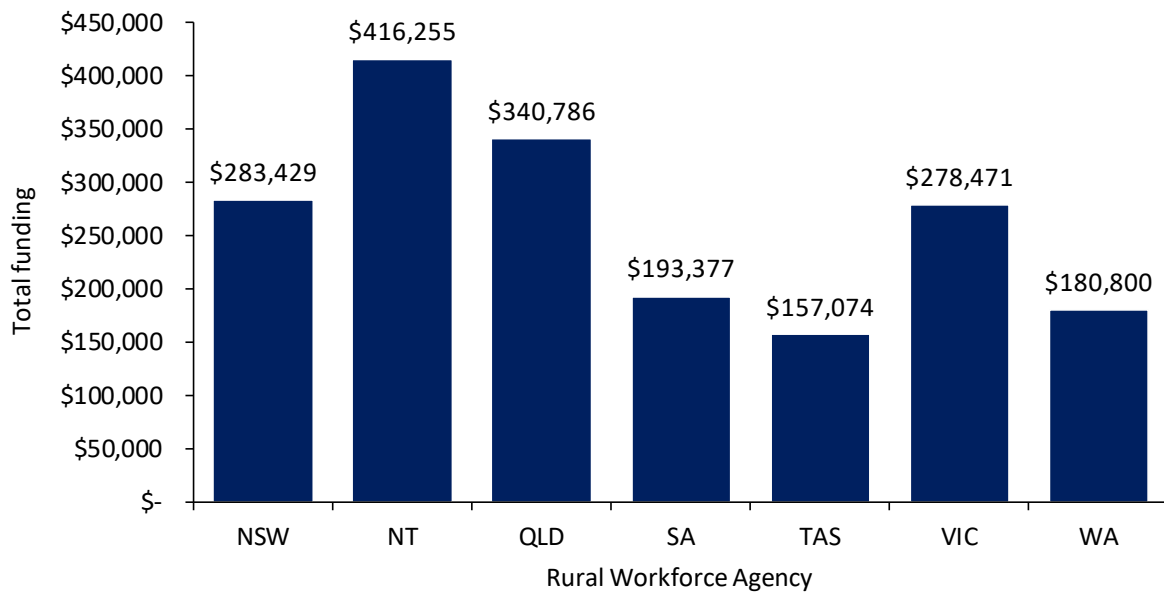
Source: Commonwealth Department of Health, analysed by KPMG

The RWAs received the same level of funding per year in 2017-18, 2018-19 and 2019-20, which totaled $26,084,865 (GST excl.) per year. The distribution of funding by RWA per year is provided in Figure 12.

Figure 12: Total funding provided to each RWA per year, for 2017-18, 2018-19 and 2019-20[11]
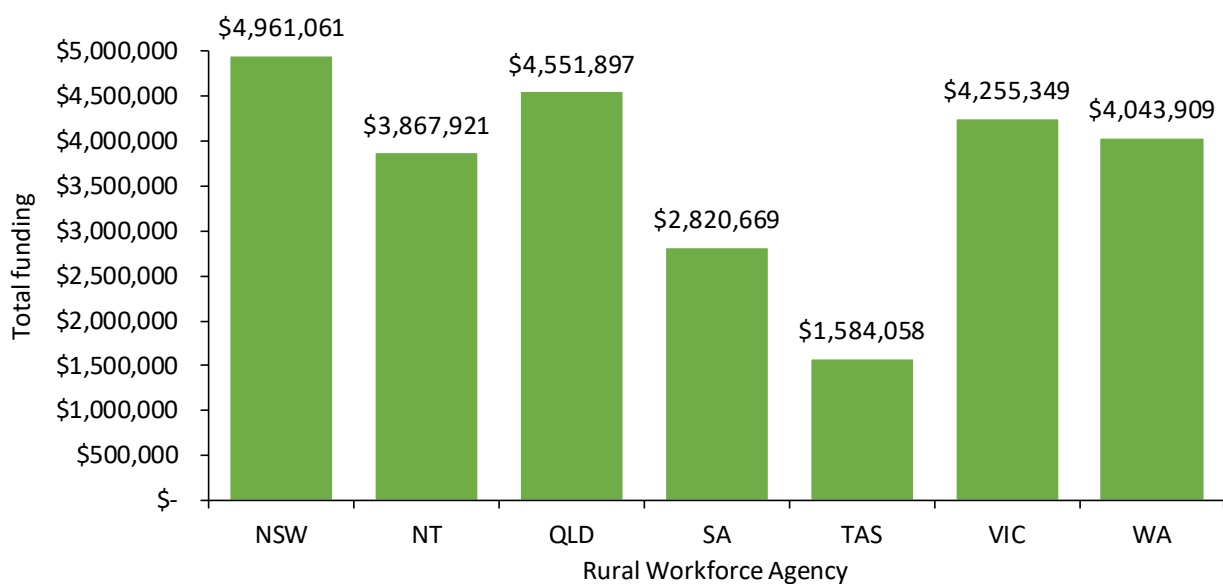
Source: Commonwealth Department of Health, analysed by KPMG

The total funding and proportion of funding provided to each RWA over the program period is provided in Table 17 below. NSW received the highest proportion of total funding (18.9%) followed by NT (15.0%). TAS received the lowest proportion of total funding (6.1%).

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[10] Figures are GST exclusive.
[11] Figures are GST exclusive.

Table 17: The total funding and proportion of funding for each RWA in the RHWSA program, from 2016-17 to 2019-20

RWA	Total funding from 2016-17 to 2019-20 ($)[12]	Proportion of total funding
NSW	15,166,611.76	18.9%
NT	12,020,017.24	15.0%
QLD	13,996,478.16	17.5%
SA	8,655,384.55	10.8%
TAS	4,909,248.18	6.1%
VIC	13,044,518.21	16.3%
WA	12,312,527.30	15.4%
Total	**80,104,785.40**	**100.0%**

Source: Commonwealth Department of Health, analysed by KPMG

Cost of the program by program element

In the Standard Funding Agreement Schedule, funding is allocated to each element, with Access allocated 40% of total funding and Quality and Sustainability each allocated 30% of total funding for each RWA. The overall funding provided to each element in the program is provided in Table 18 below.

Table 18: Total funding provided for each program element in the RHWSA program, from 2016-17 to 2019-20

Program element	Total funding provided to the RWAs, from 2016-17 to 2019-20 ($)
Access	32,041,919.96
Quality	24,031,432.72
Sustainability	24,031,432.72
Total funding	**80,104,785.40**

Source: Commonwealth Department of Health, analysed by KPMG

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[12] Figures are GST exclusive.

C.2 How is funding allocated to different RWAs and activities? What may influence this (e.g. level of need, remoteness, complexity)?

This question is analysed by considering:

- How funding is allocated to the RWAs.

- How funding is allocated by the RWAs to activities in the program, including the contractual requirements for this allocation.

Allocation of funds to the RWAs

The Department advised that the allocation of funds to each RWA was informed by the following factors:

- MM

- Aboriginal and Torres Strait Islander population

- Population over the age of 65

- SEIFA decile.

There is insufficient data to comment on whether the level of funding is appropriate for the RWAs to deliver the RHWSA program. The allocation of funding for each RWA should be reviewed before the commencement of the next funding agreement. One RWA commented that they would appreciate increased transparency with how the funding envelope is calculated and distributed for the RWAs.

Allocation of funds to activities in the program

As described in Section A.4, the RWAs have flexibility within the program to deliver eligible activities for areas of need, as identified by the HWNA. The RWAs can allocate the funds to eligible activities, with the following requirements:

- The funds are allocated to the program elements (as discussed in Section C.1).

- The funds are allocated through three funding streams, which are Grants and Incentives, Operational Funds and Program Delivery.

- The RWA is required to sub-contract RHWA to provide national representation, coordination and administration.

The section below describes the allocation of funds to the three funding streams, the allocation of funds to the RHWA, the movement of funds between elements and streams, and the cost drivers of the program.

Funding streams

At the beginning of the program, the allocations per funding stream were defined in the Standard Funding Agreement Schedule between the Department and each RWA as:

- Grants and Incentives: must not be less than 50 per cent of a Grant applicant's total budget for the program.

- Operational Funds: must not exceed 15 per cent of a Grant applicant's total budget for the program.

- Program Delivery: must not exceed 35 per cent of a Grant applicant's total budget for the program.

There was a two-year transition period (1 July 2017 – 30 June 2019), where RWAs were to demonstrate transitioning of funding to the three streams, with a requirement to transition to the funding stream model in 2019-20.

Figure 13 below illustrates the allocation of funds to each stream for 2017-18 and 2018-19. In 2017-18 and 2018-19, no RWAs met the allocation of funding to the funding streams.

Figure 13: Proportion of total cost per funding stream for each RWA in 2017-18 and 2018-19[13]
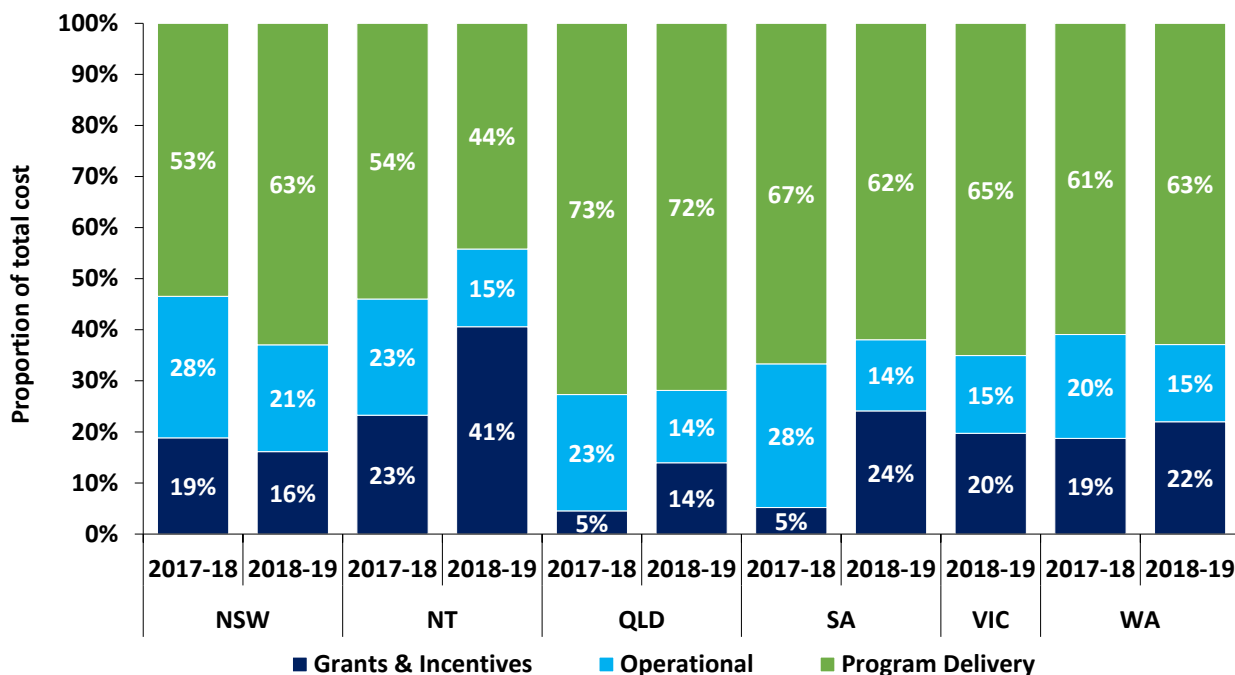
Source: Commonwealth Department of Health, analysed by KPMG

In the performance reports in 2018-19, all RWAs raised the risk relating to the grants and incentive ratio needing to be 50% or greater of the total budget. During consultations, some RWAs explained that the requirement to have 50% or greater of the total budget for grants and incentives did not provide the RWA with sufficient flexibility to undertake activities for the identified need.

In the 2018-19 performance reports, the RWAs reported that the Department and the RWAs had agreed in principle that the requirement will be adjusted to a minimum of 20% of total funding, however this was yet to be formalised.

The Department advised that the funding stream amendments were approved on 1 April 2019. A Deed of Variation with the RWAs formalised this in 2020, where the ratios for the funding streams changed to:

- Grants and Incentives: must be more than 20 per cent of a Grant applicant's total budget for the program.

- Operational Funds: must not exceed 15 per cent of a Grant applicant's total budget for the program.

- Program Delivery: must not exceed 65 per cent of a Grant applicant's total budget for the program.

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[13] The income and expenditure statement for TAS in 2017-18 and 2018-19 does not include a breakdown by funding stream. The information for VIC for 2017-18 was not available for the analysis. The analysis for VIC for 2018-19 excludes expenditure related to rolled over funds from 2017-18, as it was not allocated to a funding stream.

During consultations, the RWAs identified that this was a positive move, to support using the funds in a manner to best meet the identified needs in the HWNA.

Allocation of funds to RHWA

The RWAs are required to sub-contract RHWA to provide national representation, coordination and administration for the RWAs. RWAs are required to provide at least 2% of funding from each element toward funding national representation and coordination, which is allocated to the Program Delivery funding stream.

Movement of funds between elements and streams

The RWAs may request from the Department approval to move funds between the elements or between funding streams, with supporting evidence that illustrates that it will improve outcomes for the jurisdiction. Written agreement from the Department is required for funds to move between funding streams, and a Deed of Variation to the Funding Agreement is required for funds to move between elements (2).

Cost Drivers

The cost drivers for the RHWSA program are provided below.

- The total amount of funding the RWA receives is a driver for the amount of funding spent on activities in the RHWSA program.

- The required allocation of funding to the program elements and the funding streams is a driver in the allocation of funds to activities.

- The identified needs for each jurisdiction is a driver for the activities that the RWAs undertake.

C.3 What is the relative cost of each of the three elements of the program?

The program reporting data did not provide a breakdown of the costs per activity, limiting the ability for a unit cost per program activity to be determined. This question is answered based on the following approach:

- Examining the actual costs incurred by the RWAs in delivering the program in 2018-19.

- Examining the proportion of RWAs' costs for the program elements in 2017-18 and 2018-19.

Costs incurred by RWAs in delivering the program

The costs incurred by the RWAs in delivering the program was analysed for 2018-19, to understand variability between the funding received and the expenditure for the year[14]. Table 19 below provides the total income and expenditure to deliver the program for 2018-19. The total income for 2018-19 includes unspent funds from the prior year, funds brought forward, other income, and interest received on grant funds. The difference between income and expenditure varied between the RWAs. One RWA (TAS) had greater expenditure than total income for 2018-19. The largest underspend was NT ($1,131,089, 23% unspent funds) and SA ($588,207, 17% unspent funds).

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[14] Financial reporting information for 2017-18 was not available for all RWAs.

Table 19: Total income and expenditure for 2018-19 by RWA

RWA	Total income for 2018-19 ($)[15]	Expenditure for 2018-19 ($)	Difference ($)	Difference (%)
NSW	5,496,811	5,421,811	75,000	- 1%
NT	4,944,020	3,812,931	1,131,089	- 23%
QLD	4,981,887	4,981,887	0	0%
SA	3,374,561	2,786,354	588,207	- 17%
TAS	1,736,111	1,766,625	(30,514)	+ 2%
VIC	4,779,421	4,598,196	181,225	- 4%
WA	4,110,886	4,019,353	91,533	- 2%

Source: Commonwealth Department of Health, analysed by KPMG

Proportion of RWAs costs for the program elements

The costs incurred by the RWAs in delivering the program was analysed per element. Table 20 below provides the difference in total income and expenditure for each element in 2018-19. A positive value indicates that the RWAs had more income than expenditure for that period. During 2018-19, no RWA had a greater expenditure for the Sustainability element than income for the period. TAS was the only RWA that had greater expenditure than income in 2017-18, for the Access element ($30,205) and Sustainability element ($615). Overall, the Sustainability element had the largest underspend ($1,048,169) followed by Access ($767,466) and Quality ($220,924).

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[15] Includes unspent funds from prior year, funds brought forward, other income, and interest received on grant funds.

Table 20: Difference in total income and expenditure for each element, in 2018-19

RWA	Access ($)	Quality ($)	Sustainability ($)
NSW	30,000	22,500	22,500
NT	440,564	112,395	578,130
QLD	-	-	-
SA	231,866	2,852	353,489
TAS	- 30,205	- 615	306
VIC	87,898	21,694	71,632
WA	7,323	62,098	22,112
Total	**767,466**	**220,924**	**1,048,169**

Source: Commonwealth Department of Health, analysed by KPMG

Figure 14 below illustrates the proportion of total cost per element for each RWA for 2017-18 and 2018-19. While there was variability in expenditure in 2017-18, most RWAs came close to the proportions for funding for each element.

Figure 14: Proportion of total cost per element for each RWA in 2017-18 and 2018-19[16]
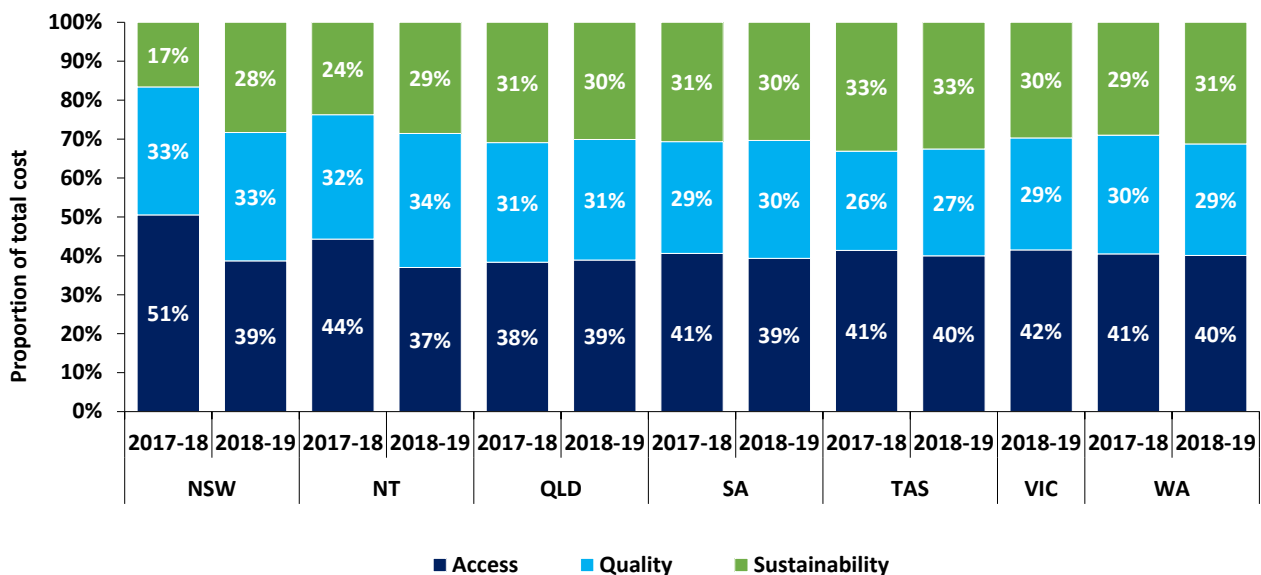
Source: Commonwealth Department of Health, analysed by KPMG

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[16] The information for VIC for 2017-18 was not available for the analysis.

C.4 What, if any, changes should be made to the funding model for the program?

During consultations, most RWAs communicated that the notional splits between program elements and funding streams were unhelpful. Some RWAs commented that having more flexibility to move funding between program elements and program streams would support the delivery of the program in a manner that more directly aligns with the identified needs in their jurisdiction. A revised funding arrangement could also support discretionary and innovative solutions. Some views from the consultations are provided below:

- One RWA commented that overlapping the program element funding allocations with the funding stream allocations was difficult.

- One RWA commented that it is difficult to be innovative with the current funding model, as there are various 'buckets' of funding that they are required to deliver activities within.

- One RWA commented that following co-designing a workforce solution with stakeholders, they would need to retrofit the solution within the 'funding buckets'.

- One RWA commented that it is difficult to allocate time used for collaboration within the funding streams.

- Two RWAs commented that the requirement to use unspent funds from the prior year within the same program element is restrictive, and suggested that it would be beneficial to be able to use these funds within any of the program elements.

- One RWA commented that under the current funding arrangement, there is limited opportunity to support investments in infrastructure projects (e.g. telehealth).

- One RWA suggested that if the funding allocations remain, including bands (e.g. plus or minus 5% of the funding allocation) would be beneficial.

There is an opportunity to consider revising the funding model to be more flexible, to support the RWAs in delivering the program to meet the identified needs in their jurisdiction.

C.5 How can the efficiency of the program be improved in the future (e.g. are there potential overlaps or synergies with other rural workforce programs funded through State and Territory or other sources (including PHNs))?

Opportunities to improve efficiency of the program are explored through opportunities at the jurisdictional level and the national level.

Jurisdictional level

As described in Section A.3, there are duplicative needs assessment processes occurring across multiple organisations, including RWAs, PHNs, GP training organsiations and State Governments. Although they differ in objective and depth, there is an opportunity to consider streamlining the process, through data collection, analysis and reporting, to support a more efficient process.

During consultations, most stakeholders identified a need to clarify roles of PHNs and RWAs with regard to needs assessment and subsequent workforce planning. Clarifying the roles and responsibilities of the different stakeholders

will help to minimise any duplicate activities being undertaken by stakeholders and potentially increase efficiency for the RHWSA program.

National level

The RWAs provide 2% of their funding to RHWA, however some RWAs reported a view that the role of RHWA is unclear in supporting delivery of the program. There was a view that the functions could be better fulfilled by the individual RWAs. There are opportunities to clarify the roles and responsibilities of RHWA or to consider other opportunities to support more efficient national representation of the program.

D. Engagement

Engagement measures the extent of stakeholder engagement and input in the achievement of program objectives, and whether duplication and / or synergy exists in relation to wider objectives (particularly of the PHNs). The engagement domain is examined through four questions, which are discussed individually in this section.

D.1 How do each of the RWAs currently engage 1) local communities and 2) the rural health workforce? What are the key factors that may influence this?

This question is answered based on the following approach:

- Desktop review including an analysis of all HWNAs, AWPs, Financial Statements, Annual Reports, Operational Guidelines.

- Identification of stakeholders' views on the design of the program through consultation.

- Examination of the underlying evidence base through a literature scan considering contemporary best practice in improving the rural health workforce.

- Exploration of relevant case studies.

Local communities

How RWAs engage with local communities

Community engagement is identified as a key data source for informing the HWNA planning process in the RHWSA program's operational guidelines (2). These guidelines stipulate community consultation as essential for obtaining information about perceived local community need, insights into the experiences of patients, consumers and carers and their views on improvements in the delivery of local primary health services (2).

The review found that most RWAs have some touchpoints with local communities. This includes through the following means:

- Survey distribution.

- Consultations with local council, local government and local mayors.

- Local community advisory groups.

- Newsletters and annual report distribution.

- Social media activities.

- Community events, e.g. local high school career expos or family days.

Key factors influencing RWAs' engagement with local communities

A key factor influencing engagement with local communities is response to a local workforce crisis. During consultations, two RWAs identified working with local communities (i.e. with local council/governments) in response to an immediate or potential future health workforce crisis in their districts. These crises could include when a GP

unexpectedly closes their business or when they are nearing retirement. In these instances, RWAs sought to work collaboratively with the community and other local health workforce stakeholders (e.g. PHNs) to understand the local needs and skills-mix required to replace the existing health care provider, and then determine who could be recruited to provide this service.

For example, in one jurisdiction, previous investments in one community had not resulted in positive outcomes for workforce retention, and local clinicians had identified community access to general practice services was a significant issue. To address this, the RWA convened a working group including representatives from the local councils, local health districts, PHNs and ACCHS to understand the underlying issues. Through this working group, it was identified that the GPs in this town were not effectively collaborating with the LHDs and this was working against health workforce recruitment and retention in this area. The working group sought to collaboratively address the regulated systems and competitive challenges that prevented a stable workforce in this community. The RWA advised that one outcome from this working group was increased engagement between the local community and incoming health professionals through events such as a health professional networking evening. This was identified as key to breaking practitioner isolation.

During consultations, only one RWA identified meeting with local community and other stakeholders for strategic forward planning purposes. Feedback surveys analysed as part of these consultations moved beyond the medical workforce and identified a market gap around the need for nursing and allied programs similar to the John Flynn Placement Program. The outcomes of these consultations saw the establishment of a three-year program providing medical, nursing and allied health students an opportunity to experience comprehensive clinical practice in rural and remote communities. This program is now delivered collaboratively between the jurisdictional RWA and relevant University Department of Rural Health.

The rural health workforce

How RWAs engage with the rural health workforce

As with community engagement above, the RHWSA operational guidelines stipulates that the perspective of health professionals, providers and funders are equally as important for informing needs assessment, and the views of these groups may differ considerably to those of the local community (2). Consultation with the rural health workforce is outlined as another key activity for the identification of health service issues and needs (2).

The review found that jurisdictional RWAs directly engage with rural health services and professionals. This includes through the following means:

- Boutique GP practice support services including practice manager support programs.

- Collaboration with GP registrars (identified as the future workforce).

- Engagement with health student bodies through scholarship provision and partnerships with student clubs.

- Supporting the provision of health workforce to local health services.

- Personalised touchpoints where possible.

Key factors influencing RWAs' engagement with the rural health workforce

It was largely acknowledged throughout consultations that engagement with health professionals, especially the private rural and remote GP and allied health sector, was challenging for most RWAs. Consultations identified this cohort was typically hard to engage with as often they are engaged in clinical service delivery or operating businesses which are prioritised. Some RWAs developed work around strategies to supplement engagement with this sector through other means, which included:

- Engaging with the GPs / allied health specialists who are employed through the government and university sectors (i.e. salaried/contractual positions).

- Leveraging pre-existing networks that include representation from this sector (e.g. the PHN clinical councils may have representatives from private GPs and allied health service providers).

Key touchpoints of engagement with RWAs occur during the following circumstances:

- Engagement occurred during crisis shortage periods or when problems arose within the primary health service.

- Delivery of practice manage support programs. One RWA identified practice managers as an underlying driver for a successful health service, yet no programmatic support was provided to this key workforce group. In response the RWA recruited a practice manager to identify the common issues facing practice managers to understand what was needed to support workforce planning. Utilising a combination of grants, this RWA funded a network of professional practice managers to undertake a specially designed practice management diploma. The RWA identified this to be one of their most successful approaches for engaging with local health workforces and services and highlighted key outcomes to be increased connectivity and reduced isolation in this workforce cohort.

D.2 What are the strengths and limitations of the current approaches to engagement?

Several key strengths and limitations were identified in the current approaches to engagement. These are discussed thematically below.

Stakeholder involvement in the HWSG

Several key external rural health workforce organisations support the delivery of the RHWSA program. RWA's engage with these stakeholders through various mechanisms, most frequently through their involvement on the jurisdictional HWSG. RWAs are responsible for the convening and ongoing administration of the HWSGs, which are to include membership from:

- RTOs.

- PHNs.

- RHOF fundholders.

- Specialist Training Pathway Providers.

- RCSs.

- Regional Training Hubs.

- State Health Departments.

- Aboriginal and Torres Strait Islander Health State Peak Bodies (2).

A detailed description of the key stakeholders is provided in Appendix 6, including a description of their role in supporting the delivery of the program. Figure 15 below illustrates the role that the HWSG has with supporting collaboration with stakeholders during the RHWSA program.

Figure 15: Key stakeholder groups involved in the delivery of the RHWSA
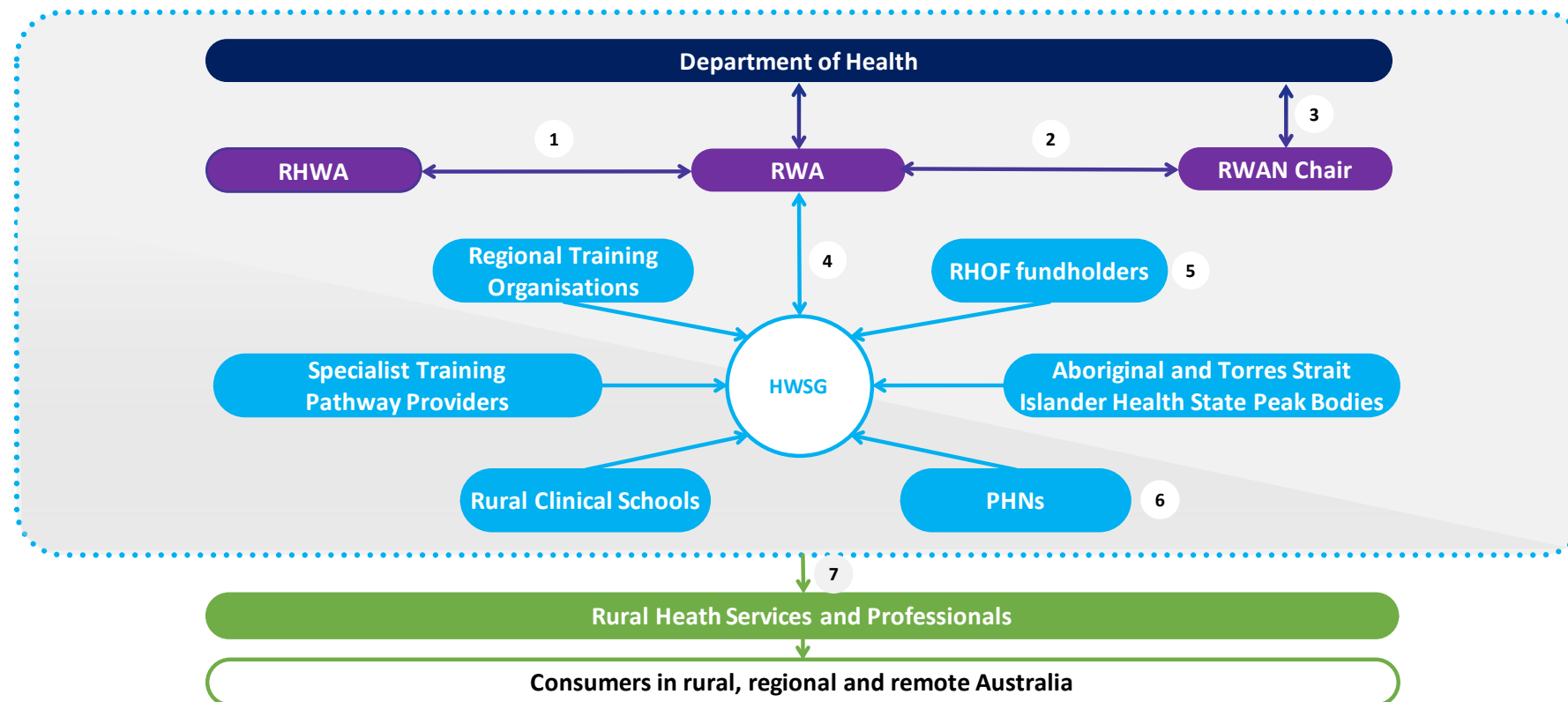
1. The **RWAs** are required to sub-contract **RHWA,** which is designated as the national peak body representing the RWAs.

2. The **RWAN Chair** has the role of chairing frequent meetings with the **RWA** Chief Executive Officers.

3. The **RWAN Chair** is a key point of contact with the **Department**.

4. The **RWA i**s responsible for convening and the ongoing administration of the **HWSG.**

5. The **RHOF fundholders** are the same organisations as the RWAs in NSW, SA, VIC and WA.

6. The **PHN** is the same organisation as the RWA in NT.

7. Support is provided to **rural health services and professionals**, to support access, quality and sustainability of health care in rural, regional and remote Australia.

Source: KPMG, 2020

Limitations

This review identified several limitations of the current approaches taken to engagement, including:

- Some stakeholders had no involvement or limited involvement in the HWSG, in either the development of the HWNA and / or the AWP. Additionally, most stakeholders identified to have limited knowledge of the scope and remit of the RWAs or where they fit within the broader health workforce stakeholder environment.

- The appetite of external agencies to participate in HWSG is varied and dependent on leadership and interagency relationships; for example, in one jurisdiction, it was noted that, although one stakeholder group was represented on the HWSG, they advised they did not want to be involved in this forum.

- Some stakeholders reported that no new information about local health workforce issues were uncovered through the needs assessment process and that no new, innovative strategies and solutions were offered to address workforce concerns. Additionally, it was noted that this forum sometimes lacked a clear direction in terms of actions for stakeholders involved.

Strengths

Some stakeholders described RWAs as willing collaborators capable of pulling together relevant stakeholders to solve local health workforce issues. These relationships had been strengthened by more formal mechanisms such as Memorandums of Understanding, formal partnership agreements, data sharing agreements and / or advisory groups. Other stakeholders spoke of a more informal, close working relationships built on trusting and respectful personal associations with long-standing executive teams and a shared commitment to improving rural and remote health outcomes.

The HWNA and AWP as tools for engagement

Limitations

In some jurisdictions, stakeholders commented that as a state-wide mapping activity, the HWNA was too highly aggregated and did not provide detail on the nuances of the local area. In these instances, stakeholders were more likely to complete their own workforce needs analysis that was regionally focused rather than using HWNA, and engage with other agencies (e.g. local PHNs) for support with local workforce issues.

Strengths

Despite the above limitations, most RWAs reported that the HWNA and AWP were considered useful tools for framing engagement with external stakeholder groups and provide a nationally consistent approach to localised health workforce planning. The key benefit was identified to be their lens and focus on community needs and challenges. This focus allowed agencies to collaborate to address a common issue rather than focus on pursuing their own organisational agenda. Additionally, some RWAs reported that the HWNA template allowed sufficient flexibility to adapt and develop their own methodologies to suit jurisdictional need.

The role of the RWAs and other key external stakeholders

Limitations

The awareness of the role of the RWAs is low among some stakeholder groups. There is also a lack of clarity regarding the roles and responsibilities of different stakeholders, often with competing objectives. Some stakeholders reported that the RWAs are not as visible to local communities compared to other external agencies (e.g. PHNs & LHDs). There is an opportunity for the RWAs to consider more strategic community engagement through clear branding, marketing and communications activities.

The difference in organisational focus is another factor influencing the way an RWA engages with key external stakeholders. Whilst the RWAs deliver programs across the continuum of the health workforce recruitment and retention pipeline, external stakeholders may only intersect with the RWAs at one point on this continuum. Some stakeholders identified indirect engagement only as a natural fallout from the execution of their own business strategies and functions. For example, there was recognition from most RTOs that their engagement with RWAs was largely through the lens of career pathway services. Although they were aware the RWAs delivered other services beyond this scope, they had little knowledge or oversight of these activities.

Strengths

In jurisdictions where there was greater understanding of the respective roles and responsibilities of RWAs and key external stakeholders, consultations identified this facilitated expanded opportunities for collaboration.

Opportunities exist for a more cohesive interagency engagement approach between RWAs and their various external stakeholder groups. Most consultations highlighted the key element supporting this effective collaboration was the clear breakdown of roles and responsibilities between agencies, including the identification of where there was overlapping priorities and potential scope for collaboration in service delivery to meet shared goals. Case Study 2 describes the co-designed and collaborative approach taken by RHW and WAPHA in the delivery of a GP practice support service known as *Practice Assist.*

The role of national agencies (e.g. the Department, RHWA, RWAN Chair and Specialist Training Pathway Providers and others)

Limitations

No evidence was provided during stakeholder consultations that the RWAN Chair and RHWA engage with local communities. During consultation, it was identified that their engagement focused on peak national agencies (e.g. the Services for Australian Rural and Remote Allied Health, Indigenous Allied Health Australia).

Despite this, it was identified through consultations with Specialist Training Pathway Providers that there does not seem to be a clear contact for the program nationally. There is an opportunity to clarify the roles and responsibilities of RHWA and / or RWAN regarding the provision a nationally consistent approach to stakeholder engagement. Additionally, there is an opportunity for the governance structure to better support Commonwealth and RWAs working together with the RHWA, RWAN and other peak national agencies.

Strengths

Overall, the RWAs highlighted a positive, productive relationship with the Department. Additionally, some RWAs acknowledged this relationship was built through the collaborative RHWSA program design process with the Department. Some RWAs explained the new RHWSA program was seen as a significant shift in focus which would require an appropriate adjustment period to fully understand the implications and respond to the refreshed RHWSA program. These RWAs expressed that they felt appropriately consulted and supported by the Department throughout this change process.

Additionally, the RWAN Chair described their role as fit for purpose in the sense that they were able to provide a nationally consistent voice if necessary, without limiting the ability of individual RWAs to highlight jurisdictional nuances when needed.

The complex stakeholder environments

The varied simplicity or complexity of the health ecosystem in which an RWA operates was identified during consultations as one of the key factors influencing their capacity to engage with their stakeholders. Figure 16 below provides an illustration of some rural and regional stakeholder organisations (regional PHNs, RTOs, regional LHNs and RCSs) involved in the RHWSA program. For comparative purposes, VIC is not included on the figure below. VIC has a different structure when compared to LHNs in other jurisdictions, involving five rural health regions, and 70 rural and regional public health services and hospitals (27).

As illustrated in Figure 16 below, each jurisdiction has a different environment in which to operate, involving varying numbers of rural and regional organisations. When considering the four stakeholder groups provided in the figure, QLD has the largest number of organisations (21) followed by NSW (19), SA (10), WA (five), NT (five) and TAS (four).

The limitations and strengths of the RWAs operating in the complex stakeholder environments is discussed further below.

Figure 16: The number of regional PHNs, RTOs, regional LHNs and RCSs operating in each jurisdiction
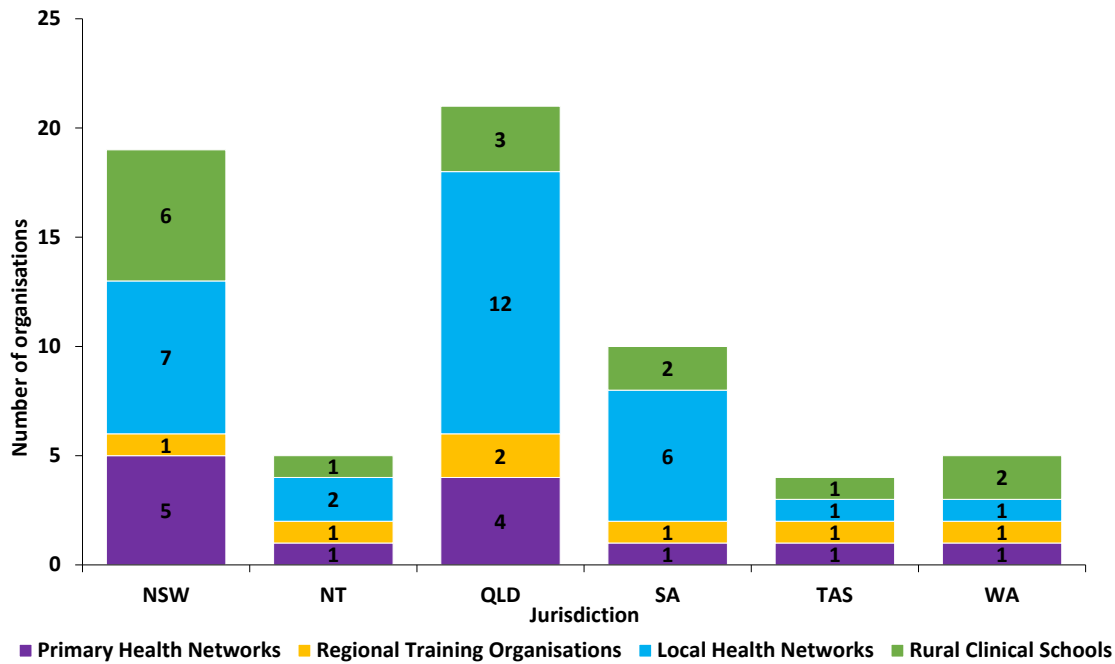
Source: Data from multiple sources (28) (29) (30) (31) (32) (33) (34) (35) (36), analysed by KPMG

The complex nature of the stakeholder environment is depicted in Figure 17 to Figure 23 below for the jurisdictions within which the RWAs operate. These figures illustrate the geographical boundaries of the PHNs, RTOs and LHNs and the locations of the RCSs. The RCSs include the University Rural Clinical Schools and the individual campuses, where the information was available.

Figure 17: Stakeholder environment for NSW
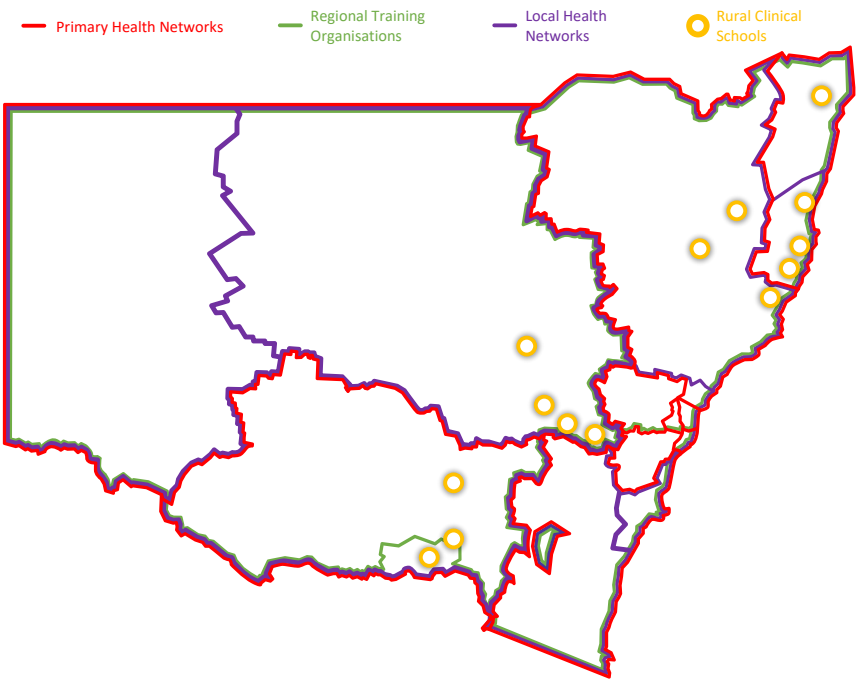
Source: KPMG, 2020

Figure 18: Stakeholder environment for NT

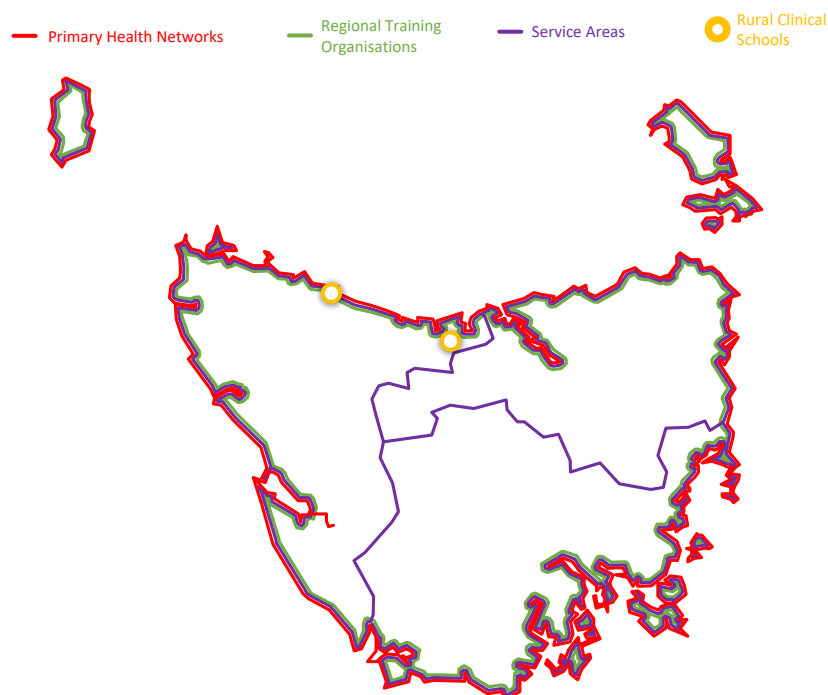*Source: KPMG, 2020*

Figure 19: Stakeholder environment for QLD
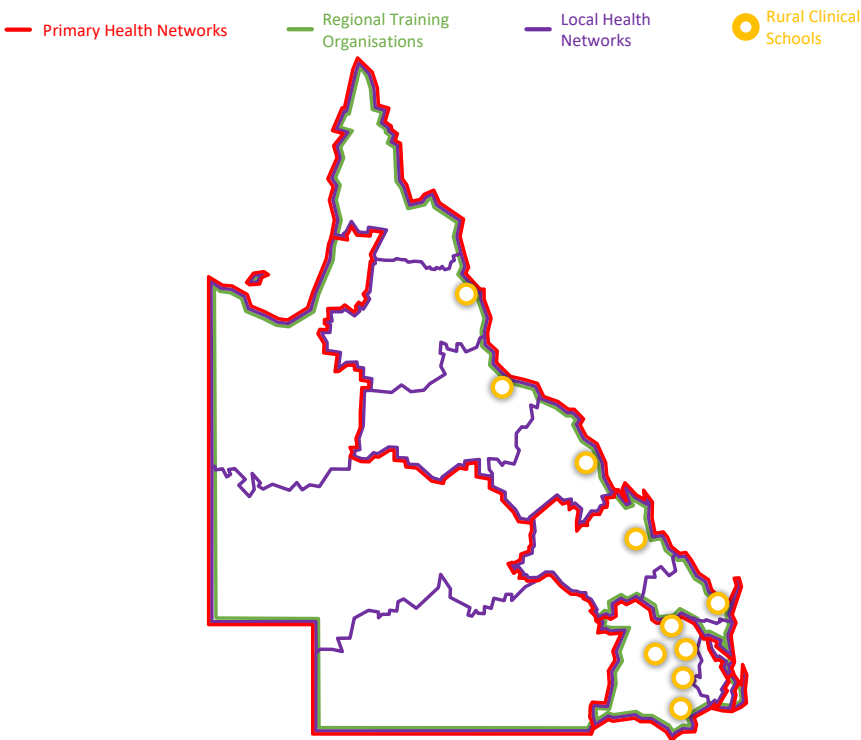
Source: KPMG, 2020
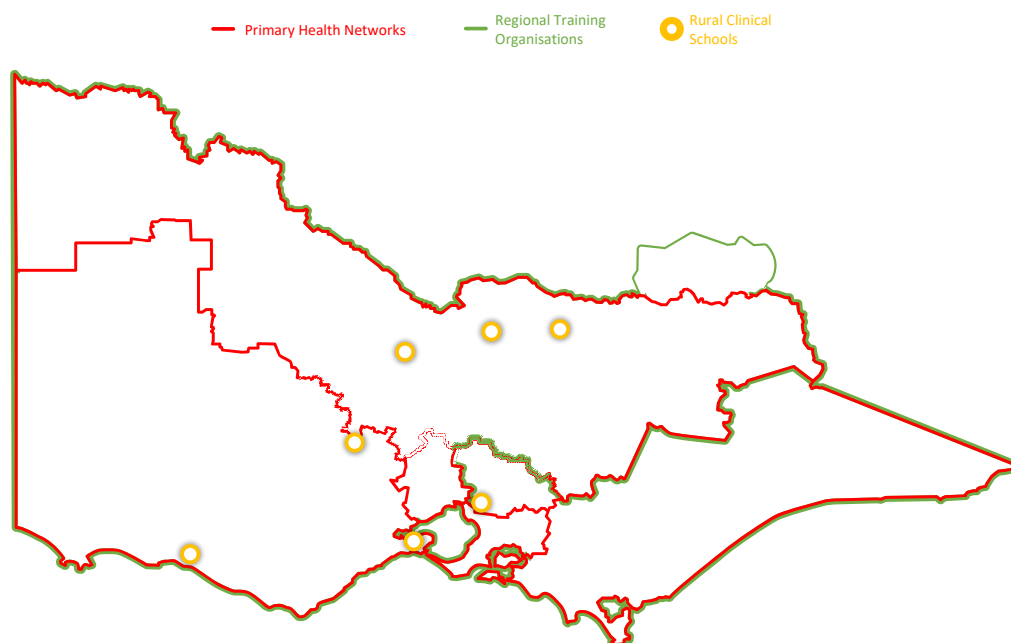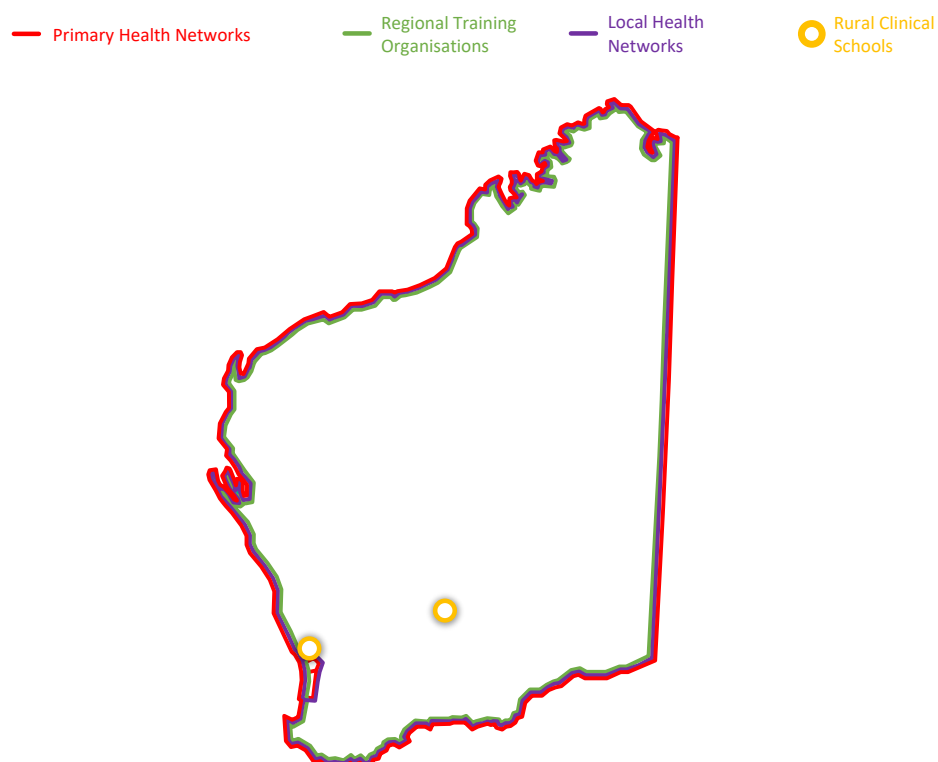
Figure 20: Stakeholder environment for SA

— Primary Health Networks   — Regional Training Organisations   — Local Health Networks   ◯ Rural Clinical Schools
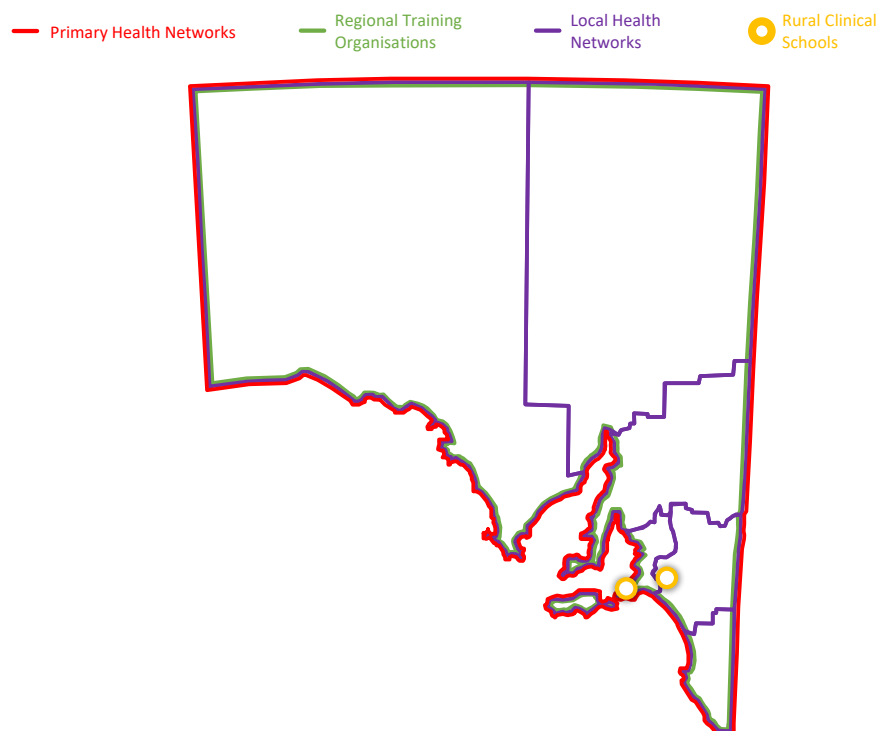
Source: KPMG, 2020

Figure 21: Stakeholder environment for TAS[17]

— Primary Health Networks   — Regional Training Organisations   — Service Areas   ◯ Rural Clinical Schools

Source: KPMG, 2020

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[17] TAS has one LHN and three Service Areas. The three Service Areas are illustrated on Figure 17.

Figure 22: Stakeholder environment for VIC[18]

— Primary Health Networks   — Regional Training Organisations   ○ Rural Clinical Schools

Source: KPMG, 2020

Figure 23: Stakeholder environment for WA

— Primary Health Networks   — Regional Training Organisations   — Local Health Networks   ○ Rural Clinical Schools

Source: KPMG, 2020

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[18] VIC has a different structure when compared to LHNs in other jurisdictions, involving five rural health regions, and 70 rural and regional public health services and hospitals (27). As such, the figure does not include an illustration of the LHNs.

Limitations

A majority of stakeholders acknowledged that the wider health workforce ecosystem was complex with lots of moving parts. The varied stakeholder engagement completed by each RWA is influenced by the complexity of the stakeholder environments in which they operate. Synchronisation throughout the complex ecosystem of stakeholders was considered vital by most stakeholders for effective engagement. For some stakeholders in jurisdictions where this synergy was lacking, engagement was identified as ineffective or even non-existent.

Success in engagement with external organisations across all jurisdictions (both complex and simple) was deemed by some stakeholders to be person-driven from effective leadership and long-standing relationships and less effective because of structural arrangements in place through the RHWSA program. Additionally, most stakeholders identified a need for greater coordination and leadership within this system with a more cohesive engagement strategy that crosses agency boundaries and clearly stipulates the roles and responsibilities of each stakeholder group within the broader ecosystem.

Some stakeholders reported a view that the centralised location of RWAs reduces their capacity to engage effectively with key stakeholders in regional, rural and remote communities. Stakeholders in these rural and remote communities acknowledged that workforce planning to solve local workforce issues should be completed by those who work and reside in these local communities and not by agencies that are based in metropolitan areas.

Strengths

Jurisdictions with simpler health ecosystems were able to engage more seamlessly through a singular HWSG with all key jurisdictional stakeholders around the table. The key factors facilitating stronger engagement in these smaller jurisdictions was the relative simplicity of their health ecosystems and the ability to more easily develop effective working relationships across agencies due to the lower volume of stakeholders with which to engage. Jurisdictions with fewer stakeholders generally described been well placed to develop and support innovative service approaches across the jurisdiction. These unique factors also offer significant opportunities for the integration of services, particularly regarding needs assessment processes and implementation of the AWP.

For example, in the NT, the RWA operates in a unique environment, operating as an embedded branch within the PHN. It is identified as a distinct and important function through unique branding and a separate subcommittee who oversee the work of the RWA. Stakeholder consultations reported that the NT PHN model was effective within this particular jurisdiction, given its unique contextual elements in terms of geographic area, population spread and primary healthcare service delivery model. Elements of this structure also enable the RWA to more easily deliver services collaboratively with the PHN through seamless joint planning initiatives which identify alignment between overlapping objectives and opportunities to either implement activities in synergy or prevent duplication. Information and data sharing is also more streamlined and easier to access.

For jurisdictions with a complex ecosystem of health stakeholders, some RWAs modified their approach to convening the HWSG through the creation of multiple, regional HWSGs, whilst others modified their HWNA

approach to distribute a state-wide needs analysis complemented with regional breakdowns. Some stakeholders in these jurisdictions acknowledged that such collaborative engagement strategies led to productive activity execution that was seen to develop real and tangible progress towards addressing the three program elements.

D.3 Are there areas of overlap in stakeholder engagement with other Commonwealth funded activities that could be better harnessed or leveraged?

This review found evidence that the key area of overlap related to stakeholder engagement was in the duplicative needs assessment process that occurs across multiple agencies. This includes needs analyses completed by the PHNs, RTOs, Regional Training Hubs and State Governments. Whilst each differ in objective and depth, it was identified that, generally, agencies were gathering their own workforce data separately and duplicating effort. An opportunity exists for more streamlined stakeholder collaboration to occur in the data collection, analysis and reporting of health workforce need with a focus on data-sharing and minimising the burden on health care providers.

Most stakeholders identified that greater collaboration across key stakeholders and government agencies in the integration and alignment of the workforce needs analyses was a key element to be better leveraged moving forward. As the RWAs mature, it was identified that it would be more valuable for them to move towards a model of proactive, succession workforce planning. Anticipating change, rather than reacting to change, was identified as a crucial element to support a more system-focused role of the RWAs within a complex stakeholder ecosystem.

The underlying issue identified by stakeholders contributing to this duplication in needs assessment and planning was the lack of clarity regarding the roles and responsibilities of the different stakeholders, often with similar or competing objectives. In a complex health workforce ecosystem, for multiple players to effectively engage with one another, transparency regarding the remit and focus of the RWAs and other agencies (PHNs in particular) is needed. Once the roles and remit of each agency within the planning process is defined, a more streamlined, collaborative approach to needs assessment and subsequent workforce planning can be realised. The Department could address this through a policy and planning framework and arrangements with the PHNs and the RWAs.

D.4 How can engagement be strengthened in the future?

There are several key areas where it was identified that stakeholder engagement of the RWAs could be strengthened in the future. The areas are considered below, with relation to engagement with the local community and engagement with broader stakeholders in delivering the program.

In local community

RWAs provide increased wrap around support to newly placed, rural and regional health workers.

Some stakeholders identified that RWAs could work more closely with local community and other local health workforce organisations to engage with newly placed health workers and deliver specialised supports. The provision of tailored, wrap around services that provide a holistic welcome and ongoing support package, including case management approaches when necessary, is one strategy identified in the underlying literature as key for addressing job dissatisfaction and isolation (39; 8; 10).

There is an opportunity to encourage RWAs to undertake specialised, tailored support services in concert with other education and training organisations that offer similar services. Additionally, it was identified that these supports may be offered as part of a customised package of financial incentives that RWAs already deliver to newly placed health workers. This 'bundling' or 'packaged' approach aligns with current best practice put forth by the supporting literature scan, which identified such strategies would be insufficient in their own right and need to be considered synonymously with other personal elements that influence a healthcare worker's decision to stay, such as family and educational supports or retention bonuses (8).

RWAs work to establish local networks of healthcare professionals across rural, regional and remote communities

RWAs could strengthen their engagement with local communities through the establishment of local networks of like-minded rural and remote healthcare professionals. Professional networks were identified as another method of providing ongoing support to healthcare practitioners in rural and remote communities, and it was identified through stakeholder consultations that RWAs have a role to play in addressing feelings of isolation and supporting improved connectedness amongst remote and regionally based healthcare professionals.

There is opportunity for RWAs to strengthen community engagement through the establishment of formalised networking groups. It was acknowledged that these groups should be extended to include nursing, allied health and any other paraprofessionals. Additionally, evidence from the literature scan supports such approaches for their twofold benefit of the establishment of support networks as well as the provision of ongoing professional development and training (21; 39; 9; 10). There is some evidence that the provision of continuous professional stimulation opportunities encourages rural practice (21). Additionally, there is some evidence that the formation of professional associations or networks have increased the retention of healthcare practitioners in regional areas (9).

Through the establishment of a formalised network of health professionals, RWAs may further increase touchpoints with local community, in particular with individual health workforce professionals who attend these forums. Expanding engagement into this space may assist RWAs to engage with health professionals, especially within the private rural and remote GP and allied health sector, which was identified by most stakeholders as a group that can be difficult to engage with.

Across the broader rural health workforce:

Consider opportunities for the RWAs to establish strategic vision / priorities with their jurisdictional stakeholders and delineating the roles and responsibilities of the stakeholders to achieve this vision

It was identified that there may be a substantial number of stakeholders with similar objectives unknowingly undertaking similar health workforce activities as the RWAs, indicating potential duplication in work between stakeholders. Various stakeholders indicated they did not have clarity on the specific remit of the RWAs and thus had no knowledge of the potential for overlapping objectives and activities.

Where stakeholders engage with one another to support the planning and delivery of activities within the RHWSA program, the roles and responsibilities of each key stakeholder should be clearly delineated. Clarity in remit and scope of each stakeholder and their responsibility within this program may assist stakeholders to more effectively engage and identify potential areas of overlap in objectives and subsequent opportunities for more streamlined collaboration in service delivery.

Case Study 2 describes RHW and WAPHA who strategically identified common outcomes and alignment in scope to support the delivery of a collaborative GP practice support service.

Consider opportunities for the RWAs to coordinate the needs assessment process with the other jurisdictional stakeholders and align with the planning cycle of PHNs for services and workforce planning

There is an opportunity for the development of a framework or set of guidelines, which details the specific requirements characterising an 'integrated' approach to long-term, primary healthcare workforce planning. This can be aligned to the planning cycles of other jurisdictional stakeholders, for example the PHNs, for service and workforce planning. In turn, jurisdictional stakeholders can know what is to be expected in terms of activities and outputs through their involvement in the RHWSA program workforce planning processes. Examples that would assist with improving service planning and coordination between stakeholders include:

- Working towards a singular data source and sharing medical, nursing, allied health and para-professional workforce planning data between stakeholders. This can be formalised through data-sharing agreements.

- Undertaking area-specific, long-term workforce needs analysis planning and activity definition in collaboration with the relevant regional stakeholders.

- Identifying overlapping objectives between stakeholders and potential areas for joint service delivery to meet shared outcomes.

- Formalised mechanisms through which stakeholders can provide feedback on planning and activities associated with the RHWSA program.

An example of an integrated approach to long-term, primary healthcare workforce planning is provided in Case Study 1, which is a case study describing the Western NSW Primary Health Workforce Planning Framework. This framework brought together over 40 regional stakeholders united through a common vision of the

development of a longer-term, integrated approach to primary health care workforce planning. This framework, led by the NSW RWA, co-commissioned by the Western NSW PHN and supported by all engaged stakeholders, identified six key immediate action areas and outlined 34 supporting activities.

Consider opportunities for the RWAs to increase their engagement with stakeholders in the implementation of workforce activities

Whilst most stakeholders largely identified the HWSG as a positive forum to be engaged with, a key criticism was outlined by some stakeholders around the forum's lack of clear direction in terms of actions for stakeholders involved. Some stakeholder consultations identified this forum was viewed as simply a sense checking exercise for stakeholders to validate and endorse the HWNA with no tangible actions to then address the identified need. The Department advised that following feedback from stakeholders, the HWSG members are to 'support' the HWNA and AWP, rather than 'endorse' the documents.

There is scope for RWAs to better leverage this forum and identify key activities that can be delivered in collaboration with other stakeholders to address needs and issues identified through the HWNA process. Additionally, the HWSG can be utilised to explore innovative solutions that draw on the various resources, skills and knowledge of all agencies involved.

Clarify the roles and responsibilities of RWAN and / or RHWA in stakeholder engagement activities

It was identified that the roles of RHWA and RWAN were unclear with respect to stakeholder engagement. These unclear governance arrangements meant external peak national organisations did not have clarity of a national representative for the program to contact and, instead, tried to maintain seven jurisdictional relationships to stay abreast with the activities associated with the RHWSA program. Inequitable engagement across the seven jurisdictional RWAs meant key national stakeholders were sometimes excluded from planning and decision-making activities. Additionally, the lack of a national profile of the RWAs meant there was no broad sense of their role and achievements in the health workforce space at a national level.

There is opportunity to clarify the roles and responsibilities of RWAN and / or RHWA with specific respect to stakeholder engagement, reporting and program delivery, or consider opportunities to support more efficient and effective national representation of the program.

Appendix 3: Literature scan

Executive Summary

Background and context

A key element of the RHWSA program review is an exploration of the literature relating to better practice approaches to supporting the recruitment and retention of health workers to rural and remote areas. This literature scan identifies a range of contemporary practice alternatives, including an exploration of discipline specific nuances between sectors of rural and remote healthcare professionals. The information ascertained through this literature scan has been used to inform the recommendations proposed for the future state design of the RHWSA program.

Methodology

The literature scan was undertaken using a defined search strategy and a scope of sources that focused on peer reviewed material and considered relevant grey literature with an evidence base.

The three research questions considered in the literature scan were:

1. What is contemporary good practice in improving the rural health workforce?
2. What evidence exists to demonstrate what works in improving the rural health workforce?
3. Are there different strategies that are more suited to different disciplines in attracting health professionals to rural health roles?

During the literature scan, the following were considered:

- **Education strategies**: strategies for educational levers designed to positively influence recruitment and retention of health workers to rural and remote settings.

- **Regulation strategies:** regulatory strategies deployed to improve the rural and remote healthcare settings, systems and services.

- **Financial strategies:** fiscal interventions commonly used to support improved health worker recruitment and retention in rural and remote healthcare settings.

- **Personal and professional support strategies**: strategies for providing personal and professional support to aid the recruitment and retention of healthcare providers to rural and remote communities.

- **Outcomes-based reporting**: role of outcomes-based reporting frameworks for measuring and monitoring performance against key defined program outcomes.

- **Place-based approaches:** role of place-based approaches for improving health and health related outcomes.

- **Considerations for different disciplines of health workers:** nuances between disciplines of health workers and discipline specific improvement strategies, where appropriate.

Considerations for the RHWSA program are summarised at the beginning of each section.

Summary of findings

Key findings from the literature scan are provided below.

Strategies for influencing the rural, regional and remote health workforce

The following findings were identified during the literature scan as strategies for influencing the rural, regional and remote health workforce.

- To best support recruitment and retention of medical professionals to rural and remote regions, the literature supports investment in broad education strategies across an **integrated rural medical workforce pipeline** with emphasis on recruiting the 'right' student for rural and remote health work. There is evidence to support the extension of this approach into the allied health practitioner and Aboriginal and Torres Strait Islander health workforce space (41; 48; 49; 21; 50; 51; 19; 39; 23; 8).

- The literature shows there are benefits in investing in **multidisciplinary teams of health workers** and delivering health services that draw on the diverse skills mix of health workers across professions, including utilising health workers with an expanded practice scope (10; 9; 19).

- There is an absence of strong evidence supporting the utilisation of bonding and contractual arrangements as a best practice method for improving the rural and remote health workforce. The literature recommends that **bonding and contractual approaches should be delivered in parallel with efforts that provide appropriate personal and professional support** to ensure these regions remain attractive to healthcare providers at the conclusion of their contractual period (21; 23; 10; 9).

- The literature emphasises the importance of ensuring that **financial incentives are carefully designed, with full consideration of the opportunity costs for individuals** associated with rural, regional and remote health work and are commensurate to the additional demands of the jobs. Additionally, the literature recommends considering financial incentives that not only support an individual's retention but also support the attraction of newer graduates to rural and remote settings. The evidence supports financial incentives for individuals to be delivered as one part of a tailored package of bundled interventions and not in isolation (43; 8; 9).

- The literature identifies evidence in support of **investments that improve the underlying physical health infrastructures and service delivery settings**. This could encompass the provision of a broad range of facilities and services, including: the provision of fit-for-purpose medical clinics, housing for residents and visiting medical staff, transport, IT and communications technology, provision of high quality accommodation, appropriate schooling opportunities for children and spousal employment opportunities (8; 9).

- A **multi-pronged approach to the provision of tailored personal and professional supports** should be considered. Tailored psychosocial strategies, such as cognitive behaviour therapy, leads to improved recruitment and retention outcomes of rural and remote healthcare providers. The provision of case management approaches is recommended for providing holistic and individualised support to health care workers relocating to rural and remote regions. Facilitating formalised networks of rural and remote healthcare professionals is recommended as

one strategy to reduce isolation and can lead to additional professional development and mentorship opportunities (21; 39; 8; 10; 9).

- There is evidence supporting the use of **flexible and innovative services models**, such as month-on / month-off, job sharing and the higher utilisation of a multidisciplinary health workforce as useful for the provision of respite and ongoing upskilling of healthcare workers. Additionally, for maximum benefits, these **service models should be delivered by qualified, competent clinical leaders** who empower remote teams and foster positive workplace environments (21; 50; 19; 41; 10; 8).

- The literature strongly **recommends individual strategies should be bundled together to form personalised packages of interventions** that are flexible and address the unique barriers of the individual context that is being targeted (8; 9; 10).

Reporting

The use of an outcomes-based reporting framework that aligns the reporting of funded activities and services to the broader program outcomes is recommended. Traditionally, performance evaluation occurs by measuring the efficiency of inputs and outputs as opposed to considering the broader interventions' progress towards achieving program outcomes. An outcomes-based reporting framework can become a useful tool for agencies as a real-time, strategic resource that measures and tracks the ongoing delivery and adjustment of activities against progression towards program outcomes (7; 6).

Place-based approach

Place-based approaches can be an effective strategy positively influencing health outcomes or health-related behaviours in populations of locational disadvantage (e.g. rural and remote communities). Collaborative partnerships between local health services / providers and the relevant government agencies are key to the design and implementation of local health programs and services (3).

Monitoring and evaluation

There is a clearly identified need in the literature for robust and ongoing data collection, analysis, monitoring and evaluation of all strategies implemented to instigate health workforce improvements in rural, regional and remote settings. The literature scan highlights the importance of implementing evaluation frameworks from the outset when designing programs that aim to support the recruitment and retention of healthcare providers in rural and remote communities, as opposed to completing these retrospectively (8; 9; 10).

Literature Scan

A literature scan has been completed to provide a basis for identifying the program's alignment to contemporary good practice and suitable options to improve outcomes into the future. Through a systematic exploration of the underlying evidence base, this literature scan identifies a range of contemporary practice strategies for attraction, recruitment and retention of rural health professionals across a range of disciplinary backgrounds (e.g. Medical, Allied Health, Nursing, Dentistry and Aboriginal and Torres Strait Islander health).

This section includes:

- Methodology of the literature scan

- Contemporary good practice for improving the rural health workforce

- Considerations for different disciplines.

Methodology

The methodology for conducting the literature scan included a search strategy and a defined scope for the sources considered. The search strategy and sources are outlined below.

Search Strategy

The search strategy was guided by three research questions and pre-determined key search terms outlined below.

The three research questions were:

1. What is contemporary good practice in improving the rural health workforce?

2. What evidence exists to demonstrate what works in improving the rural health workforce

3. Are there different strategies that are more suited to different disciplines in attracting health professionals to rural health roles?

And, the key search terms included:

1. Rural health workforce, and

2. Addressing shortages, or

3. Indigenous health workforce, or

4. Recruitment Retention, and

5. Good practice, or

6. Evaluation, or

7. Evidence base, and

8. Medical, or

9. Allied Health, or

10. Nursing, or

11. Dentistry.

Literature Sources

Publications included in this literature scan were original peer-reviewed literature and grey literature published primarily in Australia, Canada and New Zealand, although other literature from high to middle income countries was included if relevant to answering the research questions. In order to capture contemporary best practice strategies, the search period was limited to research published in English from 2015 onwards, however older research articles were considered if they were particularly seminal throughout the evidence base. A single study can often have multiple publications and, as such, the primary reference for each study was identified (and this may reflect older research). Publications were excluded if the publication was addressing strategies to improve the rural health workforce in low-income or developing countries.

Contemporary good practice for improving the rural health workforce

This section discusses strategies for influencing the rural and remote health workforce and explores contemporary good practice for improving the rural health workforce. This section focuses on the first two research questions:

1   What is contemporary good practice in improving the rural health workforce?

2   What evidence exists to demonstrate what works in improving the rural health workforce?

This section is organised by six domains, which are:

- Education

- Regulation

- Financial

- Personal and professional support

- Outcomes-based reporting

- Place-based approaches.

Education

Implications for the RHWSA program:

To best support the recruitment and retention of medical professionals to rural and remote regions, broader education strategies across the 'integrated rural medical workforce pipeline' should be considered. This includes a focus on supporting and prioritising applications of rural, remote and Aboriginal and Torres Strait Islander backgrounds accompanied by the delivery of formative medical training in rural and remote areas. Additionally, the medical curriculum needs to be contextualised to rural and remote settings and include a primary care or generalist focus. Finally, the ongoing delivery of continued professional development needs to be modified to accommodate the rural and remote context, in terms of both content and delivery.

Targeted education strategies for rural healthcare professionals were largely discussed throughout the literature in the context of career pathways. Such approaches consider how enrolment into training and appropriate education pathways can be best designed to influence the production of an appropriately qualified, acceptable and 'fit-for-purpose' rural health workforce (8; 10). Education is considered the foundation for producing competent healthcare workers and emphasis is placed on selecting the "right" student and exposing them to the methods, curricula and locations that will influence them towards future rural and remote practice (9). Consideration is placed on educational supports that span entire careers, not only the formative years of a healthcare professional's education.

Medical Workforce Pipeline Strategies

Wakerman et al concluded, of all strategies, the strongest evidence of the impact of education on ameliorating the geographical maldistribution of doctors came from the 'integrated rural medical workforce pipeline' approach (8). This approach targets key points throughout the medical workforce pipeline and considers each component in the context of how it may contribute to increasing non-metropolitan practice and the retention of doctors in rural and remote regions (8). Investment in this approach involves focusing on rural medical education programs across four key workforce pipeline components throughout the course of a healthcare professional's training development. These components have been described slightly differently within the literature captured in this scan, but broadly they include:

1. There is evidence throughout literature that prioritising applicants of rural, remote and Indigenous backgrounds, including providing appropriately tailored entry pathways, has been an effective strategy for positively influencing future rural practice choices (8; 23; 9; 10). This strategy is supported by literature demonstrating that students recruited from rural areas tend to return to work in rural areas upon receiving their qualification (23; 52; 53). In Australia, rural-origin is consistently associated with increased odds of rural practice (54).This concept forms the foundation of the WHO's recommendation of finding the "right" student for rural and remote healthcare where rural origin was identified as a key factor associated with rural practice (9). Shaping a rural curricula around rural health needs and delivering this training in schools located rurally has further evidence of effectiveness, particularly in a nursing context (8; 9; 51). It is important to recognise that students from rural areas may face additional academic, cultural and social barriers when making the transition from rural to urban areas for medical training (9). Personality attributes, such as one's adaptability, has been identified in the literature as playing a key role in influencing a health worker's rate of rural retention (19). There is less evidence for the use of preferential or targeted admissions policies in other allied health professions, and further evidence of its application needs to be assessed before it can be deemed an effective strategy in these disciplines (9; 10; 49).

2. Delivering formative medical training in rural and remote areas has been put forward as an additional strategy for influencing rural practice (9; 8; 55). However, methodological limitations exist in the evidence that underpins this recommendation, mainly due to the literature's reliance on large-scale observational studies (9). Evidence may also be confounded by the higher recruitment of rural background students into rural clinical schools (9). Despite this, Wakerman et al found evidence in support of this strategy as an effective means of addressing rural workforce shortages, identifying an increasing gradient effect, meaning the longer a student trained in a rural or remote area the more likely they were to stay there and practice (8; 51). It was further identified in Australian RCSs, that graduates with three years of rural training experience were more likely to indicate a rural region as their preferred work location (10; 56). Evidence was found of a similar effect within the nursing profession (8). Additionally, short clinical rotations in rural areas is suggested as an entry point for the exposure of students to work in rural communities, giving them a better understanding of the realities of rural work without the long-term commitment of complete immersion (8; 9). There is mixed evidence of effectiveness of a clinical rotation strategy on rural retention, however evidence to date points to its positive influence on subsequent choice to practice rurally, even on students from a metropolitan background (9). Further, students (medical, nursing and pharmacy) who completed a rural

clinical rotation demonstrated improved competencies in dealing with rural and remote medical issues (9). Evidence to date indicates that rural and remote medical training strategies may play a positive role in influencing future rural and remote health workforce shortages. It has been suggested that rural and remote medical training strategies will be more effective when complemented with other workforce pipeline strategies and should not be delivered in isolation (9; 8).

3. There is some evidence suggesting that curriculum contextualisation with a primary-care or generalist focus is more conducive to producing a health workforce equipped to work in rural and remote practice (39; 8; 9). Rural and remote medical practice differs to its metropolitan counterpart as, often, clinical assessment and management needs to be undertaken in resource-limited settings across a broader scope of medical practice (9). As such, it is suggested that a rural-specific curricula, which focuses on primary care training, provides a primary care honours track and includes advanced procedural training in key skills areas required for rural and remote practice (e.g. obstetrics, emergency medicine, anesthesia and surgery), will enhance the confidence of incoming residents, ensuring they have the appropriate capabilities for the role (39; 9; 57). Russell et al identified that, in Australia, non-procedural GPs had an increased risk of leaving a rural community compared to procedural GPs (43). As such, in the Australian context, educational reform towards a rurally oriented medical curricula with emphasis on GP procedural, hospital and emergency work may enlarge the proportion of medical students choosing to stay in rural and remote practice (39; 43; 9). The rural context must be reflected in the educational content and this may be done through various mechanisms, including the Rural Procedural Grants Programme, rural generalist pathways, funding of rural hospitals and other means (43; 9).

4. Designing CPD curricula to support rural retention needs to accommodate the rural context through both content and delivery (8; 9). This final element of the workforce pipeline considers education beyond the formative training received during medical school. Crucial to the maintenance of health workforce competence and performance is access to the necessary continuing education and professional development opportunities (8). For healthcare professionals located in regional and remote areas, access to such opportunities may be diminished if they are required to travel long distances (10; 9). To ensure the ongoing acquisition of skills, evidence suggests that strategies that support the delivery of focused, rural-specific CPD in rural areas may inadvertently increase retention, through improved competence and connection with the additional support network of a rurally oriented health workforce ecosystem (9). Support systems are crucial in rural and remote settings to reduce professional burden and feelings of isolation (10). In Australia, CPD opportunities have been identified as the second reason, after financial incentives, why recruits chose rural programs (10). Elsewhere, in Ontario, Canada CPD was identified as an enabler of nurse retention (10).

Each of the discussed components independently contributes to a rural health worker's capacity and desire to work rurally, in the context of their education and subsequent career progression.

Regulation

Implications for the RHWSA program:

To best support recruitment and retention of healthcare providers to rural and remote communities, the use of bonding and contractual arrangements in concert with other approaches should be carefully considered. In the absence of strong evidence demonstrating the effectiveness of these regulatory approaches in isolation, bonding and contractual schemes should be delivered in parallel with efforts that provide appropriate personal and professional support to ensure these regions remain attractive to healthcare providers at the conclusion of the contractual period. Additionally, strategies that support a multidisciplinary health workforce, including those that work to enhance the practice scope of appropriately qualified clinicians, should be explored to support recruiting additional health workers to practice in rural and remote areas.

Broadly, regulatory strategies encompass any government control exercised through legislative, administrative, legal or policy mechanisms (9). In the context of recruitment and retention of health workers in rural areas, regulatory approaches encompass bonding and contractual approaches, enhanced practice scope and a diversified health workforce (10; 9).

Contractual Arrangements

Compulsory service schemes can be used to support the rural and remote health workforce. Contractual strategies include the mandatory deployment of healthcare workers for a defined period of time to rural areas to meet a pre-requisite or requirement (10; 9).

In the Australian context, contractual approaches are deployed alongside targeted immigration policies, attracting medically skilled foreign medical clinicians and placing them in areas of health workforce shortage for at least a 10 year period in exchange for access to Medicare benefits (10; 9). Whilst contractual schemes show promise as a short-term demand management strategy, there was no evidence in the literature that they improved rural workforce retention long-term (10; 23; 21). Russell et al reported GPs trained overseas had a 45% increased risk of leaving a rural community compared to an Australian-trained GP (43). The risks associated with implementing compulsory service requirements are well documented having been criticised for increasing turnover in health centres, subsequently reducing continuity and quality of care (9). Such policies may even be detrimental, potentially reducing the incentive to improve working conditions, build educational capacity or possibly even alienate professionals from rural and remote work, thus becoming counter-productive (10; 21). In the absence of robust evaluation on contractual approaches to health workforce shortages, it is difficult to conclude if they are effective for addressing distributional issues, and more research is needed in this regard.

Currently in Australia, there is an increasing trend of reliance on IMGs to service rural regions (44). There is growing support for strategies that facilitate self-sufficiency however, locally trained graduates are choosing to specialise rather than go into general practice, which reduces their likelihood of moving to a rural or remote community (44). In the face of reduced inflow of IMGs, investment has been made in various educational interventions, such as RCSs, Rural Primary Care Stream and the Integrated Rural Training Pipeline including new Regional Training Hubs (56; 58; 44). It is expected that these interventions will stimulate the development of a sustainable future of the Australian rural medical workforce through more rurally based generalists and specialists (56; 44). However, these education

policies are still in their infancy, and a time lag (of up to 10 – 15 years) exists between when they are implemented to when their full outcomes are realised (44). For those communities that have appropriate training pathways and potential to "grow their own", it still takes time for a health workforce to grow and differentiate to meet community need (44). As such, IMGs still substantially continue to underpin Australia's rural and remote medical service capacity, and it is worth considering how current contractual approaches might be best combined with other types of incentives to support this crucial demographic of health workers (44). Many IMGs begin their careers in Australia working in some of the most isolated communities, with the most vulnerable populations who have the most complex health conditions, including Aboriginal and Torres Strait Islander populations who require culturally competent care (44). In this context, when utilising contractual approaches, they should be complemented with wrap around professional and personal supports allowing IMGs to acclimatise to the Australian rural and remote health system (44). Parallel efforts should be put in place to improve the living and working conditions in these communities to support retention of IMGs at the conclusion of their contracted period by making these regions enjoyable places to live and work (44).

Bonding Schemes

Bonded approaches are typically given to students in the form of bursaries or other subsidies against the cost of their education in return for a defined period of rural or regional work once qualified (10; 9).

In Australia, this strategy is deployed through the Bonded Medical Places (BMP) Scheme which provides participants a Commonwealth Supported Place at a medical school in an Australian university in exchange for one to six years of service in an under-served area post-graduation. The broader evidence around bonding schemes supports improved retention rates, however the underlying evidence is methodologically flawed, meaning findings should be interpreted with caution (9). In Australia in 2017, less than 1% of the total of 9,976 rurally bonded students had completed their return of service obligation with an additional 5% having withdrawn, breached, terminated or deceased (59). Some bonded schemes, such as Australia's BMP Scheme, offer a buyout option, and little is known about uptake rates of buyout compared to completion of obligatory service (9). In terms of nursing and other allied health professions, little is known about the application of rurally bonded schemes in these disciplines (9). Despite seemingly high retention rates, in the absence of a methodologically sound cohort of studies comparing rurally-bonded student outcomes against those who graduated without being a part of a bonding scheme, little can be ascertained in terms of effectiveness for such strategies (9). As with other strategies, higher yield might be seen through combining bonding schemes with other incentives, such as targeted admissions practices.

Enhanced Scope of Practice

In the absence of other qualified professionals, healthcare workers in rural or remote regions may often provide services beyond the remit of their formal training. This can sometimes be coined as task substitution, where the role of non-medical providers is expanded to relieve pressure on medical clinicians (10). Task substitution may take on many forms, e.g. junior clinicians take on more tasks, or new jobs are developed which are simple, and routine healthcare tasks that require less training (e.g. taking blood samples) (10).

In some instances, this enhanced scope of practice is recognised through regulatory mechanisms (i.e. through formal qualifications) with the assumption that this will increase access to health services for rural and remote communities

(9). These strategies are most widely reported on in the context of the nursing profession, and evidence exists indicating nurses in more advanced primary care roles are positively associated with increased patient satisfaction, reduced hospital admissions and reduced mortality rates (10). Additionally, these roles are either cost-neutral or even slightly cost-reducing (10). In Australia, legislative and regulatory steps have been taken towards strengthening the role of advanced nursing and midwifery disciplines through recognition of the 'nurse practitioner', thus removing barriers to extensions in their scope of practice (10). A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role (60). The nurse practitioner role has emerged as a way to expand the scope of practice for nurses in order to improve access to healthcare, particularly for remote, marginalised and vulnerable populations (61). Based on the most recent available data, there are 1,604 nurse practitioners endorsed in Australia and this number is growing (62). For example, between 2014 and 2017, the total number of nurse practitioners with general or provisional registrations has increased by 43.4% from 1,085 to 1,556 (an average annual growth of 12.8%). There is additional evidence indicating nurses with an increased scope of practice may experience increased job satisfaction (9).

Such a strategy may be met with considerable resistance from certain health workforce groups, and changes in practice scope must be carefully considered and clearly stipulated in the legislation. Whilst it is acknowledged that enhancing practice scope can contribute to the delivery of health services in rural and remote communities, little evidence exists supporting this as a specific strategy for retention (10; 9).

Diversified Health Workforce

In order to meet population need in rural and remote health workers, policies that scale-up the health workforce and introduce diverse disciplines of health workers to rural practice have been suggested. The underlying evidence for this strategy demonstrates that investment in a more diverse ecosystem of health workers will increase the number of health workers practicing in rural and remote areas, subsequently improving health outcomes. (9). Specific types of health workers can be trained in a relatively shorter amount of time compared to physicians, and can be trained to be more responsive to rural and remote community need (9). Additionally, these types of health workers may provide lower-cost alternatives in low-resource settings (9). Developing broader models of care, such as through multidisciplinary teams of health workers, was put forward as a key retention incentive for supporting diversity in rural practice (19). There is a lack of evidence that directly assesses the influence a more diverse remote health workforce plays on the retention of healthcare workers, and further research is needed to determine the efficacy of such an approach.

Financial

Implications for the RHWSA program:

It is critical that financial incentives are carefully designed with consideration of the full opportunity costs for individuals associated with regional, rural and remote health work, and that they are commensurate to the additional demands of this work. Currently, Australia's Workforce Incentive Program provides a higher payment for a longer time in service, meaning the focus is placed on retention; however, the literature

criticises such strategies as potentially wasteful through focusing on those individuals already willing to work in these regions. There is an opportunity to consider the right kind of incentive mix that might support the attraction of newer graduates to rural and remote settings. If deployed, best practice would see such financial incentives delivered as part of a tailored package that are bundled with other interventions, such as preferential recruitment of rural students or strategies that address working and living conditions (e.g. affordable housing and improved work conditions).

Financial incentives include additional benefits provided to healthcare workers to entice or keep them in rural or remote practice, including monetary, in-kind or any additional benefits that reduce the opportunity cost of working in rural and remote regions. Financial incentives seek to influence the decision-making process of health workers by ameliorating the potential lost revenue due to more limited opportunities for private practice in rural and remote communities (9).

Bundled Financial Incentives

Combinations of various fiscal incentives have been widely used as a strategy to attract and retain healthcare workers to rural and remote regions. The literature highlights salaries and allowances as one of the key factors influencing retention of healthcare professionals in rural areas (9). Over time, these financial incentives may take many different forms from an initial recruitment incentive (i.e. practice set-up allowances, relocation grants or grants for housing) to a retention-focused incentive (i.e. paid vacations, retention bonuses or hardship allowances) (8; 9). The underlying principle that supports the customised incentive mix model is that the incentive bundle must be commensurate to the demands of the job (8).

Verma et al found that, of all the strategies to improve rural heath workforce retention, the strongest evidence was for financial incentive strategies, concluding that individual recipients of financial incentives had higher retention rates in rural and remote communities (23). In Australia, this type of regional financial incentive package is delivered through the Workforce Incentive Program which has two payment streams: 1) the doctor stream, which makes direct payments to the medical practitioners who bill the MBS for eligible services, and 2) the practice stream, which provides quarterly incentive payments to accredited general practices that employ multidisciplinary teams of health professionals (16). In Australia, salaried or contracted GPs have a much greater risk of leaving a rural or remote area compared to GP principles and partners (i.e. those who privately own a practice) (43). Additionally, Gen Y graduates (born 1980 – 1994) are less inclined towards private practice ownership compared to their predecessors (23). For the Australian Workforce Incentive Program, incentive payments are dependent on time served and geographic location (16). As such, the current approach in Australia is geared more towards retention (i.e. a higher payment for longer time served) than it is towards attraction of the next generation of health workforce graduates. In the context of this incentive model, some consideration must be given towards developing the right kind of incentive mix that might attract newer graduates to rural and remote practice in the first instance (43; 8).

Financial incentives have been criticised for being wasteful by focusing on individuals who were already willing to work in rural and remote regions, regardless of government interventions (10). One review identified that recruitment and retention of healthcare professionals to rural and remote regions was more dependent on intrinsic and

idiosyncratic determinants, such as job satisfaction, than extrinsic influences, such as financial incentives (39). Further, there is a lack of well-designed and comprehensive evaluations that assess the long-term impact of financial incentives on rural and remote areas, as they are often rolled out as short-term packages in response to an immediate or crisis need (39; 9). Despite the findings of Verma et al of the success of financial interventions as a strategy for rural recruitment and retention, their underlying evidence to form this opinion was bound with education incentives that provided financial support to students in return for service, meaning their finding is less applicable to the types of financial incentives discussed in this section (23). A recent Cochrane review found that the evidence base for financial incentive strategies was largely made up of descriptive, cross-sectional surveys and retrospective cohort studies limiting the extent to which their findings can be transferred to other settings (21).

Before implementing any financial incentive programs, best practice recommendations would suggest fully understanding the opportunity costs of working in the rural and remote setting being targeted, and ensure the incentive is sufficiently large to compensate for the longer hours and more difficult working conditions (10; 9). This can be completed through discrete feasibility studies and labour market analysis prior to the implementation of financial interventions (9). An awareness of the political sensitivities around giving some healthcare workers incentive payments should also be considered. The effectiveness of such strategies might be improved when bundled with other interventions, such as preferential recruitment of rural students or strategies that address the work and living conditions (e.g. affordable housing and improved work conditions) (8; 10; 9). When deploying financial incentive strategies, comprehensive and robust evaluations need to be included in the design from the outset.

Personal and Professional support

Implications for the RHWSA program:

Innovative opportunities to implement non-financial incentives that support both the individual healthcare provider but also improve the overall health infrastructure and service settings should be considered for the regional, rural and remote health workforce. Additionally, specialised psychosocial supports targeting rural and remote health workers should be included as part of an infrastructure package with wrap around, tailored case management to support newly relocated healthcare providers. Isolation is key-driver of high-turnover in rural and remote healthcare providers; hence, it is important that like-minded rural healthcare providers are brought together in formalised settings for professional development, networking and mentorship programs. To underpin the development and implementation of tailored personal and professional support packages, service management strategies and flexible workforce models should be considered. Administering holistic and flexible workforce models to meet the ever-growing and complex demands of the evolving healthcare sector requires effective coordination and management of services. Health service management can be strengthened through the employment of qualified, competent managers who empower remote teams and foster positive environments.

Varied interventions have been implemented in an effort to provide appropriate professional and personal support for healthcare workers in rural and remote regions (21; 23; 39; 8; 10; 9). Such strategies might address the functional

work environment (i.e. physical infrastructure and equipment), effective management systems, enhanced professional development, provision of locum support, networking opportunities and improved housing and school facilities. Often, rural and remote work conveys a sense of isolation, both professionally and personally, thus strategies to address these are often put forward to complement other strategies for addressing workforce maldistribution.

Improving Health Infrastructure and Services

Investment in infrastructure that supports the rural and remote health workforce, in terms of both living and working conditions, is suggested as one strategy that might have a significant influence on ameliorating distributional issues (8; 9). This could encompass the provision of a broad range of facilities and services, including: the provision of fit-for purpose medical clinics, housing for residents and visiting medical staff, transport, IT and communications technology, provision of high quality accommodation, appropriate schooling opportunities for children and spousal employment opportunities (8; 9).

There is limited direct evidence of this approach, however a Cochrane review found supportive evidence exists, from questionnaire-based surveys, demonstrating that providing these types of supports is important (21). Specifically, it was identified that the opposite (i.e. poor living conditions and inadequate medical and schooling facilities) were a significant disincentive to the uptake of work in rural and remote communities (21; 9). Additionally, healthcare professionals are less inclined to accept offers for work in dysfunctional work environments where their ability to provide safe, good quality care is severely limited (9). Given the higher disease burden experienced by communities in rural and remote Australia, the actual cost of meeting healthcare needs in these regions is higher, and one consequence of under-funding is the inability to attract and retain a competent and qualified health workforce (12; 8).

Often, these types of strategies are bundled with other "non-financial incentives" in larger retention intervention packages making it difficult to isolate the individual effect of such a strategy on workforce distribution issues (9). It is likely that the initial upfront cost of a resource-intensive strategy, such as refurbishing health and living facilities, will achieve benefits for a longer period of time (21). It has also been suggested that these types of investments are likely to return dividends in the form of improved overall economic development in rural and remote areas, increased benefits to workers from other public sectors and increased private activities across all economic sectors (21; 9). However, in the absence of robust evaluations demonstrating the efficacy of such strategies, it is difficult to say with certainty that such approaches will positively influence distributional issues. As such, future investment in health infrastructure strategies for the purpose of health workforce retention must be coupled with comprehensive evaluation frameworks.

Specialised Supports

Social and emotional wellbeing supports have been put forth as a strategy to address job satisfaction and dissatisfaction, which have been identified as significant predictors of GP retention and turnover (39; 8; 10). It is important to understand the factors influencing job satisfaction and dissatisfaction in order to develop appropriate strategies to influence these determinants (39). For the rural and remote health workforce, job dissatisfaction has been linked with a number of variables, including increased workload intensity and volume, insufficient time, longer

hours and increased administrative and bureaucratic pressures (39; 10). Increased work strain due to these compounding factors can lead to increased feelings of stress, depression, dissatisfaction and intention to quit (39).

Psychosocial strategies, such as those that provide social and emotional support for rural and remote health practitioners, have demonstrated some evidence of positively influencing a practitioner's decision to stay (21; 23; 10). In Canada, amongst dental students, professional support was one of the key enablers for students considering rural practice (10). Russel et al found evidence in the Australian context that cognitive behaviourally coached GPs are less likely to leave rural practice within three years compared to other GPs (43). The widespread and systematic offering of evidence-based psychosocial interventions for dealing with mental health issues and stressful work conditions might play a significant role in the retention of rural and remote primary healthcare workers across all professions (43).

Another option to provide specialised support is through a case management approach where specialised rural and remote health workforce recruiters provide personalised, holistic support to healthcare workers relocating to rural and remote regions (23). There is some evidence of successful recruitment through case management strategies; however, the influence this approach has on long-term retention has not yet been robustly evaluated (23). It is also difficult to determine what would be considered an appropriate qualification and skillset for a specialised recruiter in the rural and remote health workforce space. Specialised support strategies would be considered insufficient in their own right and would need to be included as part of a customised bundle of incentives that consider supporting other personal elements that influence a healthcare worker's decision to stay, such as family and educational supports or retention bonuses (8). Prior to scaling up, small-scale pilots should be deployed with robust evaluation frameworks to demonstrate clear evidence of the efficacy of such approaches (63). Best practice would also consider an assessment of an interventions scalability, the development of a clear scale-up plan and availability of scale-up resources including funding and support from key stakeholders and decision makers (63).

Professional Development and Networking Opportunities

Isolation of healthcare professionals in rural and remote regions may have a role in negatively influencing experiences and be detrimental on overall performance (21). The need for continuous professional stimulation and support is important, and this can be provided through professional networking programs, mentorships schemes, locum support programs and academic and career development activities (21; 39; 9; 10). As the professional needs change throughout the career of a rural and remote healthcare worker, other interventions are needed that continue to support career development aspirations (8). Opportunities for professional development and ongoing training, such as attending conferences and local academic exercises, assist practitioners to remain up to date with the latest medical developments and have been identified as an important factor influencing retention (21; 9). There is some evidence, from questionnaire based surveys, that the provision of continuous professional stimulation opportunities encourages rural practice (21). Additionally, there is some evidence that the formation of professional associations or networks have increased the retention of healthcare practitioners in regional areas (9).

A clear career pathway is important for recruitment and retention, and mentorship schemes have been put forth as one strategy to assist career development at every stage (39). There is no direct evidence that implementing career ladders supports retention, but a clear and specific career path is an important factor for a health worker when making the decision to practice in rural and remote areas (9). Mentorship schemes are seen as two-fold in their

benefits, providing an opportunity for juniors to shadow more senior clinicians and gain insights into rural and remote development pathways and for the senior clinician, through the provision of learning and development activities, to provide improved feelings of satisfaction or fulfilment through variety in their role (39). This two-fold benefit contributes to aiding both GP recruitment and retention and considers the role of more senior clinicians, who are often not the focus of retention interventions (39). Such interventions may improve connectedness, morale and, ultimately, the professional status of health workers which can in turn influence job satisfaction and intentions to stay (21; 9). However, more studies are needed that assess the impact of these various career development mechanisms and their impact on rural and remote health workforce retention.

Service Management and Flexible Workforce Models

As demand for and complexity of healthcare grows, coupled with the increasing use of technology, the skillset required of rural and remote health workers has evolved. There is an increased need for transversal skills, beyond technical and clinical capability, including interpersonal skills such as communication, teamwork and an openness for continued learning (10). Different and more flexible work models, such as month-on/month-off, job sharing and the higher utilisation of a multidisciplinary health workforce may be useful for the provision of respite and ongoing upskilling of healthcare workers (8; 19). Administering holistic and flexible workforce models to meet the ever-growing and complex demands of the evolving healthcare sector requires effective coordination and management of services (8). Grobler et al identified effective health service management to be one of the key factors influencing the retention of healthcare professionals in rural and remote regions (21). Health service management can be strengthened through the employment of qualified, competent clinical leaders who empower remote teams and foster positive environments (8; 19; 50). For management, tracking and measuring performance and skills development of the healthcare workforce can prove problematic due to a lack of standardised performance measures (10). There are widely used performance management approaches including; job descriptions, scheduled work reporting, internal appraisal and external reviews, continuing professional development and external recertification (10; 41). Partnership working has been favoured as an approach to fostering employee relations through collaborating with trade unions, managers and government in key staffing decisions (10). However, with a distinct lack of frameworks that set out key competencies and skills of the rural and remote health workforce, combined with a lack of empirical evidence of the effectiveness of these approaches, it is difficult to make sound recommendation for a best practice service management and workforce model.

Outcomes-based reporting

Implications for the RHWSA program:

Activities completed as part of a program should be monitored, measured and evaluated to ensure they remain relevant and effective in achieving the outcomes of the program. Traditionally, performance evaluation occurs by measuring the efficiency of inputs and outputs as opposed to considering the broader interventions' progress towards achieving program outcomes. Emerging literature suggests aligning government funded services, activities and reporting frameworks towards improving outcomes, as opposed

to simply measuring throughputs. As such, a reporting and monitoring framework should be geared towards measuring the program's achievement of its outcomes.

Traditionally, health service systems and hospitals in Australia measure and evaluate their performance on inputs and outputs, and the focus is placed on the efficiency of these throughputs as opposed to the effectiveness of the interventions more broadly. Many of these efficiency indicators will be output-focused, neglecting broader measures of intervention effectiveness which are primarily outcomes focused. Generally, whilst it is accepted that influencing health determinants will influence health status and in turn health outcomes, the casual pathways remain unclear and further work is required to develop appropriate indicators that demonstrate evidence of change. Emerging literature suggests benchmarking health services not only with regards to cost but also regarding quality (7).

The health outcomes focus reflects a broader paradigm shift in the health sector towards an increased focus on implementing best-practice strategies which have demonstrated evidence of effectiveness, as opposed to those with little or no evidence of positive health benefit. When considering the allocation and distribution of finite health resources, assessing the relative effectiveness of healthcare interventions is
key. It is also important to understand when the drive for efficiency is at the detriment of quality or longer-term health outcomes (7). Where the concern for efficiency outstrips the concern for effectiveness, perverse outcomes may result and health resources may be spent on inexpensive services from a unit-cost perspective that fail to deliver positive health outcomes. Reporting frameworks therefore need to move beyond simply understanding the cost per unit of a health service and towards understanding to what extent funded services achieve positive outcomes for their target populations (6).

It has been suggested that any government funded service should align each part of its service, including its reporting framework, towards improving outcomes; however, some considerations must be taken when designing these frameworks to ensure they are 'fit-for-purpose'. Care must also be taken to ensure reporting requirements are not so onerous, in terms of complexity and time, as to conflict with the achievements of the desired outcomes. Reporting requirements should not take up a disproportionately larger time commitment to that of service delivery. Organisations often report expending precious time undertaking 'one-way' compliance-type reporting activities that add little to service delivery and receive little to no feedback in return. The literature surrounding outcomes-based reporting suggests that these types of reporting tools, when correctly applied, can be used by providers as a real-time, strategic resource for the ongoing delivery and adjustment of health services. It is recommended that any re-design of reporting frameworks geared towards the improvement of outcomes of services should encompass what is reported, to whom it is reported and the frequency of reporting in order to be sufficient for providing real insights into the impact of such service on the target population (6).

Place-based approaches

Implications for the RHWSA program:

Place-based approaches can be an effective strategy positively influencing health outcomes or health-related behaviours in populations of locational disadvantage (e.g. rural and remote communities).

Collaborative partnerships between local health services / providers and the relevant government agencies are key to the design and implementation of local health programs and services.

Place-based approaches typically encompass sophisticated programs designed specifically to address unique locational issues, leveraging the resources from partnerships / coalitions of agencies to implement multi-component interventions aimed at influencing change in physical, social and economic environments (3; 64). Place-based approaches are often targeted at the underlying determinants associated with poorer health outcomes, as opposed to targeting specific health conditions (3). There is evidence throughout the literature demonstrating the efficacy of place-based approaches for modifying health and health-related outcomes in communities of locational disadvantage (e.g. rural and remote communities) (3). There is further evidence demonstrating the efficacy of place-based approaches in broader arenas such as childcare and education, the relevant lessons from these fields are applicable to place-based approaches in healthcare and are also considered throughout (65). Key to a place-based approach to health planning is the use of collaborative partnerships between local health services / providers and relevant local / state / national government agencies to design and implement health programs and services (3; 65). It is this collaboration that articulates local health needs, defines localised strategies, generates a shared vision and ensures the targets of the program align local health care planning and implementation to address identified need (66). A key benefit of place-based planning is the use of local population characteristics which can be used to support service delivery models (e.g. linguistically and culturally diverse services) (66; 3). Crimeen et al (2017) identified several key considerations for facilitating best practice place-based interventions in health (3). Those relevant to this literature scan include:

- **Local partnerships processes and community involvement**: Partnerships form the foundation of place-based approaches and are crucial for improving the influence, engagement, implementation and ultimate success of place-based interventions. Engaging early and consistently in communities fosters a sense of ownership, driving participation in needs identification and willingness to develop and deliver programs collaboratively. Additionally, another systematic review completed by Haldane et al (2019) concluded sufficient evidence exists to link community involvement in health service planning, development and implementation to positive health impacts, particularly when supported by strong organisational and community processes (67). There is potential for increased efficiency and effectiveness in both the planning and implementation where the involvement of local groups reduces time taken to identify need. Place-based interventions which rally around a health-related issue allow each partner to identify which program actions they can deliver that address the health issue and align with their core business objectives and capabilities. Through leveraging existing community assets and collaboratively workshopping acceptable, fit-for-purpose solutions, a place-based approach can also contribute to sustainability.

- **Funding duration and cycles:** The most effective place-based programs demonstrating successful outcomes upon evaluation were supported by robust, multi-year government funded structures which were better able to capture evaluation metrics. There was still some evidence of successful place-based approaches with inadequate funding structures, indicating funding is not the only factor influencing success.

- **Governance:** Multiple levels of partnerships require clear governance structures, however, these are often overlooked in place-based approaches. Evidence indicates a clear need for effective governance processes,

including formation and management of networks, an appropriately qualified health workforce and underlying support infrastructures.

- **Political contexts:** Consideration of place-based political drivers is significant. The literature clearly points to change in political environments (such as policy change or insecure funding) as a significant factor influencing program outcomes. Political decisions were often seen as a significant barrier to the implementation of strategies that tackled health inequalities.

- **Implementation and outcome factors**: The literature identified infrequent reporting on implementation activities, and it was often unclear how the activities delineated in place-based approaches were delivered on the ground. There is a need for robust implementation measures to ensure fidelity of program activities against the frameworks postulated during planning; the opposite may result in the deviation of a program's outcomes from its goals. Additionally, the literature acknowledged demonstrating effectiveness of place-based approaches is challenging to varied, external confounding factors, the breadth of place-based interventions and varied quality of evaluations. Overarchingly, value was demonstrated in well-designed, well-funded place-based interventions.

The literature indicates that, when developed properly, place-based approaches can be an effective strategy positively influencing health outcomes or health related behaviours in populations of locational disadvantage.

Considerations for different disciplines

This section focuses on the third research question, which is: "Are there different strategies that are more suited to different disciplines in attracting health professionals to rural health roles?" While the broader research outlined above identifies a range of strategies across the broad healthcare workforce, there are some important and specific differences within each health discipline. The following section calls out key strategies that are specific to certain health disciplines and discusses how approaches can be best tailored to meet the differing discipline specific contexts. This section considers discipline-specific strategies for addressing rural and remote health workforce improvement across the following disciplines:

- Medical

- Nursing

- Allied Health

- Dentistry

- Aboriginal and Torres Strait Islander Health Practitioners and Workers.

Discipline-specific strategies that have been identified in the literature scan are discussed below.

Medical

The broader literature outlined above is largely supported by an evidence base made up predominantly of strategies that have been applied and evaluated to the medical profession. To that end, all strategies that are mentioned above are applicable to the rural and remote medical workforce with no additional, discipline-specific strategies having been identified.

Nursing

As with the medical discipline above, no additional strategies have been identified in this literature scan that are specifically unique to the nursing context. The most recent review of the literature on effective strategies to support the rural and remote nursing health workforce was an umbrella review of the literature in 2013 (68). Strategies identified that are specific to nursing have been called out above in the broader scan of contemporary best practice strategies for improving the rural health workforce.

Allied Health

Implications for the RHWSA program:

Like the integrated medical workforce pipeline approach discussed previously, there is a need for a clear, accessible pathway for rural allied health training and qualification. This pipeline should include prioritisation of rural-background applicants, modified curriculum and training for rural contexts, and additional scholarship and bridging opportunities to support the transition between secondary and technical training facilities. Once qualified, to aid recruitment and retention of rural allied health practitioners, there is a need to clearly define the distinct scope of practice for the breadth of allied health practitioners' service in rural and remote regions. To support viable practice, recruitment of both junior and senior allied health practitioners will facilitate growth in the allied health practitioner base whilst also supporting opportunities for regional traineeships, mentoring and career progression. Finally, there should be consideration for how multidisciplinary teams of health professionals can be best coordinated throughout regions of priority catchment areas. Investment in allied health should occur in parallel with improvements in service coordination, including mapping locally based services against corresponding outreach and telehealth services.

Supply of the allied health workforce in rural and remote communities is a persistent challenge with shortages leaving communities less able to receive appropriate health care (49; 41; 69). To date, the focus of investment in rural health workforce recruitment and retention has primarily been in the medical profession (69). Increasingly, it is recognised that strategies addressing the access, distribution and quality of the allied health workforce in rural and remote communities is a key consideration for improving health outcomes of these communities. Many barriers prevent recruitment of students to allied health tertiary studies in rural and remote communities, namely secondary education disadvantage, excessive financial burden, social isolation and separation from family, inadequate administrative support, and discouragement due to the cumulative commitment involved (69). Based on the evidence to date, there are a few key strategies that have been suggested to positively influence the access, distribution and quality of the rural and remote allied health workforce. These strategies are not dissimilar to those suggested above, however, they must be modified to specifically address allied health workforce issues.

Based on a comprehensive literature review recently completed by the Department of Health's National Rural Health Commissioner (2020), a number of strategies have been identified as crucial for supporting the recruitment and long-term retention of allied health practitioners to rural and remote communities (41). The strategies recommended in this report are presented thematically below.

Education and training strategies

- There is a need for a clear, accessible pathway to rural allied health training for students from rural backgrounds, and the concept of the rural workforce pipeline model has been suggested as one method of enhancing the recruitment and retention of allied health professionals to these regions.

- A workforce pathway or pipeline approach has already been discussed above, however briefly here: rural students are attracted to allied health practitioner training roles, linked with rural training pathways and local mentors and provided with additional scholarship and bridging opportunities to support transition between secondary and technical training facilities. Focus should be placed on selecting the student who chooses to participate in rural training as opposed to bonded pathway approaches which have demonstrated limited effectiveness on retention.

- Additionally, developing rural-specific allied health curriculums which address context specific workforce and service needs has been proposed as another approach to support the allied health workforce. Evidence indicates that high-quality allied health training can be delivered beyond metropolitan hospital settings, including in regional community and primary health centres. Mixed placement opportunity in both regional and primary care facilities improves the distribution of allied health practitioners compared to hospital placement alone.

- Micro-credentialing – the process where other health workers gain targeted allied health qualifications – has been proposed as another strategy to improve access to allied health services. Key to this is ensuring these roles remain flexible and can be adaptable to both context (rural and remote) and discipline (private or public practice).

Enhanced Scope of Practice

- Once qualified, rural allied health practitioners work across a broad remit of practice, large geographies, multiple communities and require a broad range of skills and knowledge. Similar to the medical profession, allied health practitioners in rural and remote communities have fewer resources, higher patient volumes with more complex health concerns and more limited health facilities than their urban counterparts. For this reason, strategies which clarify the distinct scope of practice for the breadth of allied health practitioner services in rural and remote regions has been suggested. Agreeing on rural allied health practitioners' key credentials, training, disciplines, skillsets and scope may aid retention in rural and remote allied health services (41).

Growth and viable practice models

- Improving the rural health workforce invariably requires growth in the number of practicing allied health practitioners. It is recommended that this growth is accompanied by the recruitment of more senior allied health practitioners and supported by viable practice models. Recruiting senior allied health practitioners provides two-fold benefits of increased potential for regional trainee supervision and an obvious career progression pathway for junior allied health practitioners.

- Growth in the primary health service base should be accompanied by viable practice models which are critical for attracting and retaining private providers.

- Additionally, both public and private sectors could improve onboarding processes, facilitate more role autonomy and support sector growth through the inclusion of more salaried roles.

- To support tailored responses to individual need, bundled retention incentives are recommended for rural and remote allied health practitioner care.

Improved service co-ordination

- There are many private and public agencies operating in the allied health space often working towards complex and differing agendas. Improving service coordination through regional level planning of allied health teams around priority catchment areas has been suggested as one way to support the rural and remote allied health workforce. Networked services operate best when they have clear eligibility and referral pathways whilst remaining flexible to the varied practice models in both the public and private spheres.

- Patient centred planning provides one useful framework for mapping services that can be provided locally complemented with extended services that can be provided through outreach and telehealth avenues. When utilising outreach and telehealth services to implement allied health care plans, consideration must be given to the capacity and capability of local staff to support these extended services. When leveraged effectively, outreach programs have the potential to be expanded to specifically address service coordination roles that support multidisciplinary allied health teams.

Dentistry

Implications for the RHWSA program:

As with other disciplines, facilitation of the recruitment and retention of rurally oriented dentists is best supported through the recruitment of rural background students and the delivery of dental clinical rotations in rural settings.

Dentists are a critical group of health workforce professionals with oral diseases being a major health problem, particularly for those in disadvantaged populations (41). Despite this, there is limited evidence of effective strategies that support the recruitment and retention of dental professionals into rural and remote communities (70). However, some literature has sought to assess the impact of interventions targeting the retention of dental professionals in rural and remote areas with a focus on rural exposure strategies. Suphanchaimat et al. (2016) identified two strategies that have demonstrated evidence of effectiveness in the dental workforce including:

- Recruitment of students from a rural background,

- Implementation of dental clinical rotations in rural areas.

Through rural exposure strategies, students are more attuned to the oral health needs of disadvantaged populations and improve their clinical knowledge and skills (70). One meta-analysis concluded dental students exposed to rural practice had a fourfold higher chance of proceeding or intending to return to serve in rural communities compared to those who were not exposed (70). Further evidence for dental specific strategies to improve the rural and remote dental workforce is limited and more research is needed to determine the effectiveness of other interventions in the dental context.

Aboriginal and Torres Strait Islander Health

Implications for the RHWSA program:

Students who undertake well-supported placements with good supervision in rural and remote Aboriginal communities are more likely to return to work in these communities once qualified. Best practice would see inclusiveness and cultural safety training built into the pathway and support provided from culturally competent human resource practices and strong leadership. Appropriate interpersonal support for skilled non-Aboriginal health clinicians and workers needs to be provided, and this can be facilitated through specific mentorship programs that link non-Aboriginal workers to qualified Aboriginal and Torres Strait Islander mentors. These programs bolster both clinical and cultural skills of the health worker and provide them with a link to community. Additionally, service delivery models should draw on the skills mix of multidisciplinary teams and identify the appropriate capability and knowledge needed by health workers to address the unique, complex healthcare needs of these communities.

Aboriginal and Torres Strait Islander people make up a small proportion of the health workforce and face additional, significant challenges with entering and remaining in the health workforce (50). Currently, there are not enough

appropriately skilled and qualified clinicians to meet the needs of Aboriginal people in rural and remote communities and, of those with the technical skills, their cultural competence is variable (50). Current distribution of appropriately qualified Aboriginal Health Workers (AHWs) is uneven and, coupled with the ageing demographic of this workforce, creates a need for strategies that address health workforce factors and are sensitive to the unique Australian Aboriginal and Torres Strait Islander culture, context and history.

Gwynne & Lincoln (2017) completed a systematic review examining effective strategies across four broad categories for developing the Australian Aboriginal and Torres Strait Islander health workforce. The strategies outlined in their systematic review are presented thematically below.

Education and training pathways

- Aboriginal and Torres Strait Islander people in the health workforce are more likely to face additional challenges of racism, stress, isolation from family, poorer education and additional family responsibilities compared to their non-Indigenous counterparts. Experiences during training will likely impact engagement with education, training and future employment. One strategy to support the increased representation of AHWs is through the use of explicit training pathways which systematically address and overcome the unique barriers faced by Aboriginal and Torres Strait Islander people in gaining or upgrading their qualifications

- Best practice would see inclusiveness and cultural safety training built into this pathway which is supported by culturally competent HR practices and strong leadership. As with other strategies put forward in this literature scan, independent evaluation of this approach is needed to determine effectiveness.

Student placement

- Student placements in rural and remote communities will positively influence learning, providing graduates with increased cultural competence. Consistent with the broader literature, students who undertake well-supported placements with good supervision in rural and remote Aboriginal communities are more likely to return to work in these communities once qualified. Such placements may positively contribute to the rural and remote health workforce supply over time, although more robust evaluation is needed.

Non-Aboriginal health workforce in Aboriginal health

- Effectiveness and retention of the non-Aboriginal workforce who work in Aboriginal health needs to be supported through appropriate longevity strategies. The literature emphasises the importance of providing appropriate interpersonal support to skilled health clinicians and workers in order to improve the availability of Aboriginal health services in rural and remote Australia. This can occur from the outset with careful job design and recruitment strategies employing appropriate non-Aboriginal health workers with the relevant clinical experience, skills and qualifications.

- Best practice would see the provision of ongoing and timely access to learning and professional development, supervision and peer support. The literature indicates that non-Aboriginal health workers should be given specific mentorship by an appropriately trained Aboriginal mentor who is able to provide both clinical and cultural support, linking non-Aboriginal health workers with the Aboriginal and Torres Strait Islander community. More

robust evaluations of tailored strategies to support non-Aboriginal health workers to continue working in Aboriginal and Torres Strait Islander communities is needed to determine effectiveness.

Service delivery models

- To effectively implement and deliver health care services in rural and remote Aboriginal communities, the literatures emphasises the need for collaborative care-based models that draw upon the skills mix of multidisciplinary teams, Central to this service model is an in-depth understanding of the target group and the attitudes and behaviours of the workforce towards this group.

- To support these service models, the design and delivery of service training needs to target both the health worker, through specific skills and knowledge related to rural and remote Aboriginal health work, as well as the key characteristics of the target patient group. Understanding the unique healthcare needs of the target community will inform the appropriate health worker skills mix and service delivery models required to effectively provide healthcare services to Aboriginal people. Robust evaluations of various service delivery models are required to determine the most effective model for these types of rural and remote communities.

Appendix 4: List of stakeholders consulted

The table below details the stakeholder consultations which were completed during the review.

Table 21: Stakeholder consultations

No.	Stakeholder Group	Stakeholder	Date
1	RWA	HR+	19/06/2020
2		Rural Doctors Workforce Agency	23/06/2020
3		Health Workforce Queensland	29/06/2020
4		New South Wales Rural Doctors Network	30/06/2020
5		Rural Workforce Agency Victoria	30/06/2020
6		Rural Health West	1/07/2020
7		Northern Territory Primary Health Network	1/07/2020
8	RHWA	RHWA	26/06/2020
9	RWAN Chair	RWAN Chair	4/08/2020
10	RTOs	Western Australian General Practice Education and Training	29/07/2020
11		General Practice Training Tasmania	4/08/2020
12		GP Synergy	4/08/2020
13		Northern Territory General Practice Education	10/08/2020
14		GPEx	10/08/2020
15		General Practice Training Queensland	21/08/2020
16		James Cook University	31/08/2020
17		Eastern Victoria GP Training	28/08/2020
18	Commonwealth Government	Department of Health	31/08/2020

No.	Stakeholder Group	Stakeholder	Date
19		Country WA PHN	5/08/2020
20		Country SA PHN	6/08/2020
21		Tasmania PHN (Primary Health Tasmania)	6/08/2020
22		Darling Downs and West Moreton PHN	24/08/2020
23	PHNs	Western Queensland PHN	24/08/2020
24		Central Queensland, Wide Bay, Sunshine Coast PHN	28/08/2020
25		Northern Queensland PHN	24/08/2020
26		Gippsland PHN	1/09/2020
27		Hunter New England PHN	28/08/2020
28		CheckUp Australia	6/08/2020
29	RHOF Fundholders	Tasmanian Department of Health and Human Services (TazReach)	18/08/2020
30		NT Department of Health	26/08/2020
31		Australian College of Rural and Remote Medicine	18/08/2020
32	Specialist Training Pathway Providers	The Royal Australian College of General Practitioners	21/08/2020
33		The Royal Australasian College of Physicians	20/08/2020
34		The Rural Clinical School of Western Australia	14/08/2020
35		University of Tasmania – Rural Clinical School	17/08/2020
36	RCSs	Faculty of Medicine, The University of Queensland - Rural Clinical School	18/08/2020
37		NSW Rural Clinical School	21/08/2020
38		Flinders University Rural Clinical School	25/08/2020

No.	Stakeholder Group	Stakeholder	Date
39		Deakin Rural Clinical School	24/08/2020
40		Adelaide Rural Clinical School, University of Adelaide	25/08/2020
41		Charles Darwin University	26/08/2020
42	Aboriginal and Torres Strait Islander State Peak Bodies	Aboriginal Medical Services Alliance Northern Territory	5/08/2020
43		Victorian Aboriginal Community Controlled Health Organisation	24/08/2020
44		Aboriginal Health Council of Western Australia	26/08/2020
45		Rural Doctors Association Australia	3/08/2020
46		Australian Medical Association	11/08/2020
47	Other	Royal Flying Doctor Service	17/08/2020
48		CRANAplus	18/08/2020
49		Remote Vocational Training Scheme	24/08/2020

Source: KPMG, 2020

Appendix 5: Stakeholder consultation questions

The detailed consultation guides for the stakeholder consultations are provided below. Detailed consultation guides were developed for each stakeholder group.

RWAs

Program Delivery

1. **Can you please provide an overview of how the RHWSA program is delivered within your jurisdiction?**

   – Can you please describe the planning process to determine local need? What data do you use to inform this planning process? What stakeholder engagement do you undertake to support the planning process? How is the planning process communicated outside the organisation? To what extent do the operations of other rural workforce programs inform your planning?

2. **To what extent does the RHWSA program meet an identified need in your jurisdiction?**

   – Are there any program activities which you have adapted to support achieving the program aims within your jurisdiction?

   – Do other organisations operate in your jurisdiction which deliver a similar service or meet a similar need?

3. **Since implementing the program, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in your jurisdiction?**

   – Can you please provide an overview of the performance of your organisation with implementing the program?

   – Which element (i.e. access, quality and sustainability) has supported greatest improvement in your jurisdiction to date?

   – Have there been any tools provided to your organisation that have supported implementation of activities within the program?

   – Have you implemented any activities which you do not think were effective in improving workforce access, quality or sustainability?

   – Are there any jurisdictional factors that impact (positively or negatively) on the ability for your organisation to implement the program?

     - Are there any barriers/challenges you have faced with implementing the program?

     - Are there any enablers which have supported you implementing the program?

   – Is there overlap in the delivery of the activities within the elements? Do you find the outcomes of the three elements distinct?

   – How could the structure of the program be made more efficient?

Stakeholder Engagement

4   Can you please provide an overview of how your organisation engages with the local community and the rural health workforce?

– Does your organisation engage with any other stakeholders in the delivery of the program?

– Do you deliver any services in collaboration with other organisations? Are there opportunities to strengthen stakeholder engagement in the future?

– Are there opportunities for stakeholders to provide feedback on activities completed in the program? If so, can you please explain what mechanisms (e.g. annual survey) stakeholders can use to provide feedback? *Following the workshop, KPMG will send through a data request for formal feedback received from stakeholders.*

– What support do you receive from Rural Health Workforce Australia in the delivery of the program?

Program Administration

5   Can you please explain the reporting requirements for the program?

– Do you find the performance reporting sufficiently captures your progress in implementing the program?

– How long does the performance reporting take you to complete? Is there overlap in the information you are required to report on separately for the three elements (i.e. access, quality and sustainability)?

– Would there be any changes you would like to see in the future with regards to performance reporting or other reporting requirements with the program?

– What has been your experience with communicating with the Department of Health during the program?

6   Can you please describe how funding is allocated to each activity?

– Is the funding appropriate for each element (i.e. access, quality and sustainability) to support achievement of the program objectives?

– How does the cost of implementing the program differ between the three elements (i.e. access, quality and sustainability)?

– Do you have any suggestions for improving the approach for funding the program?

Future Design

7   Are there any opportunities for improvement in the design of the program?

– Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

– Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

RHWA

Program Delivery

1   Can you please describe the involvement of your organisation in the delivery of the RHWSA program?

  – What support does your organisation provide the RWAs in the delivery of the program?

  – Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2   To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?

  – Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

3   Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in rural, regional and remote Australia?

  – Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

    - Are you aware of any barriers/challenges that have been faced with implementing the program?

    - Are you aware of any enablers which have supported implementing the program?

  – How could the structure of the program be made more efficient?

Stakeholder Engagement

4   Can you please provide an overview of any engagement you have had with stakeholders during the program?

  – Does your organisation complete any stakeholder engagement in collaboration with the RWAs?

  – Are there opportunities to strengthen stakeholder engagement in the future?

Program Administration

5   Can you please provide an overview of any support or information provided to the RWAs to assist with RHWSA program reporting?

  – Do you have any performance reporting requirements to capture your progress within the RHWSA program?

    - If yes, can you please outline these requirements? How long does this reporting take to complete?

  – How is RHWA funded to support the program? What activities do you complete with this funding?

Future Design

6   Are there any opportunities for improvement in the design of the program?

–   Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

–   Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

RWAN Chair

Program Delivery

1   Can you please provide an overview of how the RHWSA program is delivered by the RWAs?

–   What is the role of the RWAN Chair in supporting the delivery of the program?

2   To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?

–   Are you aware of any program activities which RWAs have adapted to support achieving the program aims within their jurisdiction?

–   Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

–   How could the effectiveness of the program be improved?

3   Since implementing the program, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in rural, regional and remote Australia?

–   What has been your perception of the RWA's experiences with implementing the program?

   -   Are you aware of any barriers/challenges RWAs have faced with implementing the program?

   -   Are you aware of any enablers which have supported RWAs in implementing the program?

–   Which element (i.e. access, quality and sustainability) has supported greatest improvements across RWAs to date?

–   Are you aware of any tools provided to RWAs that have supported implementation of activities within the program?

–   Have RWAs implemented any activities which you do not think were effective in improving workforce access, quality or sustainability? If not, why not?

–   Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability of RWAs to implement the program?

– Is there overlap in the delivery of the activities within the elements? Do you find the outcomes of the three elements distinct?

– How could the structure of the program be made more efficient?

Stakeholder Engagement

4 **Can you please provide an overview of how RWAs engage with the local community and the rural health workforce?**

– Are you aware of RWAs engaging with any other stakeholders in the delivery of the program?

– Are there opportunities to strengthen stakeholder engagement in the future?

– What support do you receive from Rural Health Workforce Australia in the delivery of the program?

Program Administration

5 **Can you please provide an overview of the reporting requirements for the program?**

– Do you find the performance reporting sufficiently captures the RWAs' progress in implementing the program?

– Do you know how long the performance reporting takes RWAs to complete? Is there overlap in the information they are required to report on separately for the three elements (i.e. access, quality and sustainability)?

– Would there be any changes you would like to see in the future with regards to performance reporting or other reporting requirements with the program?

– What has been your experience with communicating with the Department of Health during the program? Are there opportunities for the RWAs or yourself to provide feedback on the program to the Department of Health?

6 **Can you describe how funding is allocated to each activity?**

– Is the funding appropriate for each element (i.e. access, quality and sustainability) to support achievement of the program objectives?

– How does the cost of implementing the program differ between the three elements (i.e. access, quality and sustainability)?

– Do you have any suggestions for improving the approach for funding the program?

Future Design

7   **Are there any opportunities for improvement in the design of the program?**

– Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

– Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Regional Training Organisations

Program Delivery

1   **Can you please describe the involvement of your organisation in the delivery of the RHWSA program?**

– What support does your organisation provide the RWAs in the delivery of the program?

– Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2   **To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?**

– Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

3   **Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in your jurisdiction?**

– Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

- Are you aware of any barriers/challenges that have been faced with implementing the program?

- Are you aware of any enablers which have supported implementing the program?

– How could the structure of the program be made more efficient?

Stakeholder Engagement

4   **Can you please provide an overview of any engagement you have had with stakeholders during the program?**

– Does your organisation complete any stakeholder engagement in collaboration with the RWAs?

– Are there opportunities to strengthen stakeholder engagement in the future?

– Are there opportunities for stakeholders to provide feedback on training completed in the program? If so, can you please explain what mechanisms (e.g. annual survey) stakeholders can use to provide feedback? *Following the workshop, KPMG will send through a data request for formal feedback received from stakeholders.*

Future Design

5   Are there any opportunities for improvement in the design of the program?

–   Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

–   Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Primary Health Networks

Program Delivery

1   Can you please describe the involvement of your organisation in the delivery of the RHWSA program?

–   What support does your organisation provide the RWAs in the delivery of the program?

–   Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2   To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in your jurisdiction?

–   Does your organisation deliver a similar service or meet a similar need in your jurisdiction to the RHWSA program?

–   Do you collaborate or work on any joint initiatives and / or co-design activities with the RWAs?

–   Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

3   Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in your jurisdiction?

–   Which activities or elements in the program (i.e. access, quality or sustainability) in the program have supported greatest improvement in your jurisdiction to date?

–   Are there any activities in the program which you do not think were effective in improving workforce access, quality or sustainability?

–   Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

   -   Are you aware of any barriers/challenges that have been faced with implementing the program?

   -   Are you aware of any enablers which have supported implementing the program?

–   How could the structure of the program be made more efficient?

Stakeholder Engagement

4 **Can you please provide an overview of any engagement you have had with stakeholders during the program?**

    – Do you deliver any services or complete any stakeholder engagement in collaboration with the RWAs?

    – Are there opportunities to strengthen stakeholder engagement in the future?

Future Design

5 **Are there any opportunities for improvement in the design of the program?**

    – Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

    – Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Rural Health Outreach Fund Fundholders

Program Delivery

1 **Can you please describe the involvement of your organisation in the delivery of the RHWSA program?**

    – What support does your organisation provide the RWAs in the delivery of the program?

    – Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2 **To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?**

    – Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

    – Are there any areas of need that are not currently being met by the program, which you believe should be included in the program?

3 **Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in your jurisdiction?**

    – Which activities or elements in the program (i.e. access, quality or sustainability) in the program have supported greatest improvement in your jurisdiction to date?

    – Are there any activities in the program which you do not think were effective in improving workforce access, quality or sustainability?

    – Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

- Are you aware of any barriers/challenges that have been faced with implementing the program?

- Are you aware of any enablers which have supported implementing the program?

- How could the structure of the program be made more efficient?

Stakeholder Engagement

4 Can you please provide an overview of any engagement you have had with stakeholders during the program?

- Does your organisation complete any stakeholder engagement in collaboration with the RWAs?

- Are there opportunities to strengthen stakeholder engagement in the future?

Future Design

5 Are there any opportunities for improvement in the design of the program?

- Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

- Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Specialist Training Pathway Providers

Program Delivery

1 Can you please describe the involvement of your organisation in the delivery of the RHWSA program?

- What support does your organisation provide the RWAs in the delivery of the program?

- Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2 To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?

- Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

3 Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in rural, regional and remote Australia?

- Which activities or elements in the program (i.e. access, quality or sustainability) in the program have supported greatest improvement in rural, regional and remote Australia to date?

- Are there any activities in the program which you do not think were effective in improving workforce access, quality or sustainability?

- Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

  - Are you aware of any barriers/challenges that have been faced with implementing the program?

  - Are you aware of any enablers which have supported implementing the program?

- How could the structure of the program be made more efficient?

Stakeholder Engagement

4   Can you please provide an overview of any engagement you have had with stakeholders during the program?

- Does your organisation complete any stakeholder engagement in collaboration with the RWAs?

- Are there opportunities to strengthen stakeholder engagement in the future?

Future Design

5   Are there any opportunities for improvement in the design of the program?

- Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

- Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Rural Clinical Schools

Program Delivery

1   Can you please describe the involvement of your organisation in the delivery of the RHWSA program?

- What support does your organisation provide the RWAs in the delivery of the program?

- Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2   To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?

- Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

3   Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in your jurisdiction?

- Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

- Are you aware of any barriers/challenges that have been faced with implementing the program?

- Are you aware of any enablers which have supported implementing the program?

– How could the structure of the program be made more efficient?

Stakeholder Engagement

4 Can you please provide an overview of any engagement you have had with stakeholders during the program?

– Does your organisation complete any stakeholder engagement in collaboration with the RWAs?

– Are there opportunities to strengthen stakeholder engagement in the future?

– Are there opportunities for stakeholders to provide feedback on training completed in the program? If so, can you please explain what mechanisms (e.g. annual survey) stakeholders can use to provide feedback? *Following the workshop, KPMG will send through a data request for formal feedback received from stakeholders.*

Future Design

5 Are there any opportunities for improvement in the design of the program?

– Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

– Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Aboriginal and Torres Strait Islander Health Peak Bodies

Program Delivery

1 Can you please describe the involvement of your organisation in the delivery of the RHWSA program?

– What support does your organisation provide the RWAs in the delivery of the program?

– Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2 To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in your jurisdiction?

– Does your organisation deliver a similar service or meet a similar need in your jurisdiction to the RHWSA program?

– Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

– What role do you see the RWAs have with building a local workforce in rural, regional and remote Australia that is culturally appropriate?

- Have the health workforce in your jurisdiction completed training through the RHWSA program to support culturally appropriate health care? Have you seen any impacts on the care provided to the community?

- What role do you see the RWAs have with developing the Indigenous health workforce in rural, regional and remote Australia?

3 Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the Indigenous health workforce in your jurisdiction?

- What changes have you seen for Aboriginal Health Practitioners and Aboriginal Health Workers in your jurisdiction?

- Have you seen a change in the number of Aboriginal Health Practitioners and Aboriginal Health Workers in rural, regional and remote areas in your jurisdiction?

- Have you seen a change in the retention rate of Aboriginal Health Practitioners and Aboriginal Health Workers in rural, regional and remote areas in your jurisdiction?

- Have the Indigenous health workforce in your jurisdiction been provided with development opportunities through the program?

- Which activities or elements in the program (i.e. access, quality or sustainability) in the program have supported greatest improvement in your jurisdiction to date?

- Are there any activities in the program which you do not think were effective in improving workforce access, quality or sustainability?

- How could the structure of the program be made more efficient?

Stakeholder Engagement

4 Can you please provide an overview of any engagement you have had with stakeholders during the program?

- Do you complete any stakeholder engagement in collaboration with the RWAs?

- Have you received any feedback from participants in the RHWSA program?

- Are there opportunities to strengthen stakeholder engagement for the RHWSA program in the future?

Future Design

5 Are there any opportunities for improvement in the design of the program?

- Are there any contextual factors that should be considered in the design of the program moving forward (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)?

- Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

The Department of Health, Rural Distribution Section

Program Design

1   Can you please describe how the RHWSA program was designed?

–   What are the outcomes sought by the government in designing and funding the program?

–   To what extent did the operations of other national rural health workforce programs inform planning of the RHWSA program?

–   Can you please provide an overview of the stakeholder engagement that was undertaken to inform the RHWSA program design?

–   What data did you use to inform the program design?

–   Can you please provide an overview of any changes in the program design since it was implemented in 2017?

Program Delivery

2   Can you please provide an overview of how the RHWSA program is delivered nationally?

–   What has been your experience of implementing the program nationally? Are there any factors that impact (positively or negatively) on the ability of the Department to implement the program at a national level?

-   Are there any key barriers/challenges the Department has faced with implementing the program?

-   Are there any key enablers which have supported the Department in implementing the program?

3   To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?

–   Can you identify any overlaps in service delivery with other State and Territory funded Rural Health Workforce programs?

4   Since implementing the program, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in rural, regional and remote Australia?

–   Can you please provide an overview of the performance of the program against its objectives?

–   Which element (i.e. access, quality and sustainability) has supported greatest improvement in rural, regional and remote Australia to date? Which element (i.e. access, quality and sustainability) has demonstrated least improvement to date nationally?

–   Are you aware of any activities which have not been effective in improving workforce access, quality or sustainability?

- What activities does the Department undertake to support the delivery of the program? Have there been any tools provided by the Department to jurisdictional RWAs that have supported implementation of activities within the program?

- Is there any overlap in the delivery of the activities within the elements?

- How could the structure of the program be made more efficient?

5 **Are you aware of any factors that impact (positively or negatively) on the ability of the RWAs to implement the program?**

- Are there any significant differences between the jurisdictions in implementing activities within the program or in achieving the outcomes of the program?

- Are you aware of any program activities which needed to be adapted or modified to support achieving the program aims within particular jurisdictions?

Stakeholder Engagement

6 **Are there opportunities for stakeholders (e.g. RWAs) to provide feedback on the program?**

- How does the Department engage with its stakeholders in the delivery of the program?

- Can you identify any opportunities to strengthen stakeholder engagement in the future?

Program Administration

7 **Can you please provide an overview of the governance of the program?**

- Do you find the performance reporting sufficiently captures RWAs progress in implementing the program?

- Can you please outline the process if an RWA does not meet expectations (e.g. reporting requirements, performance expectations)?

- Would there be any changes you would like to see in the future with regards to program governance?

8 **Can you please describe how funding is allocated to each RWA?**

- How do you determine the level of funding that each RWA receives?

- How is the funding breakdown for each element (i.e. access, quality and sustainability) determined?

- How does the cost of implementing the program differ between the three elements nationally (i.e. access, quality and sustainability)?

- What is the process when the funding allocation for an RWA does not align with the allocation requirements for the three funding streams (i.e. operational funds, program delivery, and grants and incentives)?

- Do you have any suggestions for improving the approach for funding the program at a national level?

Future Design

9   Are there any opportunities for improvement in the design of the program?

–   Are there any contextual factors that should be considered in the design of the program moving forward? (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)

–   Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Other Stakeholders

Program Delivery

1   Can you please describe the involvement of your organisation in the delivery of the RHWSA program?

–   What support does your organisation provide the RWAs in the delivery of the program?

–   Is your organisation involved in the planning process to determine local need? Does your organisation undertake any stakeholder engagement to support the planning process?

2   To what extent does the RHWSA program meet an identified need for the primary and preventive health workforce in rural, regional and remote Australia?

–   Are you aware of any organisations or programs which deliver a similar service or meet a similar need to the RHWSA program?

3   Since the program was implemented in 2017, what changes, if any, have you seen for workforce access, quality and sustainability for the primary and preventive health workforce in in rural, regional and remote Australia?

–   Are you aware of any jurisdictional factors that impact (positively or negatively) on the ability for the program to be implemented?

-    Are you aware of any barriers/challenges that have been faced with implementing the program?

-    Are you aware of any enablers which have supported implementing the program?

–   How could the structure of the program be made more efficient?

Stakeholder Engagement

4   Can you please provide an overview of any engagement you have had with stakeholders during the program?

–   Does your organisation complete any stakeholder engagement in collaboration with the RWAs?

–   Are there opportunities to strengthen stakeholder engagement in the future?

Future Design

5   Are there any opportunities for improvement in the design of the program?

– Are there any contextual factors that should be considered in the design of the program moving forward? (e.g. large scale reforms impacting the rural health workforce or response to changing geographic priorities)

– Can you think of any changes to the design of the program that could improve its effectiveness in meeting the aims of the program?

Appendix 6: Key stakeholder groups

A description of the key stakeholders is provided below, including a description of their role in supporting the delivery of the program. This was informed from a desktop review and the stakeholder consultations.

RWAN Chair

The RWAN Chair has the role of chairing frequent meetings with the RWA Chief Executive Officers. Through stakeholder consultations, it was identified that the RWAN provides a forum for jurisdictional RWAs to discuss broader policy issues related to the national rural and remote health agenda. In this sense, the RWAN Chair oversees the consortium's business nationally and brings seven jurisdictional voices together.

The RWAN Chair represents the RWAs through the following activities:

- National representation: including participating in conversations with jurisdictional RWAs, facilitating a discussion of issues for the RWAN and communicating with the Department.

- Sector representation: including representing RWAs in national conversations (e.g. with national organisations such as Services for Australian Rural and Remote Allied Health, Indigenous Allied Health Australia) or through forums such as the National Rural Health Alliance.

RHWA

The RWAs are required to sub-contract RHWA, which is designated as the national peak body representing the RWAs. RHWA is to provide national representation, coordination and administration for the RWA network, including facilitating consistency across guidelines, policies and reporting. RWAs are required to provide at least two per cent of funding from each element toward funding national representation and coordination, which is allocated to the Program Delivery funding stream (2).

The RHWA represents the RWAs in all three program elements on the following activities:

- National coordination and information dissemination: includes providing quarterly reports to RWAs on the national policy agenda and emerging trends in the rural health workforce, consolidating AWPs and HWNAs to provide national stakeholders with reports on national achievements, priorities and strategies for future work and emerging rural workforce issues.

- National representation: includes collecting input from RWAs, participating and presenting a consolidated position of the RWAs at national forums and events, and reporting back to the RWAs on the discussions held.

- Sector consultation and input: includes engaging with national peak workforce groups and bodies to discuss RWAs' priorities, strategies and successes, and consulting with the sector (RWAs) and providing consolidated input to the Department and other stakeholders.[19]

RTOs

RTOs deliver GP fellowship education and training within geographically defined training regions throughout Australia. These agencies are funded by the Department to deliver the Australian General Practice Training program, training medical registrars through to GPs. Currently, there are 10 accredited RTOs throughout 11 regional training regions, positioning them to provide different learning opportunities based on the unique needs of the communities in their training region (71, 72).

The RWAs are required to include representatives from the RTOs in the HWSG (2).

PHNs

The key objectives for the PHNs are to increase the efficiency and effectiveness of medical services for patients and improve the coordination and navigation of care. This is to support patients to receive appropriate care at the right place and time (5).

Additionally, through stakeholder consultations, it was identified that PHNs undertake their own extensive needs assessment process in order to determine the priorities for services to address identified need.

The RWAs are required to include representatives from the PHN in the HWSG (2).

RHOF fundholders

The RHOF aims to improve access for all Australians to medical services and healthcare professionals, regardless of where they choose to live. The RHOF targets service delivery under four priority areas, including chronic disease management, eye health, maternity and paediatric health, and mental health. Services outside these priorities may also be supported (73).

Fundholders are successful applicants contracted by the Department for the delivery of services under the RHOF. Fundholders are required to ensure administrative supports are in place for effective planning, maintenance and delivery of services through the RHOF in their jurisdiction. Fundholders are required to undertake a detailed needs assessment and planning in consultation with communities and local health organisations, including PHNs and jurisdictional Health Departments. Based on the outcomes of the planning, fundholders will develop proposals for service delivery and, once proposals are approved, fundholders are responsible for the delivery of services in accordance with the approved plans. To facilitate this, fundholders must work closely with local stakeholders to identify gaps or opportunities to integrate RHOF activities within pre-existing jurisdictional health service delivery (73).

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[19] As outlined in the Standard Funding Agreement Schedule for the Rural Health Workforce Activity with each RWA, for the period 1/07/2017 to 31/08/2020.

Additionally, through stakeholder consultations, it was identified that the types of programs administered by RHOF fundholders are varied and can include:

- Programs that support the delivery of allied health and specialist services in rural and remote areas

- Coordinating programs delivered by the National Disability Insurance Agency, in the aged-care sector and by non-government organisation service providers

- State level coordination of the specialist health workforce

- Upskilling opportunities for the local rural and remote health workforce

- Complimentary outreach primary health programs that sit alongside larger programs aimed at building permanent primary health care services in rural and remote regions (i.e. RHOF holders fill a gap in lieu of a permanent service).

The RWAs are required to include representatives from the RHOF fundholder in the HWSG (2). The RHOF fundholders are the same organisations as the RWAs in NSW, SA, VIC and WA (74).

Specialist Training Pathway Providers

The STP aims to expose specialist registrars to a wider range of healthcare settings by delivering vocational training beyond traditional metropolitan teaching hospitals. By extending training into expanded healthcare settings, including regional, rural, remote and private facilities, specialists are exposed to more diverse training opportunities facilitating a broadened educational experience. Through leveraging positive clinical training experiences in rural and remote regions, the STP also aims to positively influence future medical specialist workforce distribution (75).

Since 2018, the STP has been delivered through 13 specialist medical colleges (also referred to as Specialist Training Pathway Providers) under funding agreements with the Department (76). The Specialist Training Pathway Providers' role includes setting professional standards, accrediting training settings and national oversight and consistency to medical specialist training. Providers under the STP program are required to establish arrangements for trainee training (75).

The RWAs are required to include representatives from the Specialist Training Pathway Providers in the HWSG (2).

RCSs

RCSs deliver significant components of the medical curriculum in a rural environment. RCSs have a role in improving the strength of the rural health workforce and the range of clinical services offered. This includes encouraging medical students and professionals undertaking placements in RCSs to take up careers in a rural practice (77).

From stakeholder consultations, it was identified that the role of RCSs is centred around the supply of appropriately qualified rural and remote clinicians. They are less focused on workforce planning aspects and more embedded with the supply, education and training elements. RCSs seek to identify appropriate students for rural practice and then deliver the appropriate training pathways to support them remaining in these regions post-graduation.

The RWAs are required to include representatives from the RCSs in the HWSG (2).

Aboriginal and Torres Strait Islander Health State Peak Bodies

The National Aboriginal Community Controlled Health Organisation is the national peak body, with eight Affiliates (also referred to as Aboriginal and Torres Strait Islander Health State Peak Bodies) that represent each State and Territory (78).

The Aboriginal and Torres Strait Islander Health State Peak Bodies provide tailored support to Aboriginal Community Controlled Health Organisations in their jurisdictions to deliver sustainable high-quality, comprehensive and culturally appropriate health care. Additionally, Aboriginal and Torres Strait Islander Health State Peak Bodies have a role to represent the sector to government and the mainstream health sector (79).

Aboriginal Community Controlled Health Services are operated by the local Aboriginal community, through a locally elected Board of Management (80).

The RWAs are required to include representatives from the Aboriginal and Torres Strait Islander Health State Peak Bodies in the HWSG (2).

Rural health services and professionals

Activities in the three program elements are restricted to MM areas 2 – 7, except activities can be undertaken in MM1 for Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations. Each jurisdictional RWA nominates a list of eligible medical, nursing and allied health professionals who are eligible to receive funding and support under the RHWSA program. This list must be endorsed by the respective jurisdictional HWSG and included in the HWNA (2).

Appendix 7: Detailed data limitations

The table below outlines the data limitations for the review. The limitations have also been referred to throughout the report where appropriate.

Table 22: Detailed data limitations for the review

Number	Data type	Data source	Data limitations
1	Comparative program data	N/A	The data available to inform potential overlaps or synergies with other programs (e.g. the PHNs) was limited to qualitative information obtained from stakeholder interviews and publicly available data.
2	KPIs	The Department	The activity performance indicators were reported on differently by the RWAs, which impacted on the analysis and comparability of some of the indicators across the RWAs.
3	Costs per activity	The Department	The program reporting data did not provide a breakdown of the costs per activity, limiting the ability for a unit cost per activity to be determined. The financial analysis instead focused on the apportionment of costs at the RWA, program element and funding stream level.
4	Income and expenditure statements	The Department	Income and expenditure statements were not available for all RWAs for 2017-18 or 2019-20. The financial analysis focused on 2018-19.

Appendix 8: Document register

The table below provides a summary of the key documents used in the review.

Table 23: Document register

Document Type	Time Period	NSW	NT	QLD	SA	TAS	VIC	WA	Background Information
Health Workforce Needs Assessment Report (All Elements)	2017-18	Y	Y	Y	Y	Y	Y	Y	-
	2018-19	Y	Y	Y	Y	Y	Y	Y	-
	2019-20	Y	Y	Y	Y	Y	Y	Y	-
Needs Analysis Assessment	2018-19	Y	Y	Y	Y	Y	Y	Y	-
Activity Work Plan (All Elements)	2017-18	Y	Y	Y	Y	Y	Y	Y	-
	2018-19	Y	Y	Y	Y	Y	Y	Y	-
	2019-20	Y	Y	Y	Y	Y	Y	Y	-
Annual Report	2017-18	Y	Y	Y	Y	-	Y	Y	-
	2018-19	Y	Y	Y	Y	-	Y	Y	-
Income and Expenditure Report	2017-18	Y	Y	Y	Y	Y	-	Y	-
	2018-19	Y	Y	Y	Y	Y	Y	Y	-
	1/07/2018 - 31/12/2018	-	-	-	Y	-	Y	-	-
Performance Report - Access Element	2017-18	Y	Y	Y	Y	Y	-	Y	-
	2018-19	Y	Y	Y	Y	Y	-	Y	-
	1/07/2017 - 31/12/2017	Y	Y	Y	Y	Y	Y	Y	-
	1/01/2018 - 30/06/2018	-	-	-	-	-	Y	-	-

Document Type	Time Period	NSW	NT	QLD	SA	TAS	VIC	WA	Background Information
	1/07/2018 - 31/12/2018	Y	Y	Y	Y	Y	Y	Y	-
	1/01/2019 - 30/06/2019	-	-	-	-	-	Y	-	-
	1/07/2019 - 31/12/2019	Y	Y	Y	Y	Y	Y	Y	-
Performance Report - Quality Element	2017-18	Y	Y	Y	Y	Y	-	Y	-
	2018-19	Y	Y	Y	Y	Y	-	Y	-
	1/07/2017 - 31/12/2017	Y	Y	Y	Y	Y	-	-	-
	1/01/2018 - 30/06/2018	-	-	-	-	-	Y	-	-
	1/07/2018 - 31/12/2018	Y	Y	Y	Y	Y	Y	Y	-
	1/01/2019 - 30/06/2019	-	-	-	-	-	Y	-	-
	1/07/2019 - 31/12/2019	Y	Y	Y	Y	Y	Y	Y	-
Performance Report - Sustainability Element	2017-18	Y	Y	Y	Y	Y	-	Y	-
	2018-19	Y	Y	Y	Y	Y	-	Y	-
	1/07/2017 - 31/12/2017	Y	Y	Y	Y	Y	Y	Y	-
	1/01/2018 - 30/06/2018	-	-	-	-	-	Y	-	-
	1/07/2018 - 31/12/2018	Y	Y	Y	Y	Y	Y	Y	-

Document Type	Time Period	NSW	NT	QLD	SA	TAS	VIC	WA	Background Information
	1/01/2019 - 30/06/2019	-	-	-	-	-	Y	-	-
	1/07/2019 - 31/12/2019	Y	Y	Y	Y	Y	Y	Y	-
Standard Funding Agreement Schedule	1/07/2017 - 30/06/2020	Y	Y	Y	Y	Y	Y	Y	-
HWNA Terms of Reference	N/A	Y	Y	Y	Y	Y	Y	Y	-
RHWSA Operational Guidelines, Commencing from 2 January 2018	N/A	-	-	-	-	-	-	-	Y
Website links for RWAs on Australian Charities and Not-for-profits Commission	N/A	-	-	-	-	-	-	-	Y

Appendix 9: Reference List

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