



Evaluation and Investigative Study of the Queensland Rural Generalist Program

Queensland Health, Office of Rural and Remote Health

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Preface

The conduct of an evaluation of a program as complex and important as the Queensland Rural Generalist Program (QRGP) could not have been achieved without the support and commitment of a number of key stakeholders.

The study team would like to acknowledge the support extended by the following individuals throughout the conduct of the study:

- ▶ Ms Janette Jones, Manager Queensland Country Practice, Rural and Remote Support Unit, Darling Downs Hospital and Health Service
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- ▶ Dr Dan Manahan, Director Rural Generalist Training, Darling Downs Hospital and Health Service
- ▶ Ms Natalie Taylor, Cunningham Centre, Darling Downs Hospital and Health Service
- ▶ Mr Duncan Hill, Queensland Health.

The overall significance of the QRGP to the broader healthcare sector (particularly those stakeholders involved in planning and responding to medical workforce needs) was made clear to the study team via the written submissions. The study team wishes to acknowledge the time taken by these organisations and thank them for formally contributing to the overall evaluation.

Finally, the study team wishes to acknowledge the trainees, graduates and supervisors involved in the QRGP. The dedication of those involved and the passion with which individuals have embraced and supported the QRGP are key factors contributing to the overall success of the program. The study team sincerely thanks all involved in the giving of their time to complete surveys, availing themselves to participate in interviews and in offering insight into the experiences involved in participating in a rural medical training program.

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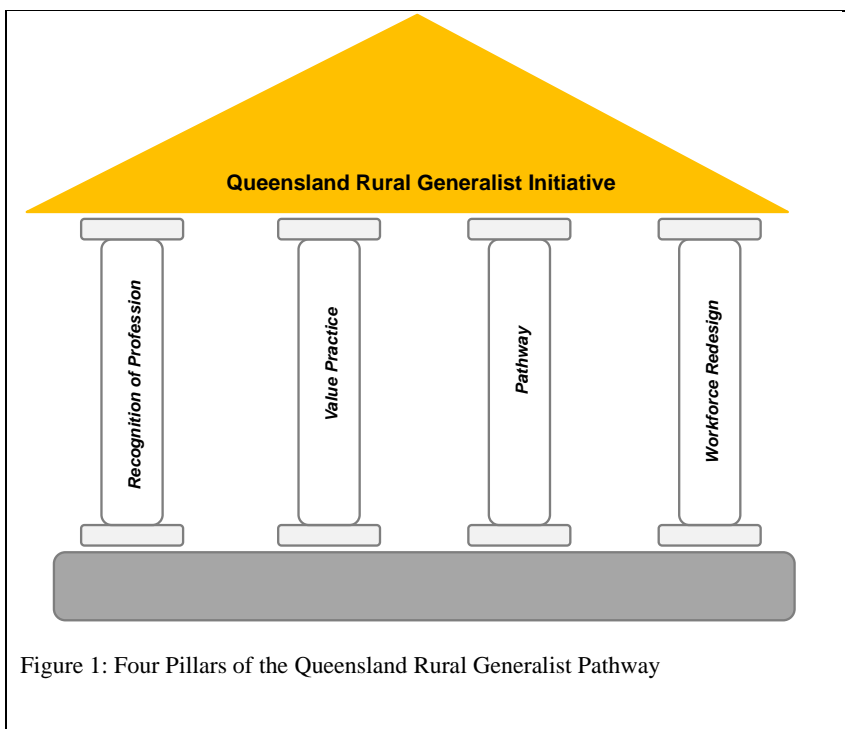
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1. Executive Summary

The Queensland Rural Generalist Program (QRGP) represents a state government workforce strategy conceived and managed by Queensland Health to address medical workforce shortages in rural communities specifically targeting public hospitals. Queensland Health defines a rural generalist as:

“a rural medical practitioner who is credentialed to serve in hospital or community-based primary medical practice as well as hospital-based secondary medical practice in at least one specialised medical discipline (commonly, but not limited to obstetrics, anaesthetics and surgery) without supervision by a specialist medical practitioner in the relevant disciplines. The practitioner may also be credentialed to serve in hospital and community-based public health practice – particularly in remote and indigenous communities.”¹



The program is founded on four key transformational pillars characterised by: recognition of rural generalist medicine as a unique medical discipline in its own right; practice value for its true worth; a supply line/pathway to vocational practice; and responsiveness to workforce redesign.

The QRGP represents one of many workforce initiatives addressing rural medical workforce needs of Australia and as such the achievements of the QRGP can help to inform the development of a national health workforce framework.

Accordingly, Queensland Health has received funding from Health Workforce Australia (HWA) to undertake a project to evaluate, analyse, quantify and engage the Queensland Rural Generalist Program (QRGP).

1.1 Objectives of the Evaluation

The objectives of the evaluation and investigative study, as outlined in the tender specifications are to:

- ▶ review the current state of the QRGP focusing on stakeholder engagement and process efficiency;
- ▶ undertake a comparative cost analysis for a Clinical Services Capability Framework level 3 site of the various available models of medical service delivery;
- ▶ consider the extent to which the QRGP meets the need and expectations of the rural communities;

¹ The factors affecting the supply of health services and medical professionals in rural areas; Community Affairs References Committee, Senate of Australia, August 2012

- ▶ undertake a workforce analysis which maps workforce requirements and service elements, determines the future needs of the QRGP with specific mapping of advanced skills and identified pertinent population drivers;
- ▶ develop a workforce framework which provides the principles, service guidelines and planning tool that will assist and inform Hospital and Health Services, training organisations and trainees in regard to training programs and pathways to meet future needs.

This report represents the findings of the evaluation, addressing the first three items of the terms of reference listed above. The engagement process used to inform the evaluation is outlined in Section 3 of this document. Workforce analyses are also presented in the report in Section 4. A workforce planning guide linking service demand to advanced skills requirements addresses the remaining terms of reference and has been submitted to the Department outside of this evaluation process.

1.2 Findings

Feedback aligned to the Four Key Pillars of the Program

Overall the feedback from key stakeholders indicates strong support for the QRGP, particularly in terms of:

- The establishment of a sustainable and effective training pathway, and
- The value of the practice of rural generalism in Queensland and its contribution to addressing rural medical workforce needs across the state.

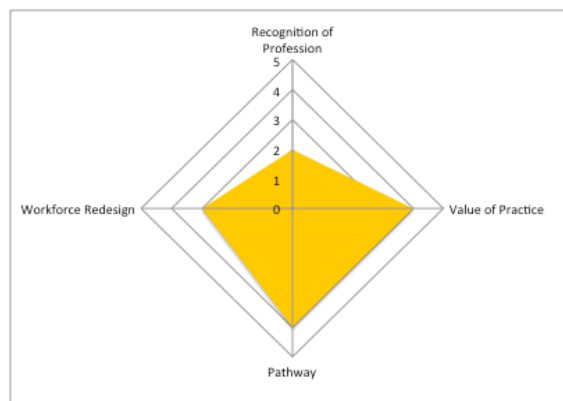


Figure 2: Stakeholder perception and support for the four pillars underpinning the QRGP.

Recognition of Profession

The greatest divergence in opinion amongst stakeholders external to the administration of the program vests with the pillar that focuses on the recognition of the rural generalist. Essentially, the divergence in opinion is philosophically based and focuses on the debate of whether:

- A rural generalist workforce strategy should be principally focussed on addressing general practice workforce needs, specifically from a primary health care/ community office based workforce perspective; or whether the rural generalist workforce strategy is a hospital focussed workforce solution.
- Depending upon the answer to the above, further debate then arises as to whether rural generalists should be considered a specialty in their own right, or continue to be deemed a general practitioner with advanced skills training.

Whilst the latter is outside of the remit of the evaluation, some insight into the first issue has been gained through the multiple data sources informing the evaluation.

There is little doubt that the Queensland Health rural generalist workforce strategy was conceived initially with the intent of addressing rural hospital medical workforce shortages and growing vacancy numbers. However the design of the model, from the onset, also

incorporated community based primary medical practice, with the intent to address primary healthcare needs as well. The construct of the model, with the early stages of the training pathway being hospital based, has resulted in the immediate benefits of the program being realised in this sector. The benefits of the program are now expected to be more evident in the primary sector as the program matures and more trainees move to the latter stages of their training, focussing on completing their requisite training in primary care.

The juxtaposition of rural medical hospital based and community based workforce is not an easy one to solve. The right blend of skills and the amount of time required to work in a hospital setting compared to a community office based or primary care setting will vary by location be it state/territory, region, or town. The appropriate configuration of medical skills and workforce numbers will need to be responsive to the changing health status of the community it serves. The right mix of primary versus secondary based medical workforce will also be dependent upon the infrastructure in place supporting this workforce. For example, there will be minimal need for a rural generalist with advanced skills in obstetrics if there is no birthing facility in the region, if there are insufficient births in the region to maintain these skills or there is no available anaesthetic skills to support service delivery.

Accordingly it is important to recognise that no single workforce solution, operating on its own, is sufficient to address the complex medical workforce needs of rural and remote Australians and their communities. Therefore, whilst the philosophical debate continues trying to shoe-horn programs, such as the QRGP, into a 'one size fits all' solution, or expecting it to fit into a rigid version of what a contemporary general practitioner should be, stakeholder views as to the value and recognition of the rural generalist will continue to vary significantly.

Value of practice

In providing input into the overall evaluation, most peak professional bodies sought feedback from their members about the perceived impact and value of the QRGP. Submissions received in the course of the evaluation indicated that the QRGP has been largely successful in attracting and training doctors as generalists. Doctors in rural and remote areas have told agencies such as AMA Queensland that *"the QRGP has, in some areas, reversed the decline of rural procedural medicine, supported existing rural health services and invigorated rural Queensland's procedural medicine services. Members observe that these gains have helped to reduce morbidity and mortality in rural areas and have reduced the need for costing patient transfers to metropolitan centres."* This is supported by workforce data provided by Queensland Health and reported upon in Section 4.

All stakeholders agreed that the QRGP has been successful in addressing Queensland Health's rural medical workforce issues. With the QRGP only now moving to a state of maturity, generating the first tranche of graduates, there is clear evidence that the program has addressed the rural hospital medical workforce needs of the state and the program has been valued highly by stakeholders for this achievement. Clear interest exists now, on whether the QRGP, as it matures and produces more graduates, will also address the rural primary medical workforce needs of the state.

Pathway

Feedback from trainees, graduates and supervisors indicates that the construct of the QRGP pathway is one of the main attractions to the program. Specifically the following features of the pathway were noted as key determinants in trainees nominating for the program:

- ▶ Fast track nature of the pathway
- ▶ Quality of training provided on the pathway
- ▶ Exposure to clinical training opportunities provided by the pathway
- ▶ Quarantined positions associated with the pathway
- ▶ Support provided along the pathway.

These are discussed further in Section 5.

Workforce Re-design

As previously noted, the QRGp is only now moving into a state of maturity. Specifically, the program has only recently started to yield graduates, and the positive impacts of the program have been largely realised by the hospitals through the filling of trainee positions and the benefits accrued with trainees moving into their advanced skills training years.

Having recognised that the program was designed with the initial goal of addressing rural hospital medical workforce shortages, as well as having the flexibility and capacity of addressing rural primary health or general practice workforce needs, the ability of the program to respond to both secondary as well as primary medical workforce needs will only truly be tested once the program has yielded a critical mass of graduates. This is best tested over the next five year period.

The program has also achieved a state of maturity in a time when major health reforms were being implemented not only at a state level but also nationally. This period of reformation challenges the flexibility of the program, particularly from an administrative perspective as well as a workforce solution perspective. The formation of Local Hospital Networks (LHNs, now referred to as Hospital and Health Services (HHS)) and the devolution of many operational and management functions to the respective Boards of Management of the HHSs requires the administrators of QRGp to be progressive in their approach with the respective Boards. Specifically the administrators of the program will need to work with the respective Boards of Management of rural HHSs in a partnership that ensures:

- ▶ the QRGp is promoted effectively
- ▶ the program can support the workforce planning requirements of the HHS, and
- ▶ that the program can be tailored to be responsive to the medium and longer term needs of the respective communities.

From a workforce solution perspective, the QRGp will need to be responsive to the diverse and competing workforce priorities of the respective HHSs. Appropriate incentives and recognition needs to be embedded into the overall program to ensure continued equity of access to graduates and the ability to place trainees and graduates into areas of need (pending appropriate supervision). For example, with greater autonomy vested in HHSs and some having greater training capability and capacity, Queensland Health does not wish to have the bulk of the QRGp workforce located in these HHSs at the detriment of others.

The need to fine tune the QRGp as it moves towards a steady mature state and begins to yield a trained workforce is both timely and expected. Section 6 provides further detail about workforce re-design and the remaining pillars of the program.

Stakeholder engagement and feedback

The engagement strategy adopted in this evaluation identified a number of stakeholders (refer Appendix A) and grouped them according to whether they fit the category of:

- ▶ trainees, graduates, supervisors
- ▶ vested parties originally involved in the Roma Agreement
- ▶ other stakeholders.

The Roma Agreement, developed in August 2005, underpins the design and strategic direction of the QRGp and is named after the town in which a team of senior medical superintendents, rural medical advisors and a number of other key stakeholders assembled to assess rural medical workforce issues. It was at this meeting that the generalist training pathway towards a definitive career in rural medical practice was tailored fit for Queensland Health's purpose.²

Trainees and graduates were engaged in the evaluation via an on-line survey (n=77, approximately one third of all program trainees and graduates) and a sample of interviews conducted across Mackay, Kingaroy and Longreach. Supervisors at each of these sites were also consulted either via face to face interviews or teleconference.

² A Brief History of the Rural Generalist Pathway (2007), Queensland Health, Queensland Government.

Those stakeholders involved in the Roma Agreement, were issued with invitations to participate in the study. A set of questions were then distributed and interviews, either via the phone or face to face were conducted by the evaluation team.

The other stakeholders were issued with invitations to participate in the evaluation via written submission, or via a telephone based interview with members of the evaluation team.

Section 5 provides a profile of trainees and graduates as derived from the database maintained by the program administrators within the Cunningham Centre, Darling Downs HHS. Trainee and graduate feedback to the online survey also appears in this section. In general, trainees and graduates reported having positive experiences on the program. They indicated that the attraction to the program was:

- ▶ working rural
- ▶ the fast track nature of the program
- ▶ the diversity of career offered through the obtaining of a rural generalist qualification
- ▶ the reputation of the quality of clinical training offered by the program.

Feedback provided by trainees to the online survey indicated that approximately:

- ▶ 42% of respondents were anticipating seeking fellowship with both the Australian College of Rural and Remote Medicine (ACCRM) and the Royal Australian College of General Practitioners (RACGP)
- ▶ 42% were anticipating seeking fellowship with the Australian College of Rural and Remote Medicine; and
- ▶ 12% were anticipating seeking fellowship with the Royal Australian College of General Practitioners.

The remainder were unsure which College they would seek fellowship with.

Of those trainees undertaking their advanced skills training, a large majority were training in anaesthetics. As noted previously, one of the attractions of the program is the fast tracking of the program, and this was reaffirmed to the evaluation team during consultations with trainees. This view was particularly strong amongst new recruits to the program. However, those trainees who had progressed further into the program indicated that they were seeking greater flexibility within the program to commence advanced skills training in post graduate years 4 and 5 and would happily see the program extended. Trainees advocating for this change indicated that they thought they would benefit from at least one more year of general training and exposure to rural medicine building experience and confidence. A number of trainees also suggested that they thought that exposure to community based general practice earlier in the program, followed by advanced skills training may be more beneficial to building their confidence and exposure to different clinical settings.

Stakeholders involved in the construct of the original Roma Agreement re-affirmed the general content of the agreement noting that overall the principles of the agreement continue to be contemporary and relevant to the medical workforce needs of today.

Areas where refinements or improvements were warranted included:

Principle iii – The educational standards of the training program will be set externally by the appropriate College

The Australasian College of Emergency Medicine (ACEM) provided commentary specific to this principle. ACEM expressed that the credentialing process for rural generalists in emergency medicine through the QRGP is not occurring via ACEM and therefore is not in line with the tenor of this principle. The College contends that, as the relevant specialist college, it has an important collaborative role in establishing the standards of training and criteria by which trainees are assessed in advanced skills emergency medicine. Recommendations for the QRGP to work collaboratively with ACEM and ACRRM to ensure that the AST in emergency medicine offered through the training pathway is appropriately recognised and endorsed by ACEM is made in Section 6.

Aligned to these discussions, trainees, supervisors and other stakeholders indicated that there may be value in reviewing the basic structure of the QRGP to make AST training in emergency medicine a compulsory component along with one other advance skill. There was general consensus amongst trainees that they needed to maximise their exposure to emergency medicine training, recognising that throughout the years of practice in rural locations they will be calling on these skills more often than not. The majority of trainees and supervisors indicated that access to a one year Diploma course in Emergency Medicine (similar to that offered by RANZCOG for obstetrics) would be highly desirable. Consideration to making this a compulsory component of the overall QRGP training pathway is discussed further in Section 8.

Principle ix - Rural generalist trainees have priority access to appropriate accredited Queensland Health training positions. (Queensland Health integrates service placement with prevocational and vocational training in partnership with training providers.)

The implementation of this principle is considered to be a cornerstone of the QRGP. Trainees and supervisors associated with the program view this as being one of the key strengths of the program. The implementation of this key principle has however resulted in a perceived overlap in the responsibilities associated with the management of general practice training placements in Queensland. Specifically the RTP is required by the national body responsible for general practice training, GPET, to manage training positions across the state. Accordingly each RTP has a number of trainees who are registered with their organisation and for whom they must find appropriate training posts. With a number of training posts being made unavailable through the quarantining processes, or some training posts located in sites that are not deemed by Queensland Health to be a desirable site for generalist training, RTPs are finding it difficult to place some of their trainees. A potential scenario where training providers begin to limit the number of rural generalists they accept on their programs in order to avoid such dilemmas was raised in discussions with the study team.

Stakeholders clearly recognise the QRGP has been successful in placing doctors into rural locations that previously faced difficulties in attracting medical practitioners. However, the competing roles and functions of the various stakeholders involved in general practice training creates potential challenges when instituting the intent of key principle ix. Accordingly, recommendations involving RTPs, GPET and the administrators of the QRGP investigating how best to address the competing roles, functions and priorities of the respective parties, particularly in terms of managing training positions is made in Section 6. The potential expansion of the Cunningham Centre role and function, to incorporate that of an RTP may also alleviate these tensions, streamline the overall process administratively (as well as from the trainees perspective) and is another reason why this warrants further investigation.

Trainees have diverse expectations in terms of the proportion of time they expect to invest in working in a community based/office based practice compared to working in a hospital. Whilst primary care clinics within many of the hospitals, together with some emergency department based work enables trainees to gain exposure to general practice skills, most trainees recognised that the skill set required of office based general practice is different to that gained through hospital exposure.

At the time of conducting the evaluation a large number of trainees with whom the evaluation team had engaged with directly indicated that they had not experienced any direct exposure to community based general practice. For some this was appropriate due to where they were on the overall training program. However for those who were near the end of their training it was a source of concern. These individuals suggested that the program be structured to enable trainees to gain early exposure to community based general practice, followed by another term during the latter years of the program. This suggestion was echoed by supervisors and the RACGP.

Process efficiency

In discussing the overall process efficiency of the program, it is important to note that the QRGP has reached an important stage of the maturity cycle. Specifically, the QRGP has moved from its embryonic stage of being a concept, through the birthing stages of giving rise to the overall training pathway and attracting trainees to the program, to now attaining maturity as a workforce solution, yielding graduate rural generalists ready to take up positions in the workforce. Not surprisingly, the processes to date have focussed largely on establishing the program.

The focus now needs to shift to workforce planning and management to ensure the sustainability and viability of the program into the future. This shift in focus will require a closer working relationship between the administrators of the QRGP (the Cunningham Centre) and the respective HHSs. A clear understanding of the role each organisation has in the overall workforce planning; including attraction, recruitment and retention of its rural generalists needs to be established and relevant program policies and procedures need to reflect these relationships. This is discussed further in Section 7.

The evaluation consulted with the administrators of the QRGP and established a process map that identifies the range of activities involved in administering the program and the interface the program has with multiple stakeholders along the pathway. Figure 35 in Section 7 depicts the QRGP process map.

Whilst the evaluation is not intended to be a process evaluation, key issues have been identified along the pathway that may need to be further refined or enhanced to improve the overall operations and effectiveness of the pathway. These include:

- ▶ Investment in a contemporary and purpose built information management system specific to the needs of the QRGP
- ▶ Consolidation of relevant policy and procedural information into a central document
- ▶ Investment in the development of a succession plan be developed for the QRGP to ensure the future proofing of the program
- ▶ Establishing a formal mechanism that enables PGY3-5 trainees and graduates of the program to advise the Cunningham Centre on the type of supports that are needed by this cohort of trainees
- ▶ Reviewing the roles and responsibilities and the interface between RTPs and the QRGP be undertaken with a view to simplifying information access by trainees and improving the overall supports provided to trainees participating in the QRGP.

Extent to which the QRGP meets the need and expectations of the rural communities

During the conduct of the study the health system of Queensland was undergoing major organisational and cultural changes with the formation of Hospital and Health Services (HHSs). The corporate office of Queensland Health was also undergoing major redesign shifting to a role of “System Manager” that resulted in the realignment and divestiture of many traditional roles and functions. Amongst this re-organisation was the cessation of the role and function of Health Consumers Queensland, the organisation approached initially by the study team to gain consumer input. Accordingly consumer input into the evaluation has been limited. As a result, the direct measurement of the program’s alignment with community expectation was not undertaken by the evaluation team. Surrogate indicators and feedback

from a limited number of patients spoken to during site visits implies the QRGP has and continues to be responsive and appropriately designed to meet the needs of rural communities.

Specifically, workforce data presented in Section 4 shows a marked decrease in the number of critical medical vacancies reported by rural and regional HHS has occurred coinciding with the maturity of the QRGP.

Anecdotal data reported to the evaluation team indicated that *“the QRGP has, in some areas, reversed the decline of rural procedural medicine, supported existing rural health services and invigorated rural Queensland’s procedural medicine services. Members observe that these gains have helped to reduce morbidity and mortality in rural areas and have reduced the need for costly patient transfers to metropolitan centres.”*³

Other examples cited:

- ▶ *“since the appointment of Dr X (a supervisor within the QRGP), the inclusion of more doctors and the expansion of services at this hospital I have been able to come and get my dialysis and renal management on site and not have to travel several hundreds of kilometres every few days. Its been a god send”*(patient feedback to evaluation team during site visit)
- ▶ *“since the introduction of the QRGP and having local access to advanced skills trained rural generalists in obstetrics and anaesthetics we have been able to undertake an additional 57 births locally that would otherwise have had to be undertaken in Brisbane or other locations”*(HHS feedback).

Comparative cost analysis

Administrative Costs

The cost of administering and supporting the program is relatively modest. Data presented in Section 9 identifies the cost of administration and support provided by the Cunningham Centre is similar to that of other rural general training pathway support costs. The average cost of administration per trainee per annum is approximately \$5,315. This investment includes the costs associated with case managing the individual trainees, it also includes the costs associated with marketing the program, providing networking opportunities through conferences etc. and other general supports provided to trainees by the Cunningham Centre.

Recognition Costs

The Queensland Government elected to give due recognition to the profession through changes to the industrial award and remunerating rural generalists as specialists. There has been considerable conjecture that the remuneration provided by Queensland Health results in the public health system incurring an additional cost that is significant and likely to prohibitive in terms of other jurisdictions’ capacity to implement a similar program. The reality is somewhat different.

The award structure in Queensland Health already made provision for the employment of non-specialist senior medical officers – which is the position rural generalists were previously appointed to. By providing recognition for advanced skills training, and deeming the rural generalist position as a specialist discipline, the differential in payment (i.e. moving from non-specialist award rate to specialist award rate) on the base salary represented an additional cost injection of \$12,150 by the state government. This additional cost represents an annual figure for each rural generalist appointed to a salaried position in a rural hospital. The differential increases to approximately \$23,800 when differences between the overall packages are considered. This represents a modest additional investment incurred by Queensland Health for the recognition of rural generalists.

Return on Investment

One of the requirements of the evaluation was to undertake a comparative cost analysis for a Clinical Services Capability Framework level 3 site of the various available models of medical service delivery. Limitations in data availability and the capacity to undertake appropriate

³ Submission on the Queensland Rural Generalist Program, September 2012, AMA Queensland

linkages across differing datasets restricted the capacity to undertake this detailed level of analysis.

However, based on feedback from a region, a case study and cost modelling exercise was able to be completed. The implementation of the QRGP in a regional town has enabled 135 deliveries to be undertaken locally in the last year which otherwise, over 40% of which would previously have been delivered outside of the region and at larger tertiary hospitals.

Assuming that 50% of these deliveries in the past may have been emergency presentations and the other 50% represented planned complex cases; a model that identified the costs incurred by Government for travel, out of hospital accommodation and additional accrued beddays was calculated. The difference in remuneration costs of the medical teams operating in the region, past and present, were also considered as inputs into the model, with appropriate indexation applied. The employment of rural generalists with obstetric and anaesthetic advanced skills that enabled the additional 57 births to be performed locally resulted in a 120% return on investment.

Critical Success Factors

The respective stakeholders involved in the evaluation identified a number of critical factors contributing to the overall achievements of the QRGP. In no order of importance, these included:

- ▶ early immersion in rural medicine during the prevocational years
- ▶ due recognition being given to the profession of rural generalist by Queensland Health and the associated industrial and remuneration packages that accompany this recognition
- ▶ the fast track nature of the program is both attractive to trainees but also addresses the workforce needs of rural communities in a timely fashion
- ▶ the quality of the training and supervision offered on the pathway
- ▶ the effective quarantining of training placements in rural locations and the preference given to QRGP trainees
- ▶ career opportunities presented at the end of the training period, albeit currently perceived as limited to within Queensland.

1.3 Conclusions

The QRGP has been recognised by all stakeholders as an effective and sustainable training pathway that is providing a solution to rural medical workforce issues faced in Queensland. Due to the model construct, implementation and stage of development, it has, at this stage, been more successful in providing a hospital focused medical workforce solution. As it now moves to a state of maturity with ongoing supply of graduates ready to join the workforce, the impact of the program on addressing rural general practice workforce needs can only now begin to be monitored.

Figure 3 provides a summary rating of attainment against some of the more critical domains of inquiry posed by the evaluation.

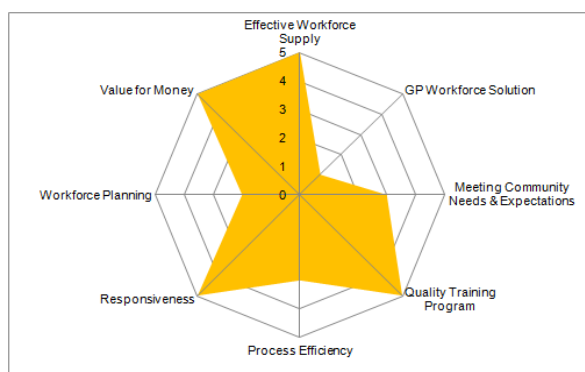


Figure 3: Rating of attainment of the QRGP

The evaluation concludes that the QRGP has:

- ▶ Provided an exceptionally high quality training program valued by trainees and graduates and reflects the commitment of senior clinicians to the program through high quality supervision and support
- ▶ Operated at an efficient level, but can be significantly improved upon through investment in relevant information management systems, consolidation of policies and processes and construct of appropriate communication protocols with key stakeholder organisations
- ▶ Demonstrated high degree of flexibility and responsiveness to the needs of the trainees
- ▶ Yet to realise its potential to support workforce planning activities undertaken by HHSs
- ▶ Met the needs of local communities through the reduction of critical shortages in medical workforce numbers and enabling health services to expand service delivery making services more accessible and affordable to local residents
- ▶ Represented value for money investment for the Queensland government with a return on investment ratio conservatively estimated to be in the vicinity of 1.2.

There are elements of the program that appear to have relevance to other pathways, strategies and workforce initiatives being trialled or considered in other jurisdictions. However, given that each jurisdiction faces its own distinct challenges in terms of population distribution, training facility capacity and workforce configurations, it is highly unlikely that the QRGP can be readily transferred into other jurisdictions in its current format without some form of customisation being required.

Work now needs to focus on refining the program to improve process efficiency and quality as well as moderating the program to fit with the individual workforce planning requirements of the respective rural HHSs.

1.4 Recommendations

A number of recommendations appear in the body of the report. The numbering identifies which section of the report the recommendation relates to (e.g. Recommendation 4.1 indicates that the recommendation appears in Section 4 of the report). The following is provided in order of appearance within the report.

Recommendation 5.1: A work program for the QRGP administrators, involving the HHSs, be developed that addresses methods of aligning QRGP trainee AST selection and preferences with workforce skill mix needs and workforce planning processes.

Recommendation 5.2: Consideration be given to the inclusion of AST training in emergency medicine as a core and compulsory component of the QRGP training pathway.

Recommendation 5.3: The feasibility of Cunningham Centre assuming the role of an RTP dedicated to the QRG program clinical placements be investigated.

Recommendation 5.4: The RTPs and QRGP collaborate to develop an appropriate response to the needs of the QRGP trainees in terms of obtaining information about AST opportunities and requirements.

Recommendation 6.1: QRGP works collaboratively with ACEM and ACRRM to ensure that the AST in emergency medicine offered through the training pathway is appropriately recognised and endorsed by ACEM.

Recommendation 6.2: QRGP works collaboratively with ACEM to ensure the Emergency Medicine Diploma offered by ACEM is included in the QRGP training pathway and offered as an AST to program trainees.

Recommendation 6.3: A work program investigating how best to address the competing priorities, roles and functions of the respective parties, particularly in terms of managing training placement, be commissioned. Stakeholders to be involved in the work program include the RTPs, GPET, the administrators of QRGP and Queensland Health.

Recommendation 7.1: A business plan, identifying the appropriate level of investment needed to develop a robust information management system that is needed to support the management, performance monitoring and reporting functions associated with the QRGP.

Recommendation 7.2: The investment for the purchase of appropriate hardware and software development be made available within the 2013/14 financial year.

Recommendation 7.3: Functional specifications for the QRGP management system be driven by Cunningham Centre.

Recommendation 7.4: The functional specifications for the QRGP management system be extended from system specifications to incorporate reporting and user requirements.

Recommendation 7.5: The administrators of the program focus on consolidating relevant policy and procedures into a central document.

Recommendation 7.6: A succession plan be developed for the QRGP to ensure the future proofing of the program.

Recommendation 7.7: The Cunningham Centre, in conjunction with the rural HHSs, establishes a mechanism through which rural HHSs can formally inform the program of their future medical workforce needs.

Recommendation 7.8: The Cunningham Centre establishes a mechanism through which the QRGP can be moderated in the future to meet the rural medical workforce needs as identified by the respective rural HHSs.

Recommendation 7.9: The Cunningham Centre develops an information session for individual rural HHSs that outlines the workforce planning guide developed as part of this study.

Recommendation 7.10: Consideration be given to investing in the development of a promotion/communication strategy that raises the awareness of the rural HHSs as to the number and skill sets of each years QRGP graduate cohort.

Recommendation 7.11: The Cunningham Centre explores how best to support rural HHSs attraction, recruitment and retention strategies and processes.

Recommendation 7.12: A formal mechanism be established that enables PGY3-5 trainees and graduates of the program to advise the Cunningham Centre on the type of supports they require.

Recommendation 7.13: A review of the roles and responsibilities, and the interface between RTPs and the QRGP be undertaken with a view to simplifying information access by trainees and improving the overall supports provided to trainees participating in the QRGP.

Recommendation 8.1: A review of the training pathway also consider whether the training pathway should be extended or modified to enable AST training to take place post PGY3 years. The impacts upon trainee uptake of the program as well as workforce impacts should be considered within this review.

Recommendation 8.2: The Cunningham Centre liaises with RANZCP and work with them to shape the QRGP such that it can offer AST in psychiatry, recognising that the responsibility for the development and specification of the actual advanced skills clinical training program vests with the College.

Recommendation 8.3: Queensland Health considers developing a program that supports hospitals used by QRGP for trainee placements to gain relevant teaching accreditation status with the respective Colleges (ACCRM and/or RACGP).

Recommendation 8.4: Cunningham Centre reviews the information needs of supervisors associated with the QRGP to determine what supports should be provided directly through the program and what supports would be best provided by RTPs.

Recommendation 8.5: A review of the utility of the Vocational Indicative Planning (VIP) process against its intended purpose should be undertaken.

Recommendation 8.6: A review of role and function of the DRGT and time required to complete the requisite duties be undertaken by the Cunningham Centre.

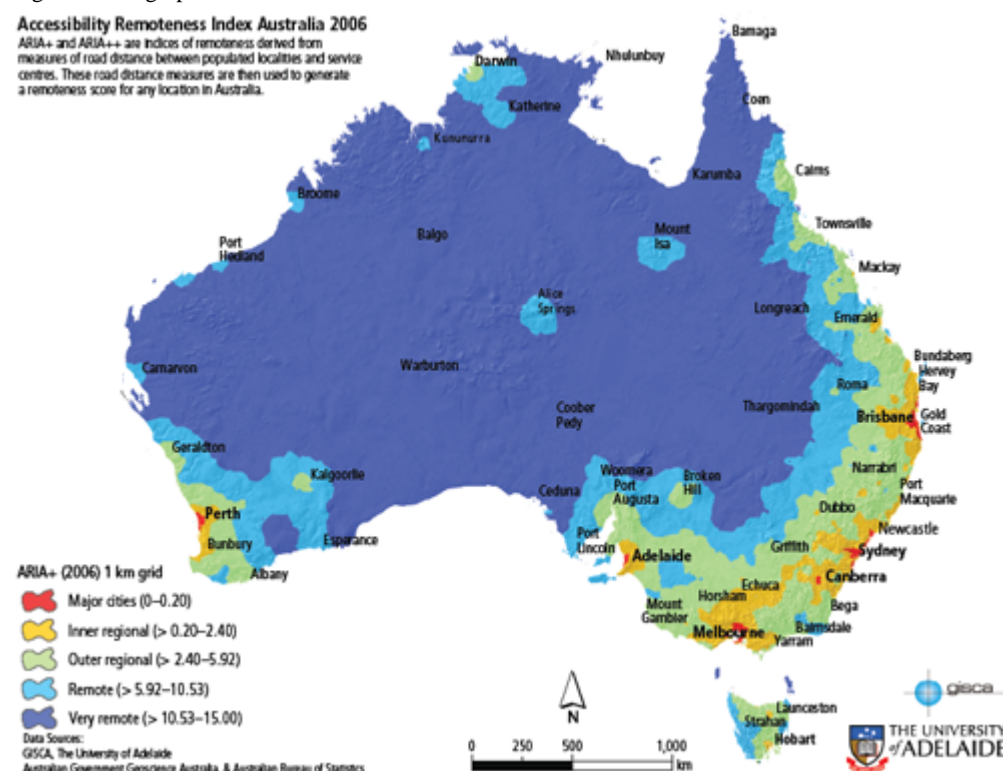
Recommendation 8.7: The capacity to gain earlier exposure to community based general practice for the QRGP trainees be explored further.

2. Introduction

2.1 Background

Over two-thirds (69%) of Australians live in major cities, one in five (20%) live in inner regional areas, one in ten (9%) in outer regional areas and around one in forty (2.3%) live in remote or very remote areas (1.5% remote and 0.8% very remote). These figures represented, in 2009, 15.1 million people living in major cities, 4.3 million in inner regional areas, 2.1 million in outer regional areas, 324,000 in remote areas and 174,000 in very remote areas (Australian Bureau of Statistics [ABS], 2010).⁴⁵

Figure 4: Geographic remoteness in Australia



Australia's living in regional, rural and remote locations have the same right to expect access to safe quality health care services that are provided in a timely fashion as their metropolitan counterparts. In fact, the *Australia's Health 2010* report identified people living in rural and remote areas have a higher risk of:

- ▶ cardiovascular diseases;
- ▶ mortality rates and lower life expectancies;
- ▶ road injury and fatality rates;
- ▶ high blood pressure, diabetes, and obesity;
- ▶ chronic diseases;
- ▶ mental health problems;
- ▶ suicides;
- ▶ alcohol abuse and smoking;
- ▶ poor antenatal and post-natal health;
- ▶ newborn babies with low birth weight to mothers⁶.

⁴ <http://www.aihs.gov.au/institute/pubs/factsheets/2011/fs201103.html> accessed October 2012

⁵ Australian Bureau of Statistics. (2010). *Australian demographic statistics, June 2010* (Cat. No. 3101.0). Canberra: ABS

⁶ AIHW (2010). *Australia's health 2010. Australia's health no. 12*. Cat. no. AUS 122. Canberra: AIHW.

Further, people in remote and rural communities are likely to hold lower health literacy, have poorer access to local health services and dental health⁷ brought about by the geographic dispersion and location of healthcare facilities and the shortage of healthcare professionals working in rural and remote locations.

2.1.1 Issues of Workforce Shortage

Given that the QRGP falls under the specialty of general practice, the focus of the following discussion is on the impacts and contributors of general practice workforce shortages. The literature describing the workforce pressures impacting the general practitioner (GP) profession is extensive⁸. The summary below provides a snapshot of the complex, and often interrelated issues, as well as generational differences that have exacerbated the challenges facing communities and government in terms of recruitment and retention of rural and remote GPs.

To quantify the level of attrition, a review in 2008 showed slightly higher than a quarter (27%) of previous medical registrars undertaking training on a designated rural pathway remained working in rural practice. A further 29% of rural pathway graduates had worked in a rural area since graduating, with only about a third of their total services being provided in rural areas.⁹ To compound the issue, a roundtable meeting held in February 2008 involving peak rural health groups estimated that 1000 doctors were immediately required in rural and remote Australia to deliver basic medical care¹⁰.

Ageing workforce

The data characterises rural GPs as having an ageing profile with the age increasing slightly over the period 2006 to 2010 (from 49.9 years to 50.6). Currently, the average age of rural GPs is 49 years (50.53 years for male GPs and 45.75 years for female GPs). Based on this data, general practitioners, in 2010, represented the medical speciality with the highest proportion of practitioners aged 55 and over (36.7%)¹¹. Further, in the coming years there is an expectation that those general practitioners aged 55 years or older will seek to reduce their working hours or retire from the workforce thereby exacerbating the current shortages in general practitioners in the rural, regional and remote locations across Australia.

Family and lifestyle

More recent studies have shown that attitudinal changes exist between different generations of doctors when it comes to attaining a work lifestyle balance. This attitudinal shift has affected the way in which medical staff are now recruited and retained within the workforce¹². Research shows that trainees and resident medical staff are less inclined to work the long hours of the previous generation for unpaid overtime. From 1999 to 2009, clinicians' average work hours per week have dropped by 7.21% from 45.8 to 42.5 hours, respectively¹³.

⁷ AIHW (2010). Australia's health 2010. Australia's health no. 12. Cat. no. AUS 122. Canberra: AIHW.

⁸ Bunker, J. & Shadbolt, N. (2009). Choosing general practice as a career: The influences of education and training. Australian Family Physician, 38(5), 341-344; Glazerbrook, R.M. & Harrison, S.L. (2006). Obstacles to maintenance of advanced procedural skills for rural and remote medical practitioners in Australia. Rural and Remote Health, 6, <<http://www.rmh.org.au/articles/showarticlenew.asp?ArticleID=502>> viewed 6 August 2012; Joyce, C.M, McNeill, J.J. & Stoelwinder, J.U. (2006). *More doctors, but not enough: Australian medical workforce supply 2001–2012*. Medical Journal of Australia, 184(9): 441–446; Eley, D.S., Synnott, R., & Chater, A.B. (2012). A decade of Australian Rural Clinical School graduates – where are they and why? Rural and Remote Health, 12 <<http://www.rmh.org.au/articles/showarticlenew.asp?ArticleID=1937>>viewed 18 August 2012.

⁹ Campbell,DG, Greacen,JH, Giddings,PH. & Skinner, LP. (2011). Regionalisation of general practice training – are we meeting the needs of rural Australia? MJA, 194(11), S72 -S71

¹⁰ Rural Doctors Association of Australia submission to Australia 2020 Summit. October 2010.

<http://www.rdaa.com.au/Uploads/Documents/RDAA%20submission%20to%20the%20Australia%202020%20Summit%20-%209%20April%202008_20101015113009.pdf> viewed 21 August 2012

¹¹ AIHW (2012). *Medical workforce 2010*. National health workforce series no.1. Cat. no. HWL 47. Canberra: AIHW

¹² AMWAC (2004). The Public Hospital Medical Workforce in Australia, AMWAC Report 2004.3, Sydney

¹³ AIHW. Medical labour force 2009. Canberra: <http://www.aihw.gov.au/publication-detail/?id=10737419680> viewed 20 August 2012

The increased proportion of women in the medical workforce has contributed to this trend. The increase in the number of women general practitioners has resulted in the introduction of more flexible working arrangements, with a large majority of this cohort of medical practitioners working on a part-time basis¹⁴. This has lowered the overall hours of availability to provide active general practice and requires a greater number of health professionals to fill a vacancy. Figures quoted in recent studies¹⁵ suggest that for each full time equivalent general practitioner retiring from the workforce, the equivalent of 1.4 full time equivalent staff need to be employed to cover the same hours of availability as offered previously by the retiree.

Specialisation

There is evidence to suggest generational differences in attitudes towards medical practice¹⁶ exist. Today, many of the newly graduated health professionals favour opportunities to work in highly recognised and well-resourced facilities that provide professional support to develop specialist skills as opposed to general practice. The risk to general practice training programs, such as the QRGP, offering advanced skills training is for trainees, once exposed to advanced skills training, to elect to shift their training and pursue fellowship with the specialty college, thereby leaving the general practice pathway. This 'leakage' from general practice pathways has been noted across the country and offered by agencies such as the Rural Doctors Association of Australia (RDAA) as a potential reason why the number of GP registrars undertaking advanced skills training are declining^{17 18}. This leakage towards other specialisation is likely to result in fewer generalists with the advanced skills to provide both medical and procedural care to rural and remote communities across the secondary *and* primary care settings.

Access, Opportunity and Professional Growth

The remoteness of rural practice requires practitioners to be able to work with a high degree of independence and autonomy. It can also foster a degree of professional isolation due to the lack of professional networks, collegial support, ongoing training, and timely access to appropriate infrastructure and resources. Professional isolation, inadequate exposure to specialist areas of practice and general lack of suitable equipment to support delivery of care can contribute to lower confidence, knowledge and skills in GPs¹⁹.

A combination of all these challenges means that, in the foreseeable future, there will be a need to not only increase the size of the general practice workforce in rural and remote Australia, but to ensure that future workforce planning is undertaken to ensure appropriate infrastructure is in place to support these healthcare professionals enabling them to provide quality and safe care to their communities.

2.2 National efforts

In response to these workforce pressures, the Federal and State governments, rural workforce agencies, Divisions of General Practice, medical schools, Colleges and communities have continued to collaborate to develop a number of initiatives that have primarily focused on securing an adequate workforce of GPs for rural and remote Australia. Programs and initiatives have considered a range of different approaches with some reliant on attracting qualified practitioners from overseas, others on attracting international medical graduates. There have been significant changes made to university intake numbers of the last five years and changes

¹⁴ AMWAC (2004). The Public Hospital Medical Workforce in Australia

¹⁵ McCulloch A., Presentation "Planning for a Rural Pathway", December 2010, Rural Doctors Workforce Agency.

¹⁶ Montour A, Baumann A, Blythe J, Hunsberger M. The changing nature of nursing work in rural and small community hospitals. Rural and Remote Health 9: 1089 <http://www.rmh.org.au/publishedarticles/article_print_1089.pdf> viewed 15 August 2012; Manahan C, Lavoie J. Who stays in rural practice? An international review of the literature on factors influencing rural nurse retention. Journal of Rural Nursing and Health Care; 8(2) <<http://www.mh.org/journal/index.php/online-journal/article/viewFile/180/230>> viewed 18 August 2012

¹⁷ Rural Doctors Association of Australia, A National Advanced Rural Program: Discussion paper June 2012.

¹⁸ In June 2012 on A National Advanced Rural Program showed that the number of rural generalist providing procedural services has declined from 24% to 20% between 2002 and 2008, with many either leaving the workforce or leaving general practice altogether. In 2010, only 56 GP registrars were recorded to be undertaking advanced skills in anaesthetics, obstetrics and / or gynaecology, compared to 73 in 2006 and 82 in 2008.

¹⁹ Hegney D, McCarthy, Rogers-Clark C, Gorman D. Why nurses are resigning from rural and remote Queensland Health Facilities. Collegian 2002; 9(2): 33-39.

to clinical training including the introduction of clinical training networks, new training pathways and methods of providing clinical training opportunities to trainees. Other schemes including the introduction of scholarships, bonded placements and financial incentives²⁰ have all been explored and implemented to varying degrees of success. The following provides a synopsis of some of these strategies, and it is important to note that each has to some degree successfully contributed to addressing medical workforce shortage issues across the country.

2.2.1 Overseas trained doctors (OTDs) and International medical graduates (IMGs)

In the early 1990's, the Federal and State governments introduced policies, regulations and legislation which allowed active recruitment of internationally trained doctors²¹. Bonded by workforce policies, most OTDs and IMGs are compelled to work in areas of need, which typically relate to locations in rural and remote Australia. Currently OTDs/IMGs account for almost 50% of the rural medical workforce in some areas, and close to 100% in others²².

Doctors placed in these locations often reported struggling with facing cultural issues, geographical and professional isolation. To combat these issues, a strong reliance was placed on the existing local clinicians not only provide appropriate supervision, mentoring and training to the newly recruited doctors, but to assist in the community assimilation of the newly recruited doctors. Perversely, the influx of OTDs and IMGs placed further pressures on the already strained and depleted workforce in rural Australia. Although this group of clinicians addressed some of the system workforce pressures, ongoing concerns are expressed regarding varying levels of clinical skills, experience, knowledge and communication and the impact this may have on the quality of care being provided to the community. Accordingly workforce strategies addressing workforce shortages have been expanded to ensure that reliance on OTDs and IMGs does not form the sole response of government.

2.2.2 Incentive schemes

Funded by the Commonwealth Government, a range of incentive schemes have been introduced over the last decade aimed to promote and retain careers in rural medicine and address the shortage of GPs in rural and remote Australia. These incentive schemes include:

- ▶ General Practice Rural Incentive Program (GPRIP)
- ▶ Rural Locum Education Assistance Program (Rural LEAP)
- ▶ Medical Rural Bonded Scholarships (MRBS)²³.

Bonded scholarships and 10 year moratoriums have received mixed support from the sector with the Rural Doctors Association of Australia (RDAA) being critical that the scholarships are potentially restrictive and coercive in nature often resulting in trainee resentment and poor practice.²⁴

2.2.3 University Placements

Before 1990, any changes to rural medical education in Australia were minor in nature largely due to rural general practice being considered the "poor cousin" of general practice and not necessarily well valued within the medical profession. Consequently, undergraduate and postgraduate training often failed to provide future rural and remote doctors with the necessary skills required to practice²⁵.

In early 1990's, a number of research and discussion papers from the *Medical Journal of Australia* and the *Australian Journal of Rural Health* outlining the risk of GP shortage and immediate need for changes to the selection of rural students into undergraduate medical

²⁰ Rural Undergraduate Steering Committee. *Rural Doctors Reforming Undergraduate Medical Education for Rural Practice. The final report of the Rural Undergraduate Steering Committee for the Department of Human Services and Health*, May 1994.

²¹ Smith, S.D. (2008). The global workforce shortages and the migration of medical professions: the Australian policy response. *Australia and New Zealand Health Policy* 2008, <<http://www.anzhealthpolicy.com/content/5/1/7#>> viewed 20 August 2012

²² RDAA. (2011). Inquiry into factors affecting the supply of health services and medical professional in rural areas <<https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=a5e02f4d-f04c-4937-88e8-3f822129ce49>> viewed 20 August 2012

²³ The Parliament of the Commonwealth of Australia (2012). *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, March 2012. Canberra: House of Representatives Standing Committee on Health and Ageing

²⁴ RDAA. (2011). *Inquiry into factors affecting the supply of health services and medical professional in rural areas*, pg.17

²⁵ Dunbabin, J. & Levitt, L. (2003). Rural origin and rural medical exposure: their impact on the rural and remote medical workforce in Australia. *Rural and remote Health*, 3 <<http://rrh.deakin.edu.au>> viewed on 22 August 2012

training in Australian universities²⁶. At the same time, the Rural Undergraduate Steering Committee recommended that medical schools exert responsibility in providing leadership and opportunities for rural exposure, training and appropriate curricula to meet the needs of the 30% of Australia who live in rural areas across the country²⁷. It was noted that smaller rural and remote high schools were significantly under-represented in terms of the overall profile of secondary schooling backgrounds of medical students (and healthcare profession students in general). Evidence being collected over this decade also showed that students with rural backgrounds were more likely to go back and work in rural locations. Consequently the intake processes for medical and other health science undergraduate courses were modified to redress this inequity in the balance of students with rural backgrounds participating in undergraduate medical programs.

In addition to increasing the number of undergraduate students with rural backgrounds participating in health sciences and medical training programs offered by universities across the country, educational facilities have, in the last few years, increased the number of undergraduate and post graduate places in an attempt to increase the trained workforce and address growing workforce shortages across most clinical health care professions. This is placing greater strain on service providers, already facing productivity challenges to create more opportunities for clinical placements. Senior clinicians are also now expected to provide preceptor, supervisor and mentor roles to a greater number of students thereby potentially diluting the level of investment available to individuals. The concerns are that the quality and experiences afforded to trainees during their clinical placement may be eroded and this is likely to have a detrimental impact upon patient safety and the future quality of health care services in Australia.

2.2.4 General practice training

The Commonwealth Government has invested heavily in general practice training in Australia by increasing prevocational and vocational training places. The training pathways have in many instances entailed generic workforce education and training, providing opportunities for rural exposure as part of general medical training. However, in some instances, this exposure is sporadic and time limited.

Feedback from students extol the benefits that arise in terms of longer and continuous exposure to rural based practice settings, enabling students to gain a broader understanding of rural issues and rural health as well as obtaining a sense of community whilst being placed in a rural community. Consequently the introduction of specific training pathways that seek to immerse trainees in rural and remote rural placements from the earliest possible stage has emerged as preferred strategies across most jurisdictions.

In summary, these initiatives have produced some very positive outcomes, including increased GP training places in rural and regional Australia. However, the retention of doctors in rural and remote areas remains a key challenge. The RDAA indicates that the “attrition rate for rural doctors with the necessary skills for rural practice over the past two decades has been far in excess of replacement rates, resulting in the closure of many small services and, more recently, some medium and even larger services”²⁸.

²⁶ Kamien, M. & Butfield, I.H. (1990). Some solutions to the shortage of general practitioners in rural Australia. Part 1. Medical school selection. Medical Journal of Australia, 153, 105-107; Kamien, M. & Butfield, I.H. (1990). Some solutions to the shortage of general practitioners in rural Australia. Part 2. Undergraduate education. Medical Journal of Australia, 153, 107-109

²⁷ Rural Undergraduate Steering Committee, *Rural doctors: Reforming undergraduate medical education for rural practice: Final report of the Rural Undergraduate Steering Committee for the Department of Human Services and Health*. 1994, Commonwealth Department of Human Services and Health: Canberra

²⁸ Rural Doctors Association of Australia, A National Advanced Training Program; Discussion Paper 2012

2.3 The Queensland Context

2.3.1 Queensland Health Challenges

Queensland is experiencing the highest rate of population growth in the country. The population has grown from 1.5 million people in 1986 to 4.1 million people in 2006, an increase of 2.6 million people in the last two decades. Growth of this scale is projected to continue into the future with Queensland's projected population in 2018 reaching double that of 1986, and will increase by threefold before 2044²⁹.

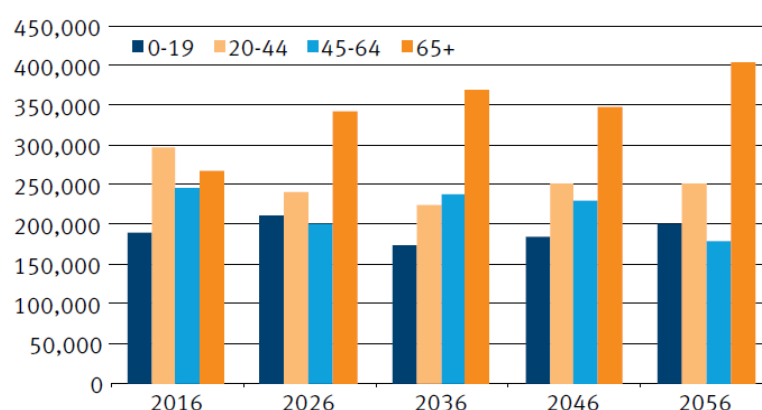
Ageing population

This growth in population is in part attributed to lifestyle changes being made by Australians who are of retirement age. Accordingly, the impact of an ageing population will become increasingly apparent over the next two decades for Queensland. The shift in age profile is marked by the following statistics:

- ▶ the median age of Queenslanders was 36.0 years in 2006
- ▶ the median age is projected to reach 39.3 years by 2026, and
- ▶ the median age is projected to increase further to 42.8 years by 2056.

Figure 5 shows that the largest population increases are projected to be among older people, especially those aged 65 years or more from 2016 onwards.

Figure 5: Projected population change by broad age groups, Queensland, decades ending 2016-2056



Source: *Queensland Government population projections to 2056: Queensland and statistical divisions 2011 edition*, Office of Economic and Statistical Research, Queensland Treasury.

Across Queensland, the number of people aged 65 years and over is projected to rapidly increase, except for South West, North West and Central West. Table 1 shows the largest increases are anticipated to occur in Brisbane, West Moreton, Fitzroy, Mackay, Northern Queensland and Far North Queensland; with the number of those aged 65 years and over projected to increase two to three times more than people aged 20-64 (working age).

²⁹ *Queensland Government population projections to 2056: Queensland and statistical divisions 2011 edition*, Office of Economic and Statistical Research, Queensland Treasury.

Table 1: Projected population change by age group across Queensland regions, years ending 30 June 2006 to 2031

Regions	0-19		20-64		65 and over		Total	
	No.	%	No.	%	No.	%	No.	%
Brisbane	210, 900	41.8	492, 700	42.8	346, 700	171.1	1, 050, 300	56.5
Gold Coast	68, 200	59.5	169, 100	58.9	94, 700	146.2	332, 000	71.2
Sunshine Coast	42, 100	55.3	102, 100	59.6	68, 900	144.1	213, 100	72.1
West Moreton	19, 300	78.3	50, 900	101.7	22, 600	192.7	92, 800	107.3
South East QLD	340, 600	47.3	814, 700	49.1	532, 800	163.0	1, 688, 100	62.4
Wide Bay-Burnett	29, 200	41.2	75, 100	50.7	56, 800	125.6	161, 100	61.0
Darling Downs	20, 200	30.7	56, 200	43.8	43, 000	136.5	119, 400	52.9
South West	200	2.7	2, 400	15.5	1, 800	59.4	4, 400	16.9
Fitzroy	30, 400	49.2	72, 300	59.0	36, 100	164.5	138, 800	67.3
Central West	-100	-3.3	900	12.1	500	29.9	1, 300	10.2
Mackay	24, 800	54.6	68, 700	69.1	26, 700	174.6	120, 00	75.1
Northern	25, 500	42.2	65, 000	51.2	45, 600	208.5	136, 400	65.0
Far North	16, 500	23.1	59, 300	39.3	49, 400	198.8	125, 300	50.7
North West	-200	-1.8	4, 100	20.2	3, 200	154.7	7, 200	21.6

Source: *Queensland Government population projections to 2056: Queensland and statistical divisions 2011 edition*, Office of Economic and Statistical Research, Queensland Treasury.

Life expectancy has also increased in the last century, leading to prolonged chronic disease management requirements affecting both primary, tertiary and community health service providers³⁰. The compounding factors of increased life expectancy and the need for complex and chronic disease management, especially in rural and remote areas will create challenges for Queensland both in terms of increased demand for health services and increased cost burdens.

Geographic distribution and Indigenous communities

Queensland also has a unique decentralised population which is supported by infrastructure not necessarily reflective of other jurisdictions. Whilst the majority of Queenslanders live in major cities, the State also has the largest number of people, who live in outer regional, remote and very remote locations to any other Australian jurisdictions³¹.

The geographical dispersion of Indigenous and non-Indigenous Queenslanders is also significantly different to other States and Territories. Specifically, non-Indigenous Queenslanders are densely centred in major cities, with only a small percentage living in remote or rural areas. In comparison, Table 2 shows that 22% of Indigenous Queenslanders live in either remote or very remote areas, with 28% in major cities³².

Table 2: 2006 Census Queensland Indigenous populations – Remoteness Areas

	Major cities	Inner regional	Outer regional	Remote	Very remote
Queensland	26%	20%	32%	8%	14%

Source: Australian Bureau of Statistics, *Australia: Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006*. Cat. no. 4705.0 .ABS: Canberra; 2009

In June 2006, Queensland had the second highest number of Indigenous Australians compared to all States and Territory with 144, 900, following closely behind NSW. The Indigenous

³⁰ AIHW 2006. Life expectancy and disability in Australia 1988 to 2003. Disability series. Cat. no. DIS 47. Canberra: AIHW.

³¹ Australian Bureau of Statistics. *Regional population growth, Australia, 2007-08*. Cat. no. 3218.0. ABS: Canberra; 2009.

³² Australian Bureau of Statistics, *Australia: Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006*. Cat. no. 4705.0 .ABS: Canberra; 2009

population in Queensland is projected to be the fastest growing with an average growth rate over the projection period of between 2.6% and 2.7% per year, exceeding the Indigenous population of New South Wales by 2016³³.

Additionally, Census data showed that Indigenous Queenslanders accounted for 3.5% of the total Queensland population, in contrast to 2.5% for the whole of Australia. Indigenous Queenslanders accounted for 1.7% of the population in metropolitan cities compared to 39.8% of inhabitants of very remote areas³⁴.

Accordingly, there are highly significant differences in health status and life expectancy within the Queensland population. The health status of Indigenous Queenslanders across all age groups is poorer than the rest of the State. The average life expectancy for male indigenous Queenslanders was 53.2 years in 2008, 24.1 years lower than non-Indigenous males (77.3 years). The life expectancy for female Indigenous Queenslanders was 62.3 years, 21.4 years lower than non-Indigenous females (83.7 years)³⁵.

Agricultural focus

Queensland has the largest area of agricultural land of any Australian State or Territories. The State's agricultural industries are made up with plant (e.g. field crop, horticulture and forestry) and animal industries (e.g. livestock and livestock products). Agricultural related injury and death in Queensland continues to be very high and has lagged behind other high risk industries (such as construction, manufacturing and transport) in areas of safety, reduction of employees' compensation claim rates and work-related deaths³⁶.

The Australian Centre for Agricultural Health and Safety reports that between 2001 and 2004, Queensland averaged over 25 fatalities and 27 serious non-fatal injuries per year, contributing 26% and 39.7%, respectively to the total in Australia³⁷.

Chronic diseases

The *Health of Queenslanders 2010* reported 15 specific chronic diseases, three causes of injury and seven communicable diseases that collectively lead to the causes of burden of disease and injury in Queensland. The leading causes of premature death and disability are:

- ▶ Lung cancer (87.9%);
- ▶ Coronary heart disease (84.3%);
- ▶ Type 2 diabetes (73.6%);
- ▶ Stroke (69.2%);
- ▶ Chronic obstructive pulmonary disease (66.3%)³⁸.

Type 2 diabetes mellitus is projected to become the largest cause of disease burden by 2023 in Queensland. This is explained by the proliferation of overweight and obesity³⁹.

The rapidly growing and ageing population who are dispersed across the State with increasing dependency upon health services contributes to the overall demand on providing a workforce that is responsive to the communities needs. Consequently, Queensland public hospitals will be confronted with difficulties in their ability to recruit adequate numbers of medical staff in all required areas. This difficulty will vary depending on the location and remoteness of the

³³ Australian Bureau of Statistics, Australia: Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians. Cat. no. 3238.0. ABS: Canberra; 2009.

³⁴ Vos T, Barker B, Stanley L, Lopez AD. *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples*. School of Population Health, The University of Queensland: Brisbane; 2007.

³⁵ Queensland Health. *The Health of Queenslanders 2010. Third Report of the Chief Health Officer Queensland*. Brisbane 2010.

³⁶ Safe Work Australia (2009). *Work-related traumatic injury fatalities, Australia 2006-07* < [http:// safeworkaustralia.gov.au](http://safeworkaustralia.gov.au)> accessed 24 August 2012

³⁷ Australian Centre for Agricultural Health and Safety. Traumatic deaths in Australian agriculture: The Facts, 2007, Facts and Figures on Farm Health and Safety Series. No 11. National Farm Injury Data Centre <http://www.aghealth.org.au/tinymce_fm/uploaded/Research%20Reports/farm_related_injuries_reported_in_the_australian_print_media_2010.pdf> viewed

³⁸ Queensland Health. *The Health of Queenslanders 2010. Third Report of the Chief Health Officer Queensland*. Brisbane 2010.

³⁹ Queensland Health. *The Health of Queenslanders 2006. Report of the Chief Health Officer Queensland*. Queensland Health, Brisbane 2006.

hospital and the services and facilities it offers. It will be harder for rural and remote areas to attract and retain medical staff than it is for the major city tertiary hospitals.

2.3.2 Medical Workforce Shortage in Rural and Remote Queensland

There has been much evidence to demonstrate the national shortage of a GP workforce across all States and Territories. However medical shortages are even more acute in Queensland in comparison to other parts of Australia⁴⁰.

Despite Federal and State efforts, by early 2000, the failure of supply of Queensland's rural and remote medical workforce had become evident. Whilst national and local initiatives such as the Queensland country Relieving Program and the Queensland Rural Scholarship Scheme appeared to generate a short-term supply, they did not address the delivery of health to rural and remote communities in a sustainable fashion.

2.3.3 The Development of Queensland Rural Generalist Pathway

By 2004, Queensland Health recognised that a strategy that best met current and predicted medical workforce shortages had to be based on a local approach that in the first instance sought to rebuild and/or stabilise services at Queensland's rural hospitals. Accordingly, the Queensland Rural Generalist Pathway was developed. Whilst fundamentally focusing on rural hospital medical workforce issues, the added attraction and benefit of the QRGP was its ability to simultaneously address the general practitioner shortages occurring across rural Queensland.

The Roma Agreement 2005

In August 2005, a team of senior medical superintendents, rural medical advisors and a number of other key stakeholders external to Queensland Health assembled in Roma, Queensland to assess rural medical workforce and tailored a generalist training pathway towards a definitive career in rural medical practice. The outcome of the meeting was the establishment of the Roma Agreement, which underpins the strategic direction of the Rural Generalist Pathway⁴¹ to this day.

The elements of agreement include:

1. Goal

“To develop and sustain an integrated service and training program to form a career pathway supplying the rural generalist workforce that the bush needs.”

2. Principles

- I. All career pathways will be easy to understand, responsive to needs, well promoted, well supported, well resourced and involve key stakeholders.
- II. A key outcome of the training program is eligibility for vocational recognition and appropriate credentialing. (The program incorporates training in hospital-based (public and private) and community-based (private and public) settings.
- III. The educational standards of the training program will be set externally by the appropriate college.
- IV. The professional standards and vocational requirements of rural generalist practice are those prescribed by the Australian College of Rural and Remote Medicine (ACRRM), whereas those of general practice are prescribed by the Royal Australian College of General Practice (RACGP).
- V. The program markets and provides a supported career path from medical school to rural generalist practice.
- VI. Vocational training will be provided by General Practice Education and Training (GPET) Training Providers and will be rural centric.

⁴⁰ *Commissions of Inquiry Order (No. 2) 2005*

⁴¹ *A Brief History of the Rural Generalist Pathway* (2007), Queensland Health, Queensland Government.

- VII. The program is underpinned by mentoring and individual learning and career planning. The personal and professional and career needs of trainees and their families are accommodated within the workforce.
- VIII. All providers including funding providers commit to the process and to provide timely decision making and action.
- IX. Rural generalist trainees have priority access to appropriate accredited Queensland Health training positions. (Queensland Health integrates service placement with prevocational and vocational training in partnership with training providers.)

Key Features of the Queensland Rural Generalist Pathway (QRGP)

A “rural generalist” is defined under QRGP as a rural medical practitioner who is credentialed to serve in:

- ▶ hospital and community-based primary medical practice;
- ▶ hospital-based secondary medical practice, without supervision by a medical specialist in at least one specialist medical discipline (commonly, but not limited to anaesthetics, emergency medicine, obstetrics and gynaecology);
- ▶ hospital and community based public health practice.

The QRGP is essentially a fast track to rural practice that also seeks to streamline processes associated with Advanced Skills Training with training endpoints of a vocational qualification which is either a Fellowship in the Australian College of Rural and Remote Medicine (FACRRM) or Royal Australian College of General Practitioners (FRACGP) or both (as shown in Table 3).

Table 3: The Rural Generalist Career Progression

PGY	RGP	QH	QHRSS	AGPT	RTVS	ACRRM	RACGP
1	Prevocational training	Intern		Application			
2		Junior House Officer	Return of service	Year 1		Core Clinical Training	Hospital Training
3	Advanced Skills Training	Registrar	Deferral year	Year 2	Application	Advanced Specialised Training	Advanced Skills Training
4	Vocational / Fellowship Training	Senior Medical Officer (Provisional Fellow)	Return of service	Year 3	Year 1	Primary Rural & Remote Training	GP Terms
5		Medical Officer with Right to Private Practice (MORPP)		Year 4	Year 2		
6	Continuing Professional Development	Senior Medical Officer Medical Superintendent with Right to Private Practice (MSRPP) & (MORPP) Visiting Medical Officer Advanced Credentialed Practice (VMOAP)			Year 3+	FACRRM (Advanced skill)	FRACGP (Advanced skills) Certified Women's Health

Source: Queensland Health; Rural Generalist Pathway, February 2012

Specifically QRGP is based on a training pathway where the professional standards and vocational requirements of rural generalist practice are those prescribed by ACRRM, whereas those of rural general practice are prescribed by RACGP or the ACRRM.

To remain on the QRGP pathway, it is expected that by the end of Post Graduate Year 2 (PGY2), trainees will have:

- ▶ applied for, and been accepted by, AGPT for a general practice training position with an RTP, or
- ▶ Applied and been accepted by the Remote Vocational Training Scheme (RVTS) (for those trainees who aspire to completing their training in remote and isolated localities).

Candidates apply to join the QRGP in the final year of the undergraduate MBBS program. The program comprises a three-stage clinical education program that is usually run over four years. The three stages are:

- ▶ prevocational training in a quarantined position at one of eleven Queensland Health regional or outer metropolitan hospitals (the first two postgraduate years);
- ▶ prevocational advanced skills training (predominantly undertaken in the third postgraduate year);
- ▶ general practice vocational training undertaken in the fourth and fifth postgraduate year (in supervised rural practice).

The QRGP is managed by five committees⁴² that provide strategic direction and support to the program, namely:

- ▶ Rural Generalist Pathway Reference Group
- ▶ Rural Generalist Pathway Executive Committee
- ▶ Rural Generalist Training Hospitals Forum
- ▶ Training Providers Executive Forum
- ▶ Training Providers Educators Forum.

These committees provide an opportunity for stakeholders and committee members to comment and advise on policy, training requirements, and educational and professional standards relevant to the QRGP.

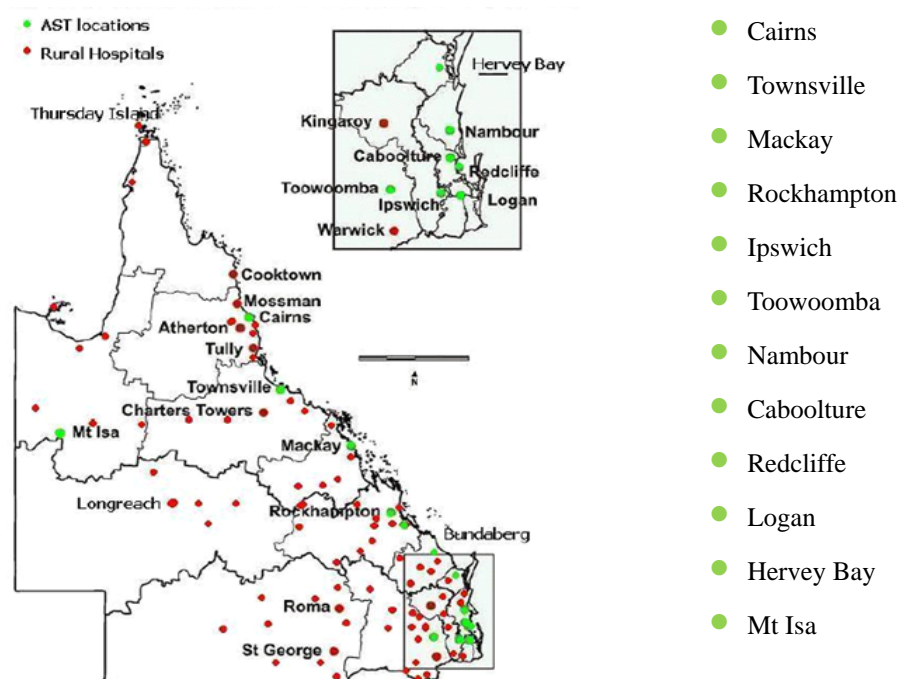
Intake into the program commenced in 2007, and in 2008, Queensland Health formally recognised rural generalist” medicine as a specialist discipline and reformed the State's salary classification⁴³. There are 55 quarantined rural generalist intern positions on offer amongst the following rural generalist training hospitals. Figure 6 illustrates the rural generalist training locations across Queensland⁴⁴.

⁴² Entry application: Queensland Health Award for Excellence in developing and supporting staff category; The Rural Generalist Pathway – providing Queensland with a rural and remote medical workforce

⁴³ www.health.qld.gov.au/ruralgeneralist accessed June 2012

⁴⁴ Manahan, D., Sen Gupta, T., Lennox, D., Taylor, N., Rowan, C., Hanson, D., McKenzie, A. Telfer, J., & Browning, J. (2011). *The rural generalist: a new generation of health professionals providing the rural medical workforce the bush needs*. Proceedings of the 11th National Rural Health Conference In: 11th National Rural Health Conference, 13-16 March 2011, Perth, Australia.

Figure 6: Rural generalist training locations



Source: Manahan, D., Sen Gupta, T., Lennox, D., Taylor, N., Rowan, C., Hanson, D., McKenzie, A., Telfer, J., & Browning, J. (2011). *The rural generalist: a new generation of health professionals providing the rural medical workforce the bush needs*.

Table 4 shows the uptake of the intern positions has steadily increased in this time reflecting the increased number of hospitals involved in the training program and the increase in intern places.

Table 4: Intern positions

	2005	2006	2007	2008	2009	2010	2011	2012
QRGP intern positions	20	24	26	25	39	42	37	43

Source: Queensland Health; Rural Generalist Pathway, February 2012

Advanced Skills Training (AST)

The range of disciplines for AST under the pathway includes, but is not limited to, anaesthetics, emergency medicine, Indigenous health, obstetrics and gynaecology and surgery. Medical advisors provide support and advice about the advanced skills training opportunities available across regional Queensland. To be eligible to apply for a quarantined training position under the QRGP, candidates must possess or have achieved:

- ▶ Australian Citizenship or Permanent Residency Status;
- ▶ Bachelor of Medicine/Bachelor of Surgery (MBBS) from an Australian university;
- ▶ Registration with the Medical Board of Australia.

The QRGP has now reached a state of maturity with the program yielding graduates who have entered the workforce. The program has harnessed a high degree of interest from other jurisdictions and nationally, in terms of presenting a viable and sustainable medical workforce solution for rural Australia.

The interest in the program has also engendered further debate nationally about the recognition of rural generalist as a specialty – noted to be one of the major founding pillars upon which the

QRGP was based.

Within this context, and given the evolution of the program, Queensland Health, through the Office of Rural and Remote Health has sought to undertake an investigation into the QRGP, the outcomes of which will be used to further the debate and construct of a rural generalist framework and workforce strategy. This report presents the findings of the commissioned investigatory study.

3 Evaluation Research Methodology and Approach

3.1 Objectives of the Evaluation

The objectives of the evaluation and investigative study, as outlined in documentation issued by Queensland Health are to:

- ▶ review the current state of the QRGP focusing on stakeholder engagement and process efficiency;
- ▶ undertake a comparative cost analysis for a Clinical Services Capability Framework level 3 site of the various available models of medical service delivery;
- ▶ consider the extent to which the QRGP meets the need and expectations of the rural communities;
- ▶ undertake a workforce analysis which maps workforce requirements and service elements, determines the future needs of the QRGP with specific mapping of advanced skills and identified pertinent population drivers;
- ▶ develop a workforce framework which provides the principles, service guidelines and planning tool that will assist and inform Hospital and Health Services, training organisations and trainees in regard to training programs and pathways to meet future needs.

This report presents findings of the evaluation that focussed on addressing the first three items of the terms of reference set out above. Workforce analyses are also presented in the report (refer Section 4). A workforce planning guide linking service demand to advanced skills requirements addresses the remaining terms of reference and has been submitted to the Department outside of this evaluation process.

3.2 Overall Approach

The overall approach adopted to evaluation the QRGP evaluation is based upon a six phase methodology outlined in Figure 7.

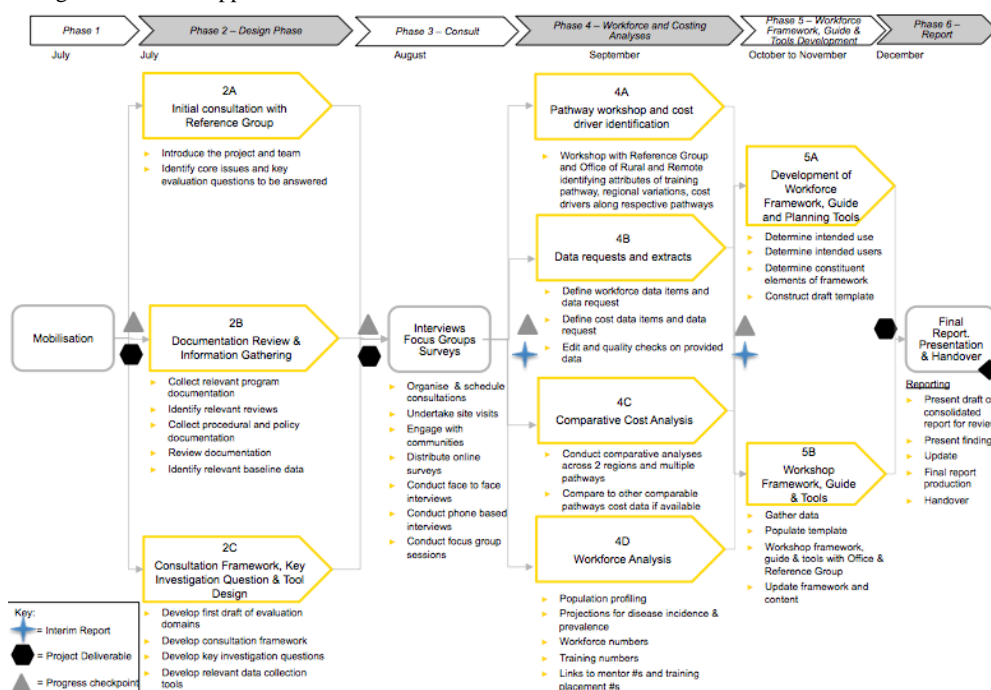
3.2.1 Stakeholder Engagement

As part of the overall evaluation, the study team undertook site visits at Mackay Hospital and Kingaroy Hospital where interviews with Hospital Executives, Medical Superintendents, Supervisors and trainees were completed. Teleconference discussions took place with a similar cohort of representatives from Longreach Hospital.

In addition, the evaluation team designed an on-line survey for trainees and graduates of the program to provide their insights into their experiences to date with the overall pathway. Approximately one third of the cohort of trainees and graduates associated with the program responded to the survey (n=77) and the feedback to the online survey is presented in Section 5.

With the QRGP pathway sitting within the GP training pathway, inherently the program interfaces with a number of key stakeholders including learned Colleges, workforce agencies, Universities, training providers, etc. The evaluation sought input from these stakeholders (refer Appendix A for the list of stakeholders approached to participate in the evaluation) via a mixed method approach including the request for submissions and direct interviews. The feedback from these processes are summarised in Section 8.

Figure 7: Overall approach and associated tasks



The study team also engaged on a number of occasions with staff from Queensland Health and Cunningham Centre involved in the design, implementation and administration of the QRGP. The feedback and contributions from all stakeholders have collectively contributed to the overall conclusions drawn by the evaluation.

Of note, during the conduct of the study, the health system of Queensland was undergoing major organisational and cultural changes with the formation of Hospital Health Services (HHSs). The corporate office of Queensland Health was also undergoing major redesign shifting to a role of “System Manager” that resulted in the realignment and divestiture of some traditional roles and functions. Amongst this re-organisation was the cessation of the role and function of Health Consumers Queensland, the organisation approached initially by the study team to gain consumer input. Accordingly consumer input into the evaluation has been limited.

3.2.2 Data Sources

A set of quantitative data were provided to the study team providing information about the profile of the participants of the QRGP, and the medical workforce profile overall of rural Queensland. Supplementary data to facilitate the fiscal analyses associated with the study was also provided. The main quantitative data sources used for evaluation of the QRGP included:

- ▶ The Australasian Medical Publishing Company (AMPCo) dataset provided by Queensland Health. This data set provided trend data for the years 2008, 2009, 2010 and 2012. The dataset for 2011 was not available.
- ▶ Panorama Payroll data, Unpublished Internal Queensland Health data generated on 27th June 2012
- ▶ Locum and rural remote internal data provided by Queensland Health
- ▶ RTGs and QHRSS data provided by QRGP, Cunningham Centre
- ▶ Medical vacancy data provided by Queensland Health.

The outcomes of the quantitative analyses are presented in Sections 4, and 9 respectively.

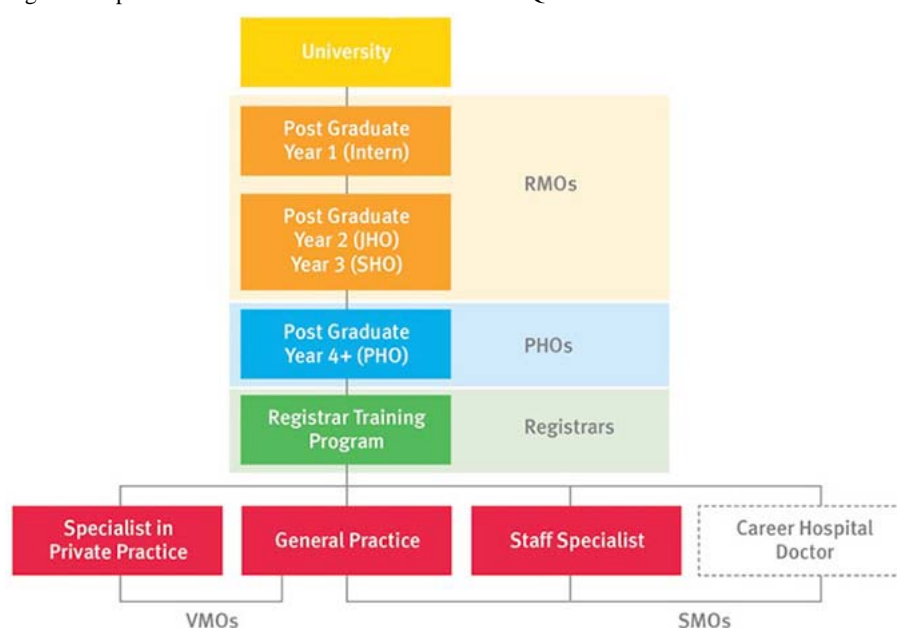
4 Workforce Analysis

The following provides an overview of the trends in medical workforce activity across Queensland. The AMPCo, Queensland Health internal payroll datasets and vacancy data were used to generate the data presented in this Section. The AMPCo data, (covering the following periods 2008-2010 and 2012) provides demographic information on all medical officers in Queensland such as age, gender, geographical dispersion, employment sector, specialisations and classifications. Queensland Health payroll data extends from 2004 to 2012 and provides the necessary depth of understanding in terms of current supply in medical officers in the Queensland public sector.

4.1 Queensland Health Medical Career Structure

Figure 8 below represents a rudimentary high-level operational structure under which Queensland Health employs medical practitioners. It is not intended to represent the Queensland Health Industrial Relations Awards Structure but provide basic contextual information about the relationship between various levels of employment and progression along the training/fellowship pathway.

Figure 8: Operational structure for medical officers in Queensland⁴⁵



⁴⁵ Source: <http://www.health.qld.gov.au/medical/career-structure.asp> accessed September 2012

An outline of the roles that differentiate between the respective classifications depicted in Figure 8 is summarised below in Table 5.

Table 5: Queensland medical officers operational definitions

Category	Level	Description
Resident Medical Officer (RMO)	Intern	A medical practitioner who holds a certificate from the Medical Board of Australia authorising an appointment as such under the Medical Practitioners Registration Act 2001. Interns are medical graduates who have been accepted into an intern training program under the supervision of their employing hospital. Generally, this will be the 1st year of practice following completion of a medical degree. In this year they must successfully complete various rotations under clinical supervision. Queensland Health is currently the sole provider of intern training in Queensland.
	Junior House Officer (JHO)	2nd post graduate year. A JHO is a medical practitioner in their first year of service after eligibility for full registration as a medical practitioner.
	Senior House Officer (SHO)	3rd post graduate year. A SHO is a medical practitioner in the second or subsequent years of practical experience after eligibility for full registration as a medical practitioner and who has not been appointed as a Registrar or Principal House Officer.
	Principal House Officer (PHO)	3rd and subsequent post graduate years. A PHO is a medical practitioner appointed as such who is not undertaking an accredited course of study leading to a higher medical qualification. A PHO position is an equivalent level to Registrar.
	Registrars	doctors who have been accepted into an accredited specialist training program in a clinical specialty with a nominated college
<i>All of the above medical staff are employed on 12 month temporary contracts and must apply for positions on an annual basis.</i>		
Senior Medical Officers (SMOs)	Include: General Practitioners Staff Specialists Career Hospital Doctors	SMOs can be appointed to work: generally (non-specialist), that is individuals who are not qualified in a specialty, but working in a specialty under the supervision of a specialist may be qualified as a specialist in another medical jurisdiction but will be employed in a Staff Grade position (formerly registered as a Deemed Specialist). IMGs maintain the title of Staff Grade position until Fellowship is conferred by the relevant Australian Specialty College.
Medical Officers/Medical Superintendents with Right of Private Practice (MORPP / MSRPP)		Are medical practitioners employed by Queensland Health who work in smaller rural hospitals. They provided services to the hospital as well as private general practice services in the town. Read the Guidelines for more information.
Visiting Medical Officers (VMO's)		are specialists that have their own private practice or General Practitioners who choose to consult within public and private hospitals on a part time basis.

4.2 Queensland Medical Workforce

4.2.1 Number and Type of Medical Officers

Table 6 shows a steady growth in supply of medical officers across the state of Queensland for the period 2008 to 2012. The overall increase of 34.1% in medical officers from 2008 to 2012 varies significantly by category of medical officer with:

- ▶ the highest increase amongst interns (604.7%) reflecting the increased university places available to study medicine
- ▶ the sharpest decrease of 78.4% amongst staff specialists.

Table 6: Number of Queensland medical officers 2008-2012

Year	GP	Intern	Medical Officer	Registrar	RMO	Senior Staff Specialist	Specialist	Staff Specialist	Total
2008	3729	128	282	873	758	572	2035	568	8989
2009	3835	271	413	966	471	811	2084	484	9382
2010	4000	359	423	819	498	963	2266	374	9749
2012	4053	902	812	998	1237	1502	2376	123	12054
Total	15617	1660	1930	3656	2964	3848	8761	1549	40174

Source: AMPCo Data 2012

Table 7 identifies that the the smallest increase has been amongst general practitioners (6.5%).

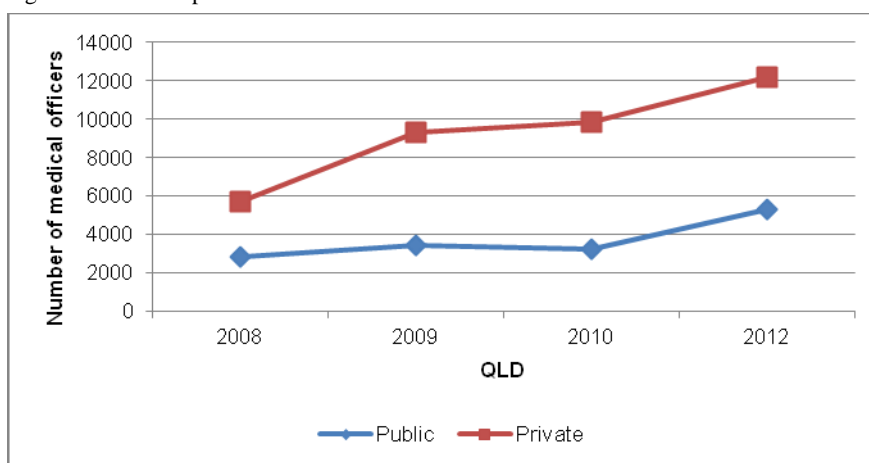
Table 7: Classifications of medical officers 2008 – 2012

Year	Anaesthesia	EM	General Practice	Internal Medicine	Medical Officers	O&G	Surgery	Grand Total
2008	510	244	4051	1100	1165	211	803	8110
2009	570	242	4171	1202	1150	287	839	8487
2010	669	264	4224	1221	1253	289	882	8827
2012	717	369	4315	1357	2927	308	976	10991
Total	2466	1119	16761	4880	6495	1095	3500	36415

Source: AMPCo Data 2012

Across the state of Queensland there has been a greater growth in the number of medical staff working in the public sector than those working in the private sector (refer Figure 9).

Figure 9: Sector of practice



Source: AMPCo Data 2012

4.2.2 Geographic Distribution

Classification of remoteness is based on the seven categories in the Rural, Remote and Metropolitan Area (RRMA) index⁴⁶ and has been used to categorise the dispersion of the Queensland medical workforce by geographic region.

⁴⁶ Rural, Remote and Metropolitan Areas (RRMA) classification <http://www.aihw.gov.au/rural-health-rrma-classification/> viewed 20 September 2012

Consistent with national trends, the majority of medical officers continue to work in metropolitan areas in Queensland. Remote areas report having the lowest number of RMOs and specialists when compared to rural or major cities, reflecting the heavy reliance on VMO and general practitioner support to deliver health care services in these locations.

In 2012, AMPCo data indicates that 98.6% of medical officers in Queensland practiced in either metropolitan or regional areas whilst the remaining 1.4% of medical officers practiced in remote communities (REM 1-2).

Table 8: Trend in geographical distribution of medical officers

Employment	Year	Metropolitan (RRMA 1 & 2)	Remote (RRMA 6 & 7)	Rural (RRMA 3, 4 & 5)	Total
General Practitioner	2008	2415	84	1230	3729
	2009	2487	92	1256	3835
	2010	2590	93	1317	4000
	2012	2629	91	1315	4035
	Total	10121	360	5118	15599
Intern	2008	98		30	128
	2009	209		62	271
	2010	289	1	69	359
	2012	704	1	197	902
	Total	1300	2	358	1660
Medical Officer	2008	162	30	90	282
	2009	278	31	104	413
	2010	290	23	110	423
	2012	580	29	203	812
	Total	1310	113	507	1930
Registrar	2008	622	22	229	873
	2009	707	16	243	966
	2010	606	18	195	819
	2012	743	21	234	998
	Total	2678	77	901	3656
Resident Medical Officer	2008	600	10	148	758
	2009	370	7	94	471
	2010	387	8	103	498
	2012	863	17	357	1237
	Total	2220	42	702	2964
Senior Staff Specialist	2008	454	4	114	572
	2009	649	4	158	811
	2010	768	3	192	963
	2012	1191	4	307	1502
	Total	3062	15	771	3848
Specialist	2008	1631	3	401	2035
	2009	1658	3	423	2084
	2010	1804	3	459	2266
	2012	1887	6	482	2375
	Total	6980	15	1765	8760
Staff Specialist	2008	441	1	126	568

Employment	Year	Metropolitan (RRMA 1 & 2)	Remote (RRMA 6 & 7)	Rural (RRMA 3, 4 & 5)	Total
	2009	364	1	119	484
	2010	262		112	374
	2012	64	2	57	123
	Total	1131	4	414	1549
	Grand Total	28802	628	10536	39966

Source: AMPCo Data 2012

Data internal to Queensland Health reaffirms this trend within the public sector and also shows the medical workforce is based upon an approximate 2:1 ratio of male to female medical staff (refer Table 9). The latest full-time equivalent (FTE) count across all HHSs based on Queensland Health's (QH) payroll data generated in June 2012 identifies approximately 1.4% of QH employed medical officers are employed and practice in remote locations.

Table 9: Current facility staffing level Medical QH June 2012

HHS	% Distribution		FTE		
	Male	Female	Male	Female	Total
Cairns & Hinterland	60.2%	39.8%	259.2	171.9	430.9
Cape York District	50%	50%	5	5	10
Central Queensland District	66.6	33.3%	152.8	76.6	229.3
Central West District	44.4%	55.6%	4	5	9
Children's Health Service	50.7%	49.3%	153.3	149.1	302.4
Darling Downs Hospital & Health Service	68.2%	31.8%	225.1	105	330.1
Gold Coast District	65.4%	34.6%	561.1	296.8	858.1
Mackay District	64%	36%	140.8	79	219.8
Metro North District	61%	39%	1213.7	776.6	1990.3
Metro South District	62.7%	37.3%	1071.3	637.2	1708.5
Metro South State-wide Services	100%	0%	1	0	1
Mt Isa District	60.8%	39.2%	31	20	51
South West	79.2%	20.8%	19	5	24
Sunshine Coast Hospital & Health Service	63.9%	36.1%	347	195	543
Torres Strait	80%	20%	12	3	15
Townsville District	59.6%	40.4%	353.9	239.6	593.4
West Moreton Health Service District	66.9%	33.1%	215.1	106.6	321.7
Wide Bay District	74.4%	25.6%	220.5	76	296.5
Systems Manager	55.8%	44.3%	136.1	108	244.1
Total	62.6%	37.4%	5122	3046	8178

Source: Panorama Payroll data, Internal QH unpublished as at June 27th 2012

4.2.3 Demographics

Age and gender profile

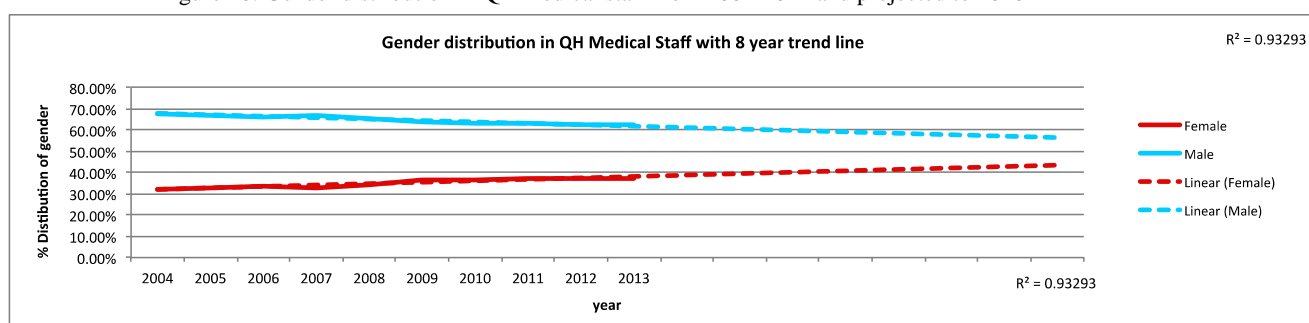
Payroll data shows a steady increase in the number of female medical staff employed by Queensland Health and projects the proportion of female medical staff to reach in excess of 40% within the next eight years. This has implications for future workforce planning, as the female workforce typically work on a part-time or reduced level of hours compared to their male counterparts (refer Section 3).

Data shows that there is a steady growth in the number of female general practitioners entering the workforce.⁴⁷ Recent work undertaken in South Australia identified that for any male GP who exits rural practice and is replaced by a female GP a one to one replacement will be inadequate to cover the same hours. Specifically for each male GP leaving rural SA practice and if replaced by a female GP, then 1.2 FTEs will be required to cover the same hours. Further, if a male GP who provides emergency on call services is to be replaced then the ratios increase further to:

- ▶ 1.25 male doctors, or
- ▶ 1.4 female doctors

required to effectively replace the GP and maintain their existing working hours⁴⁸. It is reasonable to assume similar trends are applicable within the Queensland context.

Figure 10: Gender distribution in QH medical staff from 2004-2012 and projected to 2020



Source: Panorama Payroll data, Internal QH unpublished as at June 27th 2012

The ageing profile of the medical workforce is depicted in Table 10. The data shows that the majority of medical officers are aged between 44-54 years of age. Of note, in 2008 7.32% of medical officers were aged 65+ years of age. This has now shifted in 2012 to 18.5%.

Table 10: Number of medical officers by gender and age bracket

Year	Gender	35>	35-44	44-54	55-64	65 +	Total
2008	F	703	949	896	358	76	2982
	M	756	1512	1891	1363	590	6112
	Total	1459	2461	2787	1721	666	9094
2009	F	762	1004	932	387	85	3170
	M	760	1547	1919	1428	652	6306
	Total	1522	2551	2851	1815	737	9476
2010	F	782	1030	979	434	108	3333
	M	779	1577	1987	1471	696	6510
	Total	1561	2607	2966	1905	804	9843
2012	F	1089	1048	1011	570	648	4366
	M	955	1600	2087	1562	1602	7806
	Total	2044	2648	3098	2132	2250	12172
	Grand Total	6586	10267	11702	7573	4457	40585

Source: AMPCo Data 2012

The relative proportion of the workforce electing to work in rural and regional locations in Queensland is relatively uniform across the two genders. Table 11 shows that:

⁴⁷ Primary Health Care Research & Information Service, Fact Sheets, Female GPs in Australia 2007, <http://www.phcris.org.au/fastfacts/index.php> accessed February 2011

⁴⁸ McCulloch A., Presentation "Planning for a Rural Pathway", December 2010, Rural Doctors Workforce Agency.

- ▶ In 2008, 28.99% of male medical practitioners working in the state of Queensland reported working in rural and/or remote locations. This remained relatively steady, with 28.8% reporting in 2012 to be working in similar regions.
- ▶ For the same period, 26.32% of female medical practitioners working in the state of Queensland reported working in a rural and/or remote location. This remained relatively stable with 25.73% reporting to work in similar locations in 2012.

Table 11: Number of medical officers by gender, age bracket and RRMA

MALE							
Year	RRMA	35>	35-44	44-54	55-64	65 +	Total
2008	Metropolitan	560	1074	1272	975	459	4340
	Remote	12	34	29	25	8	108
	Rural	184	404	590	363	123	1664
	Total	756	1512	1891	1363	590	6112
2009	Metropolitan	588	1097	1291	1008	509	4493
	Remote	11	32	32	24	9	108
	Rural	161	418	596	396	134	1705
	Total	760	1547	1919	1428	652	6306
2010	Metropolitan	595	1138	1338	1032	538	4641
	Remote	12	28	25	31	6	102
	Rural	172	411	624	408	152	1767
	Total	779	1577	1987	1471	696	6510
2012	Metropolitan	731	1170	1419	1090	1138	5548
	Remote	16	25	34	26	24	125
	Rural	208	399	630	443	440	2120
	Total	955	1594	2083	1559	1602	7793
	Total	3250	6230	7880	5821	3540	26721

FEMALE							
Year	RRMA	35>	35-44	44-54	55-64	65 +	Total
2008	Metropolitan	527	690	645	274	61	2197
	Remote	19	17	14	4	1	55
	Rural	157	242	237	80	14	730
	Total	703	949	896	358	76	2982
2009	Metropolitan	570	723	675	300	67	2335
	Remote	16	18	16	3	2	55
	Rural	176	263	241	84	16	780
	Total	762	1004	932	387	85	3170
2010	Metropolitan	586	741	718	334	80	2459
	Remote	22	14	18	4		58
	Rural	174	275	243	96	28	816
	Total	782	1030	979	434	108	3333
2012	Metropolitan	815	767	748	439	469	3238
	Remote	17	17	13	5	7	59
	Rural	257	263	248	123	172	1063
	Total	1089	1047	1009	567	648	4360
	Grand Total	3336	4030	3816	1746	917	13845

Source: AMPCo Data 2012

Table 12 shows the age profile of the male workforce by type of practitioner. General Practitioners aged between 44-54 years of age represent the modal group for each of the reported years.

Table 12: Number of medical officers by male, age bracket and classification and RRMA (R1-R3 and REM 1-2)

MALE								
Year	Classification	35>	35-44	44-54	55-64	65 +	Total	
2008	Anaesthesia		27	42	26	7	102	
	Emergency Medicine	1	17	17	2		37	
	General Practice	76	246	362	208	60	952	
	Internal Medicine	10	27	46	43	18	144	
	Medical Officers	97	46	30	8	6	187	
	O&G	2	9	7	17	5	40	
	Primary Health Care			1	5		6	
	Surgery	5	40	66	47	18	176	
	Total		191	412	571	356	114	1644
2009	Anaesthesia	6	29	45	28	7	115	
	Emergency Medicine	1	17	18	3		39	
	General Practice	70	237	358	225	70	960	
	Internal Medicine	8	43	47	49	20	167	
	Medical Officers	79	46	31	11	6	173	
	O&G		12	9	18	5	44	
	Primary Health Care				5		5	
	Surgery	5	40	69	47	21	182	
	Total		169	424	577	386	129	1685
2010	Anaesthesia	8	34	47	32	16	137	
	Emergency Medicine	1	19	21	5	2	48	
	General Practice	73	225	363	233	71	965	
	Internal Medicine	7	40	57	45	22	171	
	Medical Officers	88	39	29	13	7	176	
	O&G		10	11	19	5	45	
	Primary Health Care				5		5	
	Surgery		43	70	48	22	183	
	Total		177	410	598	400	145	1730
2012	Anaesthesia	9	38	49	33	25	154	
	Emergency Medicine	5	18	23	7	8	61	
	General Practice	50	204	346	261	118	979	
	Internal Medicine	1	39	56	44	38	178	
	Medical Officers	150	51	39	15	198	453	
	O&G	1	7	16	17	7	48	
	Primary Health Care				2		2	
	Surgery	5	40	79	48	33	205	
	Total		221	397	608	427	427	2080
Grand Total			758	1643	2354	1569	815	7139

Source: AMPCo Data 2012

Table 13 shows the age profile of the female workforce by type of practitioner. As with the male cohort, the modal group each year is the 44-54 year age group.

Table 13: Number of medical officers by female, age bracket, classification and RRMA (R1-R3 and REM 1-2)

FEMALE							
Year	Classification	35>	35-44	44-54	55-64	65 +	Total
2008	Anaesthesia	3	4	4	4	1	16
	Emergency Medicine	1	4	2			7
	General Practice	71	191	197	63	10	532
	Internal Medicine	7	17	17	2	2	45
	Medical Officers	88	14	11	6	1	120
	O&G	2	7	3	1		13
	Primary Health Care			1			1
	Surgery		7	7	1		15
	Total	172	244	242	77	14	749
2009	Anaesthesia		8	6	4	1	19
	Emergency Medicine	3	3	2			8
	General Practice	81	197	200	64	13	555
	Internal Medicine	7	26	15	4	2	54
	Medical Officers	95	17	7	4	1	124
	O&G	1	9	4	1		15
	Primary Health Care			2	1		3
	Surgery	2	9	7	2		20
	Total	189	269	243	80	17	798
2010	Anaesthesia	2	7	8	4	4	25
	Emergency Medicine	1	5	1	1	1	9
	General Practice	78	199	202	70	17	566
	Internal Medicine	8	29	14	5	2	58
	Medical Officers	98	18	9	5	2	132
	O&G	3	11	5	1		20
	Primary Health Care			1	2		3
	Surgery	3	11	6	3		23
	Total	193	280	246	91	26	836
2012	Anaesthesia	1	6	6	4	8	25
	Emergency Medicine	2	5	2	1	2	12
	General Practice	58	174	198	94	45	569
	Internal Medicine	8	28	16	7	7	66
	Medical Officers	194	33	12	5	102	346
	O&G	2	10	5	2	2	21
	Primary Health Care			2	2		4
	Surgery	3	10	5	3	1	22
	Total	268	266	246	118	167	1065
Grand Total		822	1059	977	366	224	3448

Source: AMPCo Data 2012

4.2.4 Working Arrangements

Employment status

Table 14 illustrates the employment arrangement for QH medical officers across all HHS. As indicated in Table 5, Resident Medical Officers represent medical staff employed on 12 month temporary contracts and who must apply for positions on an annual basis. This cohort represents the greater proportion of employed medical officers employed by Queensland Health. Accordingly it explains why the employment status of “temporary officer” accounts for over 60% of all employment profiles.

Table 14: Employment status by HHS district

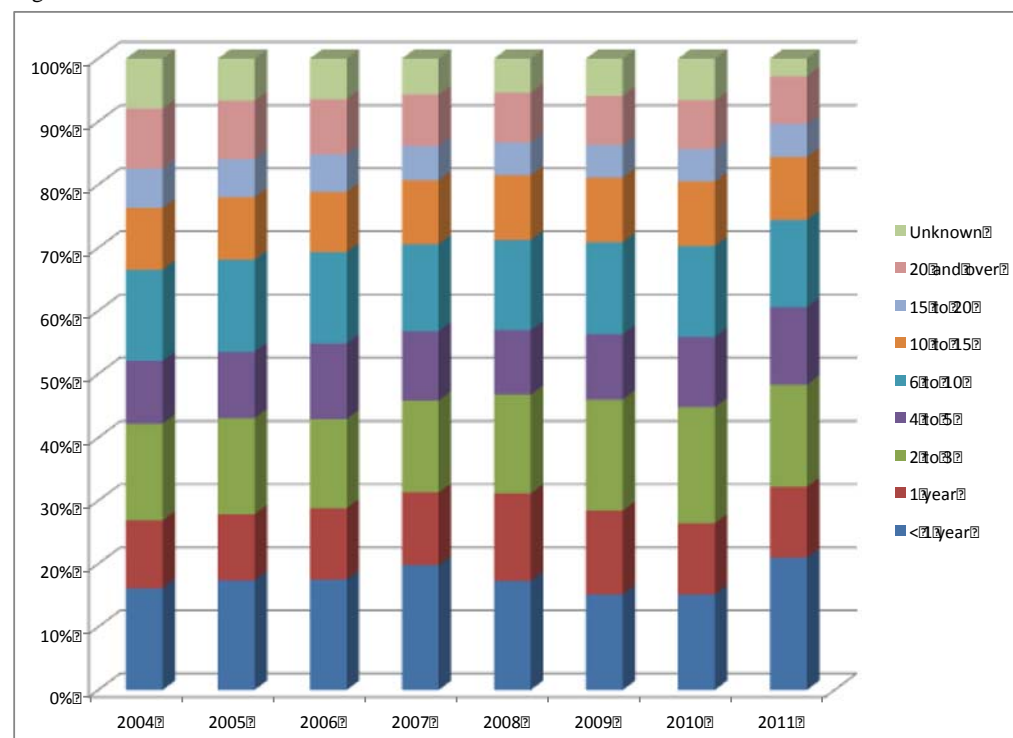
HHS	Casual	Permanent	Temporary	Total
Cairns & Hinterland	5.00	154.00	276.99	435.99
Cape York District		7.00	1.00	8
Central Queensland District		79.50	152.27	231.77
Central West District		6.00	3.00	9
Children's Health Service	3.00	131.12	154.17	288.29
Darling Downs Hospital & Health Service	1.00	145.43	188.74	335.17
Gold Coast District	1.00	295.54	567.81	864.35
Mackay District		86.75	133.00	219.75
Metro North District	8.00	813.16	1,297.48	2118.64
Metro South District	9.00	651.97	1,098.99	1759.96
South West	1.00	14.00	9.00	24
Sunshine Coast Hospital & Health Service		230.54	316.95	547.49
Torres Strait		13.00	2.00	15
Townsville District	4.00	235.21	362.62	601.83
West Moreton Health Service District		128.60	192.81	321.41
Wide Bay District	3.00	119.75	173.75	296.5
North West Hospital and Health Service		26.00	25.00	51
Corporate Office	2.00	41.60	6.25	49.85
Total	37	3179.17	4961.83	8178

Source: Panorama Payroll data, Internal QH unpublished as at June 27th 2012

Tenure

Figure 11 illustrates the trend in tenure for medical labour within QH as of June 2012. In any given year, approximately 50% of medical officers working in Queensland have worked for Queensland Health less than 5 years with this having grown to nearly 60% in 2011.

Figure 11: Trend in medical officers tenure

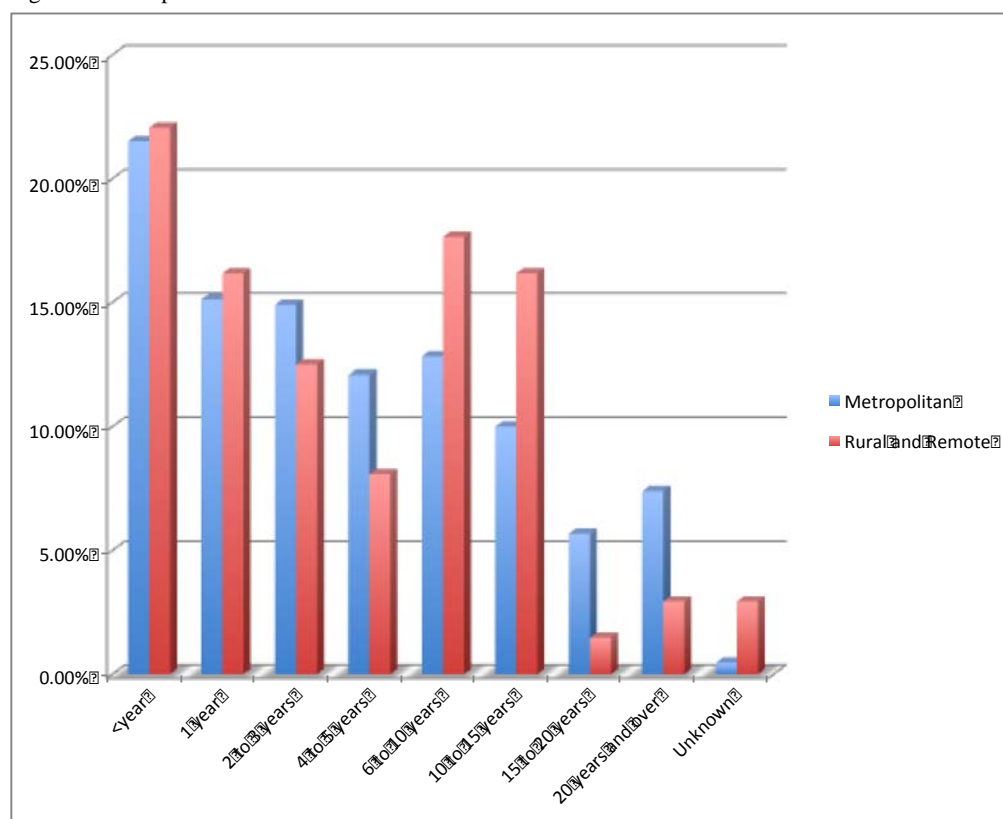


Source: Panorama Payroll data, Internal QH unpublished as at June 27th 2012

Figure 12 compares the tenure of medical labour-force working in metropolitan locations to those working in rural and remote locations. There is some attrition into the private sector once fellowship is attained which explains some of the drop off post the 6 year mark. The data

in Figure 10 indicates that if a medical practitioner has worked up to five years in a rural setting they are more likely to continue working in this setting.

Figure 12: Comparison of remote medical tenure in 2012

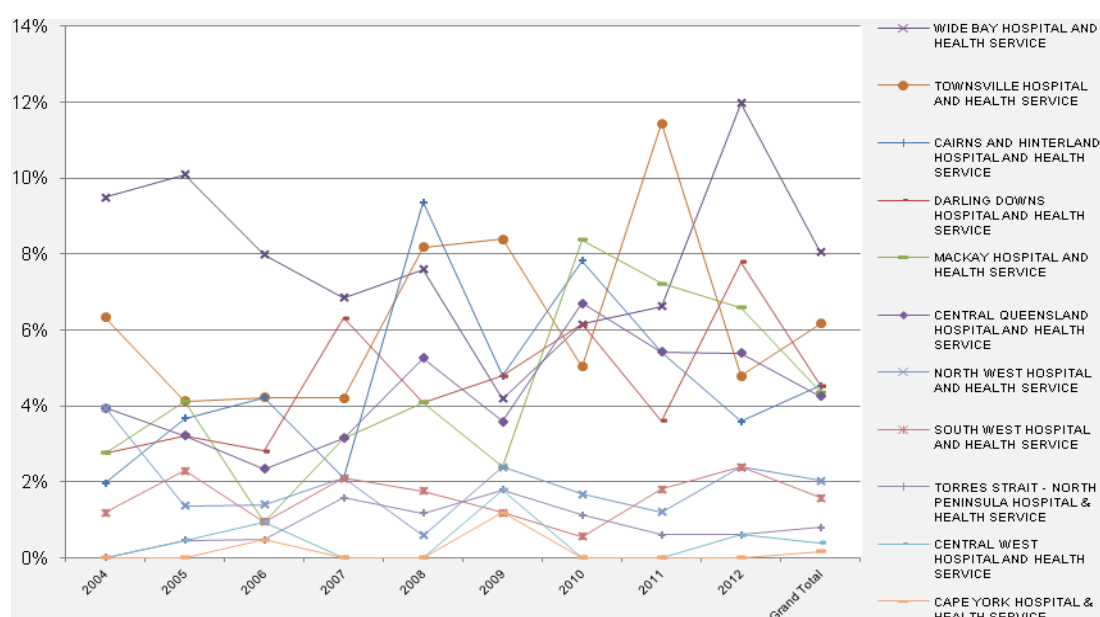


Source: Panorama Payroll data, Internal QH unpublished as at June 27th 2012

Attrition rates

The number of QH employed medical staff exiting the workforce has typically been reported by most rural and country based HHSs to fall under 10% in the last decade (refer Figure 13 overleaf). This is largely influenced by the heavy reliance these regions have placed upon VMOs and general practitioners supporting the provision of health services to their local communities.

Figure 13: Existing workforce across regional and rural HSSs from 2004 to 2012



Source: Panorama Payroll data, Internal QH unpublished as at June 27th 2012

4.3 Status of the QRGF

In the State submission⁴⁹ to the Senate Inquiry into rural health services, Queensland Health identified the achievements of the QRGF as having yielded the following outcomes:

- ▶ 2010: 4 doctors received fellowship while at the following locations: Townsville, Kingaroy, Mt Isa, Proserpine
- ▶ 2011: 4 doctors received fellowship at the following locations: Cherbourg, Moranbah, Mossman, Bundaberg
- ▶ 2012: 14 doctors completing their fellowship in the following locations: Weipa, Thursday Island, Bowen, Ayr, Stanthorpe, Longreach, Dalby, Townsville(2), Palm Island, Charters Towers, Cooktown, Gympie, Warwick.

These doctors bring the following advanced skills:

- ▶ Obstetrics (2)
- ▶ Paediatrics(1)
- ▶ Anaesthetics (8)
- ▶ Emergency Medicine (3).

⁴⁹ Queensland Health Rural Generalist Pathway, Queensland Health Submission to the Senate Inquiry "Factors affecting the supply of health services and medical professionals in rural areas", 2012

Additionally Table 15 identifies the number of trainees that are in the training program placed in hospitals across the state.

Table 15: Number of trainees currently in the training program - 2012

Training Year	Number of Trainees	Expected completion year	Advanced Skills Training
Post Graduate Year 1	42	2016	Not yet chosen
Post Graduate Year 2	39	2015	Not yet chosen
Post Graduate Year 3	35	2014	Not yet chosen
Post Graduate Year 4	21	2013	Obstetrics (5) Paediatrics(1) Adult Internal Medicine (1) Anaesthetics (6) Emergency Medicine (6) Surgery (1) Unknown (1)

4.4 Adequacy of Workforce Supply

4.3.1 Queensland Critical Medical Vacancy Reporting

Medical vacancy reporting within Queensland Health is based on a criticality rating defined as:

- ▶ Critical Level 1: Service is closed (or yet to open);
- ▶ Critical Level 2: Service is threatened to close ;
- ▶ Critical Level 3: Major delays to service and strain on staff;
- ▶ Non-critical Level 4: Moderate delays to service and strain on staff;
- ▶ Non-critical Level 5: None / minor delays to service and strain on staff.

HHSs report critical medical vacancies on a monthly basis with non-critical vacancy data reported on a quarterly basis. This practice has been in operation since January 2011, however the future availability of this data is not clear.

Vacancy statistics are often used in workforce planning as an indicator of skill shortage and labour demand. Strong growth in the number of vacancies advertised may indicate demand for skills in a particular industry and large numbers of unfilled vacancies can point to a skill shortage. Vacancy data is not only used in this manner but can indicate where potential mal-distribution of the workforce has occurred. As such, it is important to interpret vacancy figures with care and in conjunction with other indicators.

Recognising that the vacancy data held by QH is self reported by the respective HHSs, and the caveats that need to be placed in terms of the interpretation placed upon the data, the study team nevertheless requested access to this dataset. The information was sought as a means of providing further indicators of where workforce vacancy pressures were occurring.

The following analyses are based upon data that covers the period January 2010 to July 2012.

The data is grouped into regions using the following broad classifications developed by Queensland Health⁵⁰:

- ▶ Inner Metro HSSs: Metro North and Metro South
- ▶ Outer Metro HSSs: Children's Health Services, Gold Coast, Sunshine Coast, West Moreton

⁵⁰ Clinical Workforce Solutions. Statewide Critical Medical Vacancy Report July 2012. Queensland Government

- ▶ Regional HSSs: Cairns & Hinterland , Central Queensland, Darling Down, Mackay, Townsville, Wide Bay
- ▶ Rural HSSs: Cape York, Central West, Mount Isa, South West, Torres Strait and Peninsula.

4.3.2 Medical vacancies from 2010 to 2012

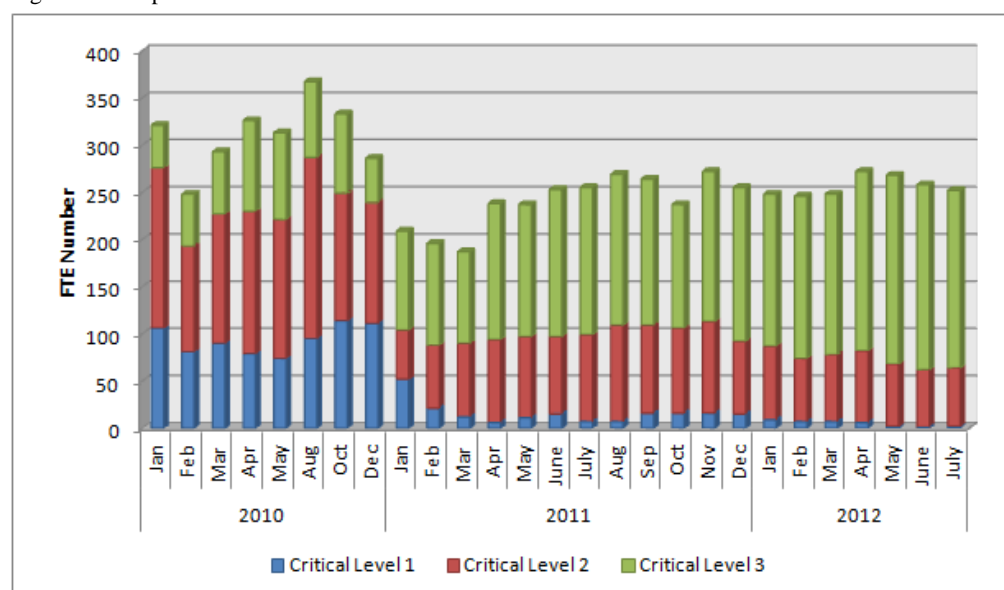
Table 16 and Figure 14 display the trend of medical vacancies over the last two and a half years in Queensland. The trends are positive for vacancies deemed to be critical (i.e. potentially threatening closure of service if not filled). As expected, the focus has been to fill these critical vacancies, placing those services with less critical workforce issues in a holding pattern with a resultant increase in Critical Level 3 vacancies occurring over the same period. With the critical vacancies now at a more stable and manageable level, focus on the recruitment to positions deemed level 3 can now occur in a more concentrated manner.

Table 16: Total of medical vacancies between 2010 and 2012

Vacancies	2010	2011	2012
Level 1	750	194 (-74.13%)	34 (-82.48%)
Level 2	1109	1004 (-9.47%)	481 (-52.09%)
Level 3	568	1674 (194.71%)	1277 (-23.72%)
Total	2427	2872	1792

Source: Medical vacancy data as of 10/8/12, obtained from QH

Figure 14: Graph of medical vacancies between 2010 and 2012

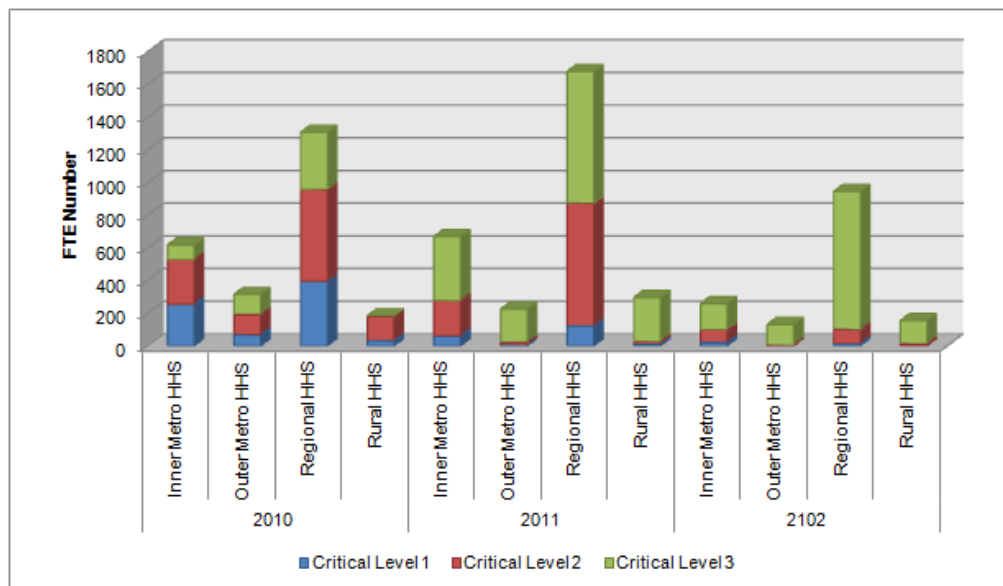


Source: Medical vacancy data as of 10/8/12, obtained from QH

A marked decrease in the number of critical medical vacancies reported by rural and regional HHS has occurred coinciding with the maturity of the QRGP.

Figure 15 shows that over the 2010-2012 period, the regional facilities in Cairns and Hinterland, Central Queensland, Darling Downs, Mackay, Townsville and Wide Bay we most affected by critical medical shortages in all three levels of criticality. Importantly the data also shows significant improvements, particularly in the filling of critical level 1 vacancies in these areas in the 2011 and 2012 periods. This coincides with the first round of graduates from the QRGP program and it is reasonable to infer that these graduates have been appointed to these vacant positions. Ongoing monitoring, particularly now of critical level 2 vacancies in rural and regional HHSs over the next few years should show similar decreases as the QRGP moves into a mature status yielding a higher number of graduates.

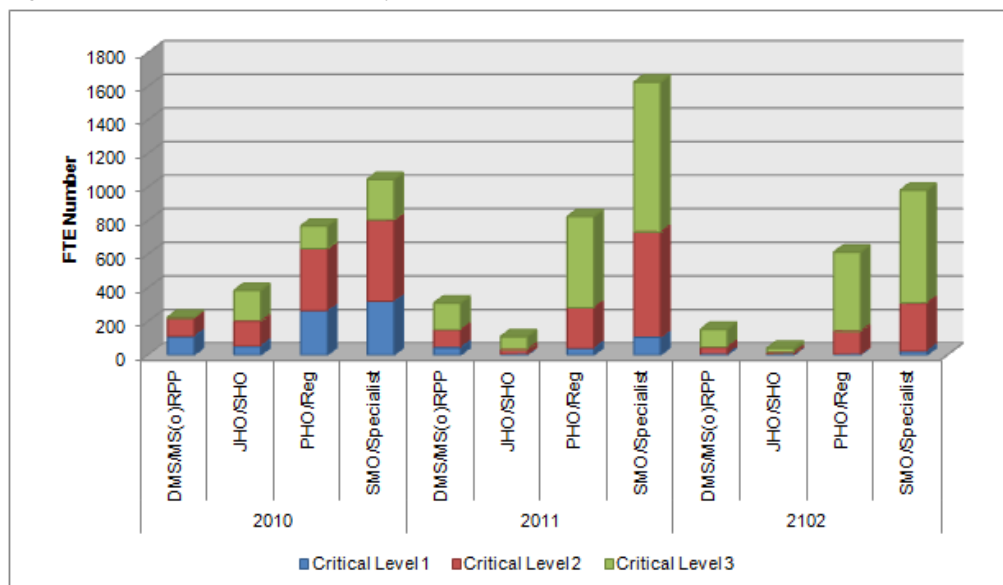
Figure 15: Critical medical vacancies by HSD



Source: Medical vacancy data as of 10/8/12, obtained from QH

The highest of vacancies reported were for PHO / Registrars and SMO / Specialists as displayed in Figure 16.

Figure 16: Critical medical vacancies by classification



Source: Medical vacancy data as of 10/8/12, obtained from QH

The trend data (refer Table 17) shows the positive impact workforce strategies adopted by Queensland Health have had in addressing critical level 1 (and to a lesser extent critical level 2) vacancies amongst Principal House Officers (PHO) and Senior Medical Officers.

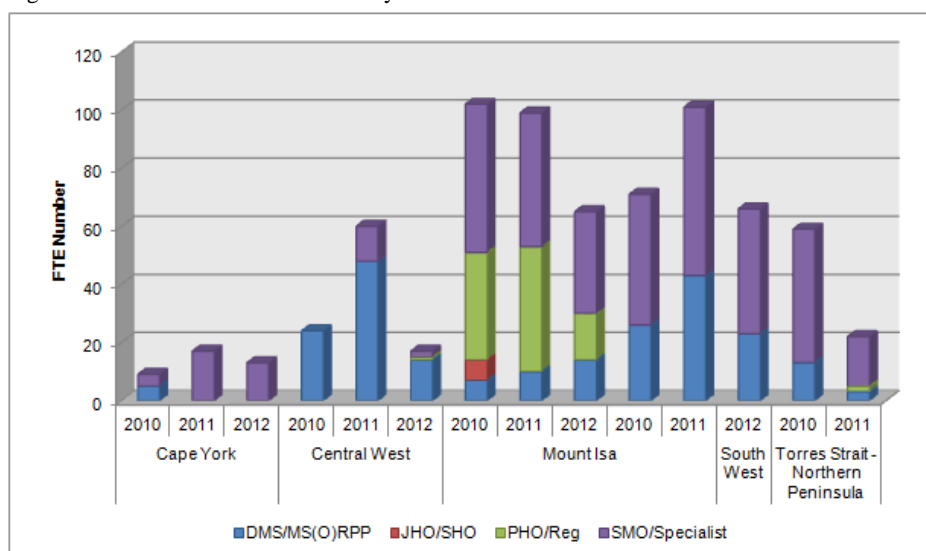
Table 17: Shortage in PHO/Registrar and SMO/Specialist

Vacancies	2010	2011	2012
PHO / Reg			
Level 1	265	40 (-84.9%)	4 (-90.0%)
Level 2	370	242 (-34.6%)	138 (-43.0%)
Level 3	134	543 (305.2%)	471 (-13.3%)
SMO / Specialist			
Level 1	322	106 (-67.1%)	23 (-78.3%)
Level 2	483	627 (29.9%)	287 (-54.2%)
Level 3	242	893 (269.0%)	673 (-24.6%)

Source: Medical vacancy data as of 10/8/12, obtained from QH

In terms of rural HHSs, Figure 17 there continues to be a need to supply SMOs and MSRPP/MORPs. Mount Isa HHS is the only HHS identifying an ongoing critical vacancy in PHO/Registrars.

Figure 17: Critical medical vacancies by rural HSDs and classifications



Source: Medical vacancy data as of 10/8/12, obtained from QH

In summary, high vacancy rates are recognised as being symptomatic of medical workforce shortages. The data presented above shows that across rural and regional HHSs, Queensland Health has been successful in reducing the number of critical medical vacancies that, if left unfilled, threaten service delivery and closure of health services. This reduction coincides with the maturing of the QRGP in which critical mass in trainee numbers is being achieved and graduates from the program are starting to be produced.

Whilst this is extremely positive, the QRGP now needs to move from a position of development to stabilising the program. Specifically QRGP will need to shift some of its focus from activities associated with the attraction and recruitment of trainees to the program to working more closely with the respective HHSs to ensure that the program is responsive to workforce planning requirements of the respective regions.

5 QRGP Trainees & Graduates Profile and Feedback

The Cunningham Centre in Darling Downs Hospital and Health Service administers the QRGP. The Centre assumes the role of custodian of data about the respective QRGP trainees. The information is housed on a rudimentary database originally designed to support the Queensland Health Rural Scholarship Scheme (QHRSS). Further discussion about the impacts this database has upon program process efficiency is presented in Section 7.

A profile of the QRGP trainees and graduates is presented in the following section and is primarily based upon the data extracted from the system operated by the Cunningham Centre. Supplementary data obtained through the trainee online survey (refer Appendix B) reflecting feedback from 77 QRGP trainees (approximately one third of all trainees and graduates involved in the QRGP) constructed and administered by the study team is also referenced in this section.

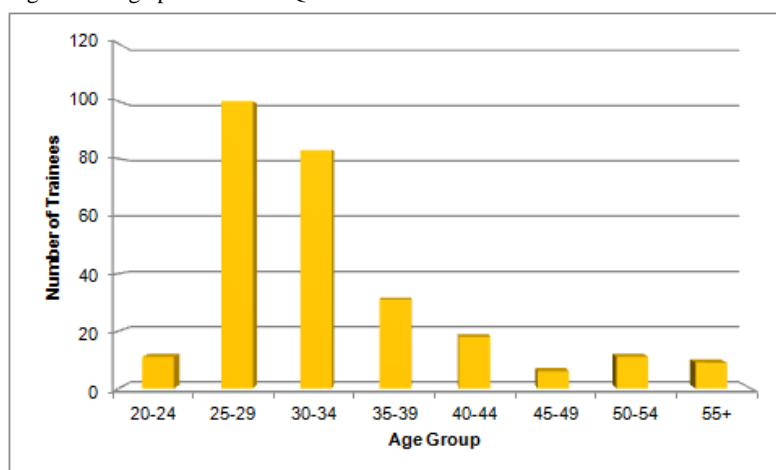
5.1 Profile of the QRGP Trainees

5.1.1 Demographics

Age and gender profile

Figure 18 depicts the age profile of the cohort of QRGP trainees as of September 2012. This profile excludes medical undergraduates and QRGP withdrawals. The QRGP cohort is relatively young, ranging from 23 to 63 years of age with a mean of 31 years of age. The modal age group is the 25-29 year age cohort accounting for 37.2% of all QRGP trainees on the program.

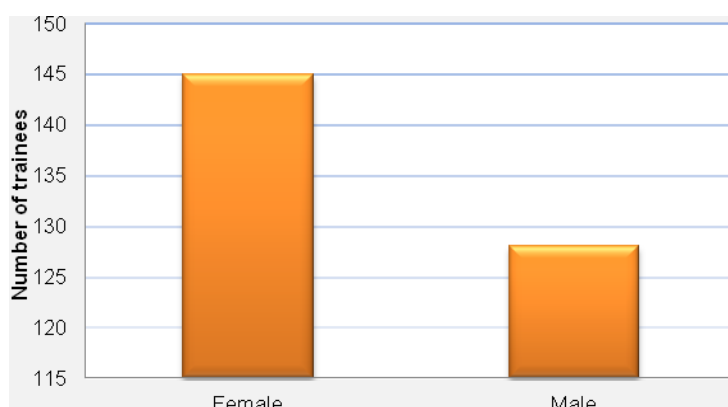
Figure 18: Age profile of the QRGP cohort



Source: QRGP Trainees and QHRSSs all details as at 20.9.12 from QRGP Cunningham Centre

Similar to the gender distribution and workforce demographic trends reported in Section 4, the QRGP trainee cohort comprises a slightly greater proportion of female trainees. The specific distribution, based on numbers reported as at September 2012 is 53.1% female trainees compared to 46.9% male trainees (refer Figure 19).

Figure 19: Gender profile of the QRGF cohort

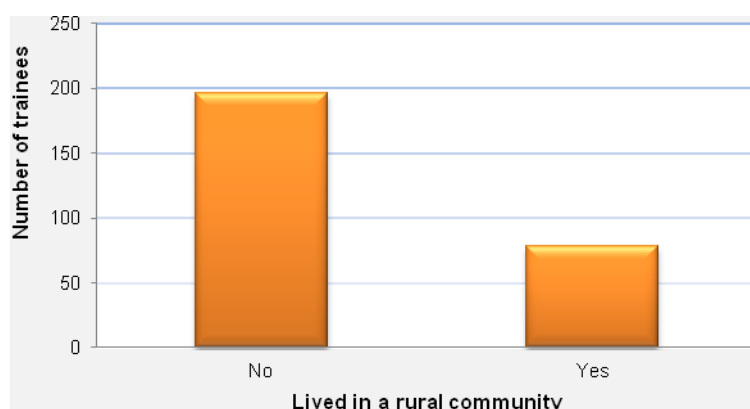


Source: QRGF Trainees and QHRSSs all details as at 20.9.12 from QRGF Cunningham Centre

Rural Background

Based on the data contained in the Cunningham database, only 28.5% of QRGF trainees reported having a rural background (refer Figure 20). This is incongruous with the feedback received via the site interview and the trainee on-line survey and caution needs to be extended in the interpretation placed on this data. For example, all trainees interviewed by the study team indicated that they had a rural background and the trainee online survey (refer Section 6) reported over 75% of respondents having a rural background. The discrepancy between these observations and the data contained in the administrators database may be attributed to the fact that the database is not purpose built and consequently the input of data relating to this field may be incomplete.

Figure 20: Rural background

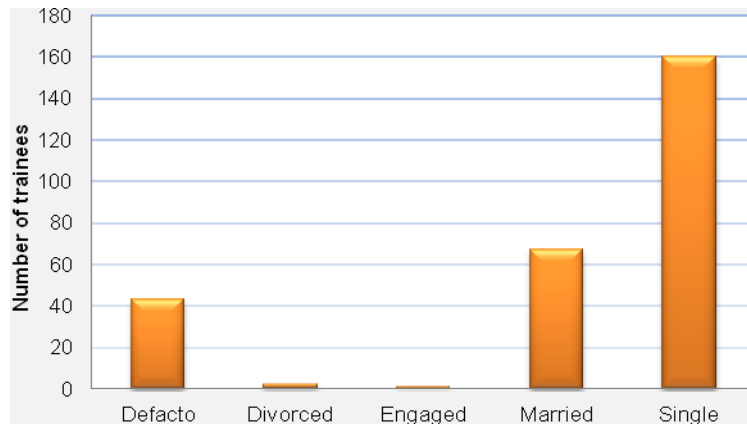


Source: QRGF Trainees and QHRSSs all details as at 20.9.12 from QRGF Cunningham Centre

Marital status

The majority of QRGP trainees are single (58.6%). Additionally, 87.5% of the cohort did not have children reflecting with the modal age group (25-29 years of age) of the trainee cohort.

Figure 21: Marital status

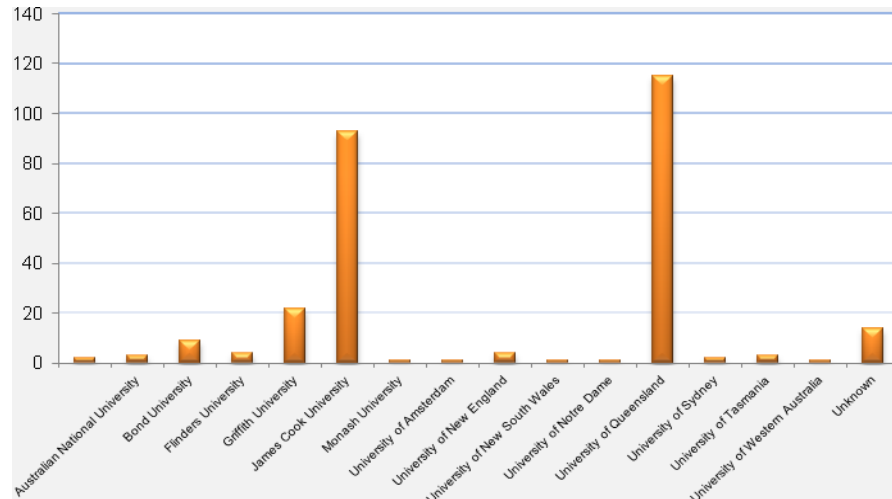


Source: QRGP Trainees and QHRSSs all details as at 20.9.12 from QRGP Cunningham Centre

Education

QRGP trainees are predominately represented by clinical rural school's alumni from the University of Queensland (41.7%) and James Cook University (33.7%). The remaining two Queensland medical schools, Griffith University and Bond University, collectively represented 11.2% of the total cohort.

Figure 22: Rural Clinical Schools

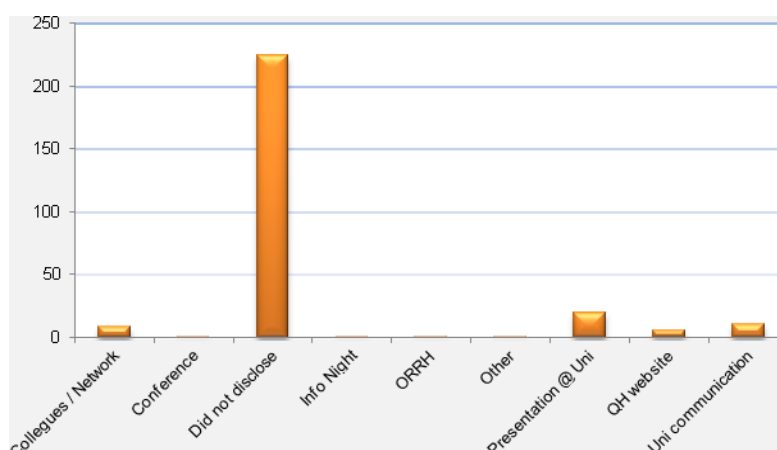


Source: QRGP Trainees and QHRSSs all details as at 20.9.12 from QRGP Cunningham Centre

Information about QRGP

The program database does not yield much insight into how trainees learnt about the existence of the QRGP. Figure 23 displays only 7.3% of the trainees indicating that they were informed of the QRGP by the program administrators, whilst 4% obtained information about the QRGP from colleagues and their professional network.

Figure 23: Where QRGP trainees learnt about the pathway



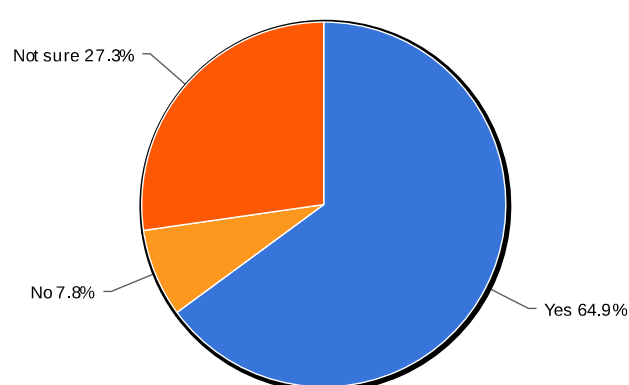
Source: QRGP Trainees and QHRSSs all details as at 20.9.12 from QRGP Cunningham Centre

Feedback obtained through the trainee online survey provides further insight in terms of where/how medical graduates are finding information about the QRGP. Specifically of the 77 QRGP respondents to the online trainee survey:

- ▶ 11.8% indicated that they obtained information about the QRGP via presentations made during O-week
- ▶ 42.1% indicated that they obtained information about the QRGP via presentations made by the program administrators nearing the end of their undergraduate years at university
- ▶ 17.1% indicated that they obtained information about the QRGP via the student club
- ▶ 11.8% indicated that they obtained information about the QRGP via the internet
- ▶ 34.2% indicated that they obtained information about the QRGP from colleagues.

Respondents to the online survey indicated that it was relatively easy to find information about the QRGP (refer Figure 24).

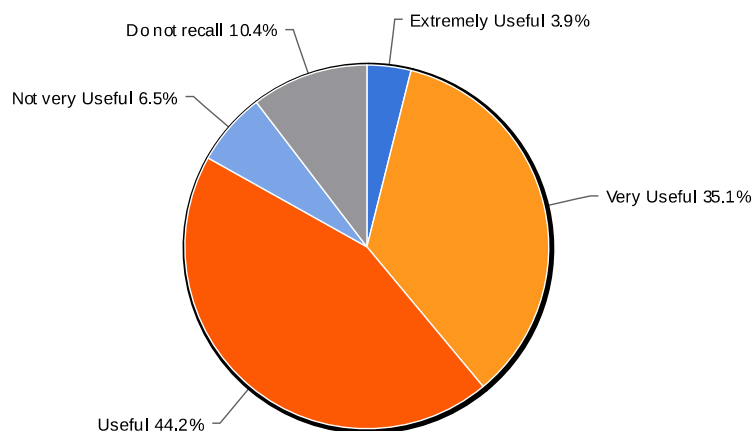
Figure 24: Where QRGP trainees learnt about the pathway – online survey respondents



Source: QRGP Trainee Online Survey September 2012

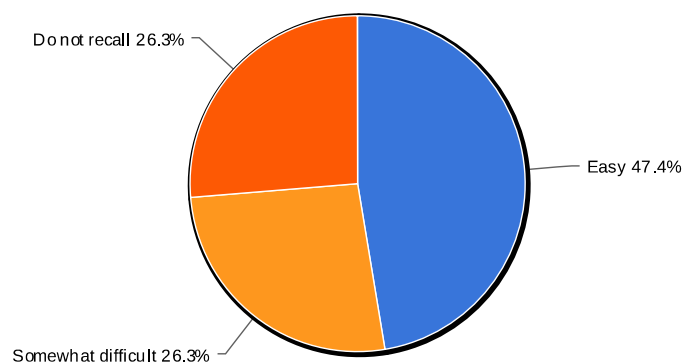
The majority of respondents to the on-line survey rated the information about the QRGP to be very useful and easy to interpret (refer Figures 25 and 26).

Figure 25: How useful is the information about the QRGP?



Source: QRGP Trainee Online Survey September 2012

Figure 26: How easy is it to interpret the information about the QRGP?



Source: QRGP Trainee Online Survey September 2012

5.1.2 Scholarship holders

There are four scholarship schemes available to medical students in Queensland with the aim to encourage careers in rural and remote practice. The Queensland Health Rural Scholarship Scheme (QHRSS) is offered by Queensland Health for students studying health sciences disciplines. The conditions of the scheme require scholarship recipients to spend generally four years and practice in rural communities either during or after their medical training. Based on the Cunningham Centre database Table 18 shows that as at September 20th 2012, there are 128 trainees who are recipients of QHRSS. Of this number 32% are in their first intern years whilst 19.5% are medical undergraduates.

Table 18: QHRSS Holders

Status	QHRSS /QRGP
Deferred PGY 2	1
Deferred PGY 3	18
Deferred PGY 4	5
Deferred PGY 5+	2
Deferred Process	4
Deferred Undergraduate	1
PGY 1/2 (Intern/pre-voc)	41
PGY 3	3
PGY 4	8
PGY 5+	20
Undergraduate	25
Total	128

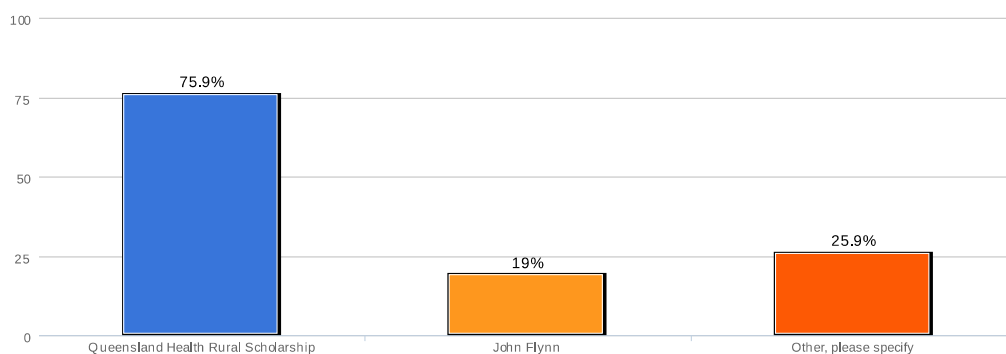
Source: QRGP Trainees QHRSSs as at 20.9.12 from QRGP Cunningham Centre

Presently, there are 89 QRGP trainees who are in receipt of the QHRSS and actively pursuing postgraduate training, whilst 46 have elected to defer their scholarship at some stage in their medical training.

Based upon the feedback received from the trainee online survey and supplementary data collected by Cunningham Centre, a number of QRGP trainees have accessed other scholarship schemes as well as, or instead of, the QHRSS. The additional scholarship schemes accessed include:

- ▶ John Flynn Scholarships
- ▶ Rural Australia Medical Undergraduate Scholarship (RAMUS)
- ▶ Medical Bonded Scholarship
- ▶ TJ Ryan Memorial Medal.

Figure 27 Scholarships accessed by QRGP trainees



Source: QRGP Trainee Online Survey September 2012

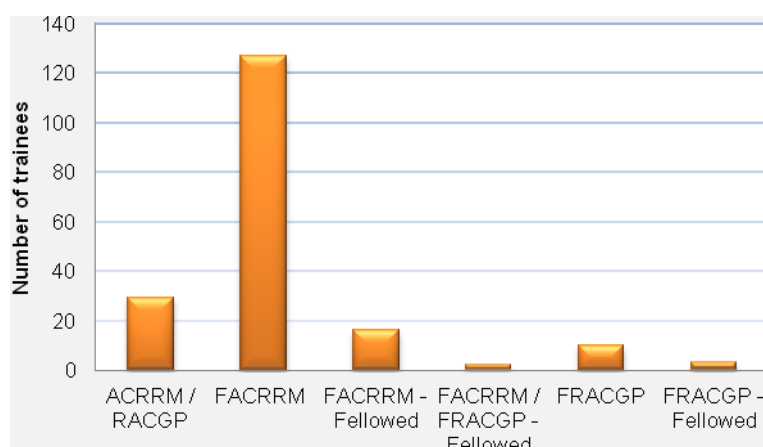
These scholarship schemes have been entered into either to supplement income source or improve access to clinical training opportunities at some point during the trainees undergraduate or post graduate training program.

5.1.3 Fellowship Preference

Of the 273 QRGP registrants profile held on the Cunningham database, 187 trainees have identified their preferences regarding which College(s) Fellowship they are likely to pursue. Over two thirds of this cohort (67.9%) indicated they were likely to seek fellowship through the Australian College of Rural and Remote Medicine (ACRRM) program, whilst 5.3% preferred Royal Australasian College of General Practice (RACGP) curriculum. Figure 28

show that 15.5% of trainees are currently undertaking both ACRRM and RACGP. In this group, 8.6% have reported to complete their fellowship with ACRRM whilst 5.3% have completed their fellowship with RACGP.

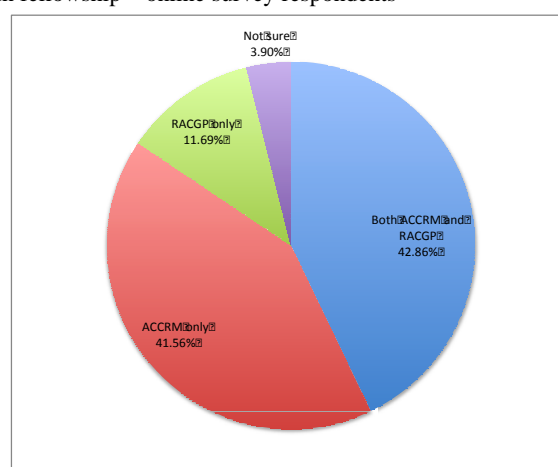
Figure 28: Preference in fellowship



Source: *QRGP Trainees and QHRSSs all details as at 20.9.12 from QRGP Cunningham Centre*

This is consistent with the feedback provided by trainees to the online survey (refer Figure 29) and also internal data reported by the QRGP⁵¹. Survey respondents indicated that the majority of trainees are either anticipating seeking fellowship with both colleges or with ACRRM. This aligns with feedback provided by trainees in the study team's site visits, where the choice of College fellowship is dependent upon the trainees' long-term career aspiration.

Figure 29: Preference in fellowship – online survey respondents



Source: *QRGP Trainee Online Survey September 2012*

⁵¹ Supervisor Letter, QRGP, February 2012

5.2 Advanced Skills Training

5.2.1 Preferences

The Cunningham data identifies 34 of the QRGP as having commenced their advanced skills training (AST) (slightly over 12% of the total trainee cohort). Of this cohort, 15 have deferred their training.

The majority of these trainees have indicated pursuing advanced skills training in anaesthetics. Table 19 also reflects that approximately 44% of QRGP trainees elected to defer their AST training in the 3rd or 4th year. Interview data reinforced this finding as trainees indicated that they preferred to defer the pursuit of an AST for at least an extra year to allow them to gain further general exposure in rural health service delivery and to build both confidence and maturity before undertaking AST.

Table 19: AST preferences

AST	AST (not identified whether QRGP or not)		RURALGEN					Total
	New Applicant	PGY 3	Deferred PGY 3	Deferred PGY 4	PGY 3	PGY 4	PGY 5	
AST - ANAES		2	6		3	2		13
AST - EM			2		1	1		4
AST - INT MED			1	1				2
AST - O&G			3	1	1		1	6
AST - PAED						1		1
AST - PENDING	6							6
AST - SURG				1	1			2
Total	6	2	12	3	6	4	1	34

Source: QRGP Trainees and QHRSSs all details as at 20.9.12 from QRGP Cunningham Centre

Reasons for deferring AST training are varied and summarised in Table 20.

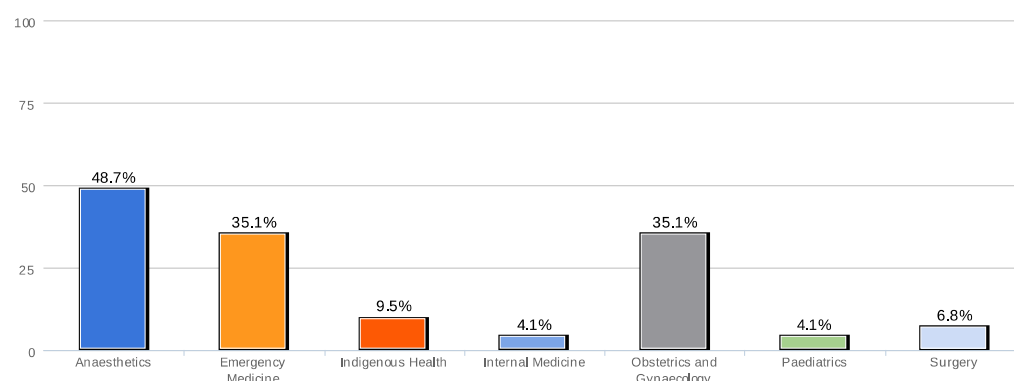
Table 20: Reasons for not progressing AST

Reasons for not progressing to AST	Locations for AS Training 2011		
Travel	Cairns	Rockhampton	Redcliffe
Private practice in rural location	Townsville	Gladstone	Toowoomba
Deferral to consider specialty	McKay	Hervey Bay	Ipswich
Deferral for personal reasons	Mt Isa	Caboolture	Logan

Source: The rural generalist: a new generation of health professionals providing the rural medical workforce the bush needs, Manahan D, 11th National Rural Health Conference

The online survey asked trainees to identify which areas they intended to pursue advanced skills training in. Responses to the survey show that a number of respondents are interested in pursuing advanced skills training in more than one discipline. Further the feedback from this survey (Figure 30 and Table 21) aligns with the data from the administrators database (Table 19) showing the majority of trainees are interested in pursuing advanced skills training in anaesthetics.

Figure 30: Preference in fellowship – online survey respondents



Source: QRGP Trainee Online Survey September 2012

Table 21: AST preferences

Value	Count	Percent %	Statistics	
Anaesthetics	36	48.7%	Total Responses	74
Emergency Medicine	26	35.1%		
Indigenous Health	7	9.5%		
Internal Medicine	3	4.1%		
Mental Health	0	0.0%		
Obstetrics and Gynaecology	26	35.1%		
Paediatrics	3	4.1%		
Surgery	5	6.8%		

Source: QRGP Trainee Online Survey September 2012

The AST selection by trainees poses one of the newer challenges to the QRGP in terms of addressing medical workforce and skill needs in rural and remote Queensland. Initially efforts and resources associated with the program were focussed on design activities to ensure that the program was appropriately established and subscribed to. It has established the critical mass of trainees needed to ensure the programs ongoing sustainability. Focus now needs to be shifted to ensure that the QRGP yields graduates with the skill set needed to meet the demands of the communities across rural and regional Queensland. Based upon the data presented in the previous two tables, there is a risk that the program may produce an oversupply of rural generalists with anaesthetic advanced skills training at the expense of other disciplines. A way to manage this process needs to be investigated further and will need to include the input of the respective HHSs to ensure that the program is responsive to their respective workforce needs.

The responsibility of workforce supply is seen to vest with the QRGP, however the responsibility for workforce planning vests with the respective HHSs and to a more broader extent the corporate office of Queensland Health. Accordingly future changes to the QRGP will need to take into account the various roles and functions of these respective stakeholders in medical workforce planning, recruitment and retention across rural and remote Queensland. This is discussed further in Sections 7 and 8.

Recommendation 5.1: A work program for the QRGP administrators, involving the HHSs be developed that addresses methods of aligning QRGP trainee AST selection and preferences with workforce skill mix needs and workforce planning processes.

Of the trainees responding to the online survey, almost half had commenced their AST training (refer Table 22).

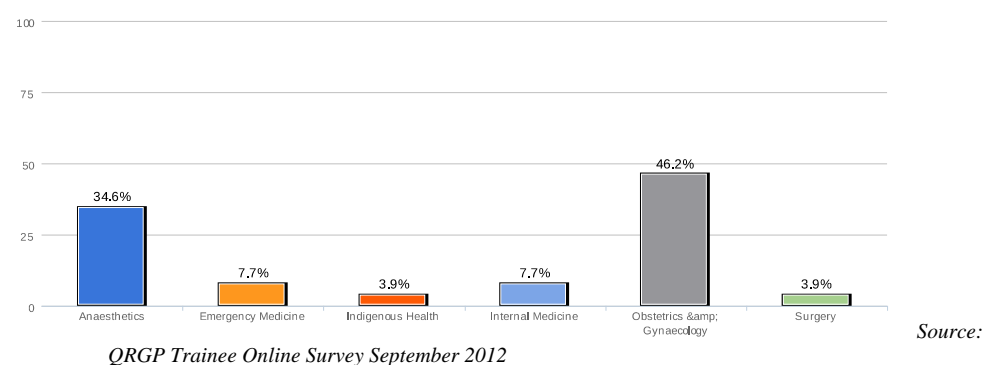
Table 22: AST training commenced – online trainee respondents

Value	Count	Percent %	Statistics	
Yes	39	50.7%	Total Responses	77
No	38	49.4%		

Source: QRGP Trainee Online Survey September 2012

Of those that had commenced their AST training, the majority reported to be doing the training in obstetrics and gynaecology (refer Figure 31). Caution needs to be extended in the interpretation of this data, as some respondents had not actually commenced their AST but as PGY2 trainees were undertaking a rotation in obstetrics and gynaecology and did not appreciate the difference between their rotation and what is involved in AS training. This confusion was evident in discussions held with trainees whilst undertaking site visits, and demonstrates an area where further clarity, information and support could be provided by the administrators of the QRGP and RTPs as well.

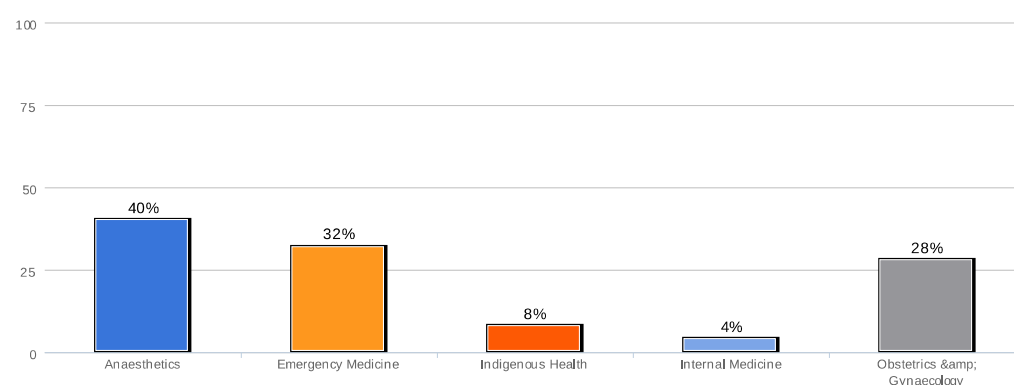
Figure 31: AST training commenced – online trainee respondents



Twenty-five (25) of the 77 online survey respondents indicated that they had completed AST training in one discipline as depicted in Figure 32. Of these the majority (40%) had completed AST in anaesthetics.

Figure 32: AST training commenced – online trainee respondents

Which AST have you already acquired?



Source: QRGP Trainee Online Survey September 2012

The online survey also asked respondents to identify why they were disinterested in pursuing AST in certain specialty areas. Responses included:

Mental Health

- ▶ Mental Health does not represent an area of interest for me
- ▶ Demand is less compared to O&G
- ▶ Not very much information was made available on this AST

- ▶ *Less opportunity relative to other interests*
- ▶ *Not varied enough*
- ▶ *Get enough exposure in ED*
- ▶ *Inadequate length of training*
- ▶ *Perceived lack of training positions*
- ▶ *Not procedural*
- ▶ *An area that I will train in further during my GP training, practice as a rural generalist and CME. Completed rotation in psychiatry as an RMO.*

Surgery

- ▶ *Demand is less compared to O&G*
- ▶ *Not relevant in my community*
- ▶ *I thought ED would be more useful*
- ▶ *Not really surgically minded. I would be reluctant to undertake procedures without supervision*
- ▶ *Not enough ability to gain hands on early*
- ▶ *Can't be picky about location if I do this AST*
- ▶ *Interested but prefer anaesthesia*
- ▶ *Interested but very few placements available and little use as independent practitioner in most rural hospitals.*
- ▶ *Inadequate length of training.*
- ▶ *? Ability to maintain required training requirements in rural environment*
- ▶ *Too wide a scope of practice. I didn't enjoy it as much as anaesthetics as an RMO which may be in part because I was not involved in much of the procedural work*
- ▶ *Unsure of future scope of practice*
- ▶ *Would love to but seems as though there is less certainty of work.*

Paediatrics

- ▶ *I feel there is good paediatric cover in rural Australia (or telehealth opportunities already)*
- ▶ *Demand is less compared to O&G*
- ▶ *Too specialised a role.*
- ▶ *Developing skills in emergency medicine paediatrics*
- ▶ *Not varied enough*
- ▶ *I don't think this is fully developed yet*
- ▶ *This was my 1st choice for my AST, but I was not successful*
- ▶ *Inadequate length of training*
- ▶ *Little jobs at end*
- ▶ *I believe is redundant as will work in this field regardless of AST*
- ▶ *Enjoy working with neonates/young children, and emergencies in children, but not as interested in behavioural/adolescent health*

Trainees seek greater flexibility within the program to commence AST in PGY4 or 5

The perceived adequacy of the duration of AST provided in a number of disciplines was raised both via the online survey as well as through the discussions with trainees at the respective facilities. A number of trainees suggested that greater flexibility needs to be introduced in the QRGP to enable AST to commence in PGY4 or 5 rather than in PGY3. Trainees advocating for this change to the program indicated that they thought it would be useful to obtain at least one more year of general training and exposure to rural medicine building experience and confidence. This was also supported by the supervisors at the respective sites.

Trainees also considered the amount of time spent in emergency medicine training was insufficient to equip them for the range of trauma and presentations they were likely to encounter in rural and regional locations. Many considered it would be useful to have extended training in emergency medicine or making AST in emergency medicine a compulsory component of the overall program. This view is consistent with feedback provided by external stakeholders presented in Section 8. This warrants further investigation and discussion with relevant training providers and colleges.

Recommendation 5.2: Consideration be given to the inclusion of AST training in emergency medicine as a core and compulsory component of the QRGP training pathway.

5.2.2 Regional Training Providers

Tropical Medicine Training (TMT) is one of three registered training providers (RTPs) supporting medical graduates on general practice rural training pathways in Queensland. TMT covers the top two-thirds of Queensland beginning from Sarina in the south, up to major regional centres of Mackay, Townsville and Cairns, to the Torres Strait and down through Mount Isa and Longreach. As such, of the three RTPs in Queensland, Table 23 shows that TMT provides training and education to over half (50.5%) of RGP trainees. This is followed by Central and Southern Queensland Training Consortium (CSQTC) providing rural training to 15.3% of the total QRGPs trainees.

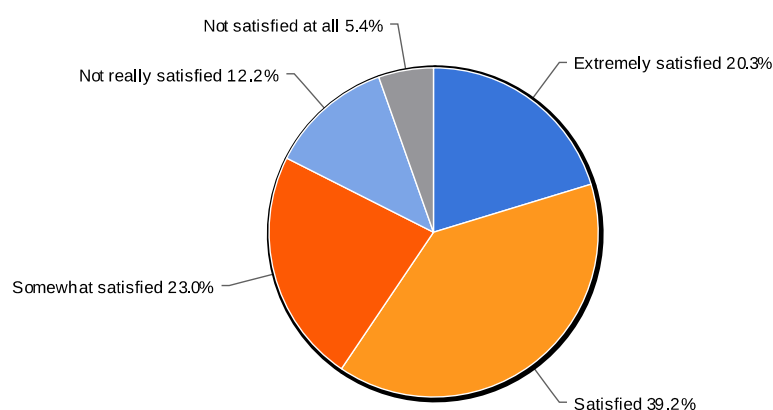
Table 23: QRGPs Trainees' allocation to RTPs

Status	CSQTC	QRME	RVTS	TMT
Deferred PGY 2				1
Deferred PGY 3	5	3		2
Deferred PGY 4	2	1		2
Deferred PGY 5+				2
Deferring Process	1	2		1
Fellow	2	10		5
New Applicant		1		5
PGY 1/2 (Intern / pre-voc)	8	21	2	27
PGY 3	1	5	1	14
PGY 4	1	1	1	8
PGY 5+	6	5	2	21
Post Bond	1	9	1	4
Withdrew, Other	4	4		10
Total	31	62	7	102

Source: QRGPs Trainees and QHRSSs all details as at 20.9.12 from QRGPs Cunningham Centre

Approximately 59.5% of respondents indicated that they were “satisfied” or “extremely satisfied” with the support provided by Regional Training Provider (RTP) (refer to Figure 33).

Figure 33: AST training commenced – online trainee respondents



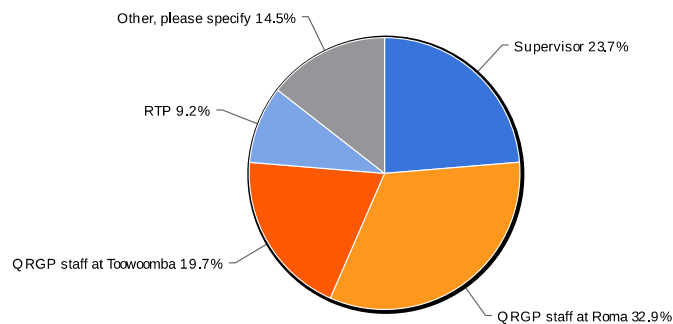
Source: QRGPs Trainee Online Survey September 2012

The framework within which RTPs operate does not align well with the pillar of Recognition underpinning the overall construct of the QRGp which is resulting in disconnect between the RTPs and QRGp trainees

Illustrations from some individuals indicate the RTPs services are of a generic form, catering to the broader needs of general practice training and not necessarily tuned to the specific requirements of the QRGp or Queensland Health. This is reflective of the current framework within which the RTPs are required to work. Specifically, the RTPs operate within a national framework targeting general practice training pathways, of which the QRGp is but one. Further the focus of these RTPs is on general practice and not rural generalism. Accordingly, the RTPs do not necessarily reflect the underlying pillar of recognition underpinning the QRGp. This may need to be investigated further with the RTPs and AGPT that governs the scope of services and framework within which the RTPs operate.

A number of respondents also expressed confusion as to the role of the RTP compared to Cunningham Centre. Trainees first port of call for support and information is the program administrator (Cunningham Centre) or their supervisor rather than the RTP (refer Figure 34).

Figure 34: Who trainees turn to, to resolve problems



Source: QRGp Trainee Online Survey September 2012

Reasons for turning to these organisations or individuals in the first instance include:

- ▶ *Seems logical first point of contact*
- ▶ *They are extremely helpful and effective*
- ▶ *I have spoken to them before and find them helpful.*
- ▶ *Geography.*

Comments provided within the trainee survey regarding why they primarily contact the Cunningham Centre or supervisor were:

- ▶ *Cunningham Centre always understand my problem and know what steps to take to fix it. I know I can trust them to address the situation. They advocate on my behalf and always do a good job.*
- ▶ *Easily accessible, friendly with enquiries in the past*
- ▶ *That's where my scholarship emails come from!*
- ▶ *Either Toowoomba or Roma because they were people that I knew or had met. My supervisor and RTP didn't know a lot about the rural generalist program so not much point seeking assistance from them first.*
- ▶ *Easier to discuss this issue with them*
- ▶ *Because the supervisor provides all the training.*
- ▶ *Whenever I have contacted the staff at QRGp they have always been able to assist me or put me in touch with someone who can. I have always been dealt with professionally and in a timely manner.*
- ▶ *First point of call is direct supervisor*
- ▶ *Either Roma or Toowoomba, quickly available on the phone. They can always get into contact someone who knows the answers*
- ▶ *Cunningham Centre, as the RTP tends to just refer you on anyway!*

Given that the scope of services offered by the Cunningham Centre has a high degree of overlap with the services provided by RTPs further consideration may be warranted as to whether the Cunningham Centre seeks to obtain RTP status managing the QRGp clinical placement process.

Recommendation 5.3: The feasibility of Cunningham Centre assuming the role of an RTP dedicated to the QRG program clinical placements be investigated.

5.3 Factors impacting on training pathway selection

Respondents to the online survey identified a number of factors that impacted upon their decision to pursue a career as a rural generalist and to participate in the QRGp. One of these factors related to previous exposure to living in a rural or remote community as depicted by Table 24. This is consistent with findings in the literature and other research studies.

Table 24: Influence of prior experience in rural communities to pursuit of a rural medical career

Value	Count	Percent %	Statistics	
Yes	54	90.0%	Total Responses	60
No	6	10.0%		

Source: QRGp Trainee Online Survey September 2012

Respondents were asked to rate from highest (rating of 1) to lowest (rating of 7) factors that attracted them to the concept of practicing as a rural generalist. From the data contained in Table 25 it can be seen that:

- ▶ The diversity in practice was considered the highest ranking factor
- ▶ Enjoyment and anticipation of the professional challenges brought on by rural practice was the second highest factor
- ▶ Prefer rural lifestyle was the third highest factor
- ▶ Financial benefits was ranked fourth
- ▶ Close proximity to family and friends was ranked the fifth highest factor
- ▶ Commitment to a specific community was ranked 6th.

Table 25: Factors that attracted trainees to consider a career as a rural generalist

Item	Total Score ¹	Overall Rank
Diversity in practice	377	1
Enjoy the professional challenges	363	2
Prefer rural lifestyle	356	3
Financial benefits/incentives	291	4
Close to family/friends	247	5
Commitment to specific community	236	6
Other	118	7
Total Respondents: 76		
¹ Score is a weighted calculation. Items ranked first are valued higher than the following ranks, the score is the sum of all weighted rank counts.		

Source: QRGp Trainee Online Survey September 2012

There were several key factors that influenced the respondents to specifically pursue training via the QRGp. These factors included:

- ▶ the ability to work across primary and secondary health settings
- ▶ early immersion in rurally based medicine during pre-vocational years
- ▶ employment opportunities within Queensland Health at the end of the program
- ▶ location of training placements
- ▶ quality of teaching provided on the program
- ▶ recognition of the program and proceduralist skills
- ▶ remuneration packages available at the end of the program, and
- ▶ the ability to pursue interest in AST.

Table 26: Factors influencing training on the QRGP

	Extremely Important	Somewhat Important	Neutral	Of little Importance	Not Important Responses at all	
Access to funds through scholarship program	24.7% 19	35.1% 27	9.1% 7	6.5% 5	24.7% 19	77
Ability to work across primary and secondary health settings (office based and hospital based settings)	42.9% 33	44.2% 34	10.4% 8	1.3% 1	1.3% 1	77
Early immersion in rurally based medicine during pre-vocational years	36.4% 28	44.2% 34	10.4% 8	3.9% 3	5.2% 4	77
Employment opportunities within Queensland Health at the end of the program	50.6% 39	40.3% 31	2.6% 2	6.5% 5	0.0% 0	77
Location of training placements	37.7% 29	44.2% 34	10.4% 8	7.8% 6	0.0% 0	77
Quality of the teaching provided on the program	33.8% 26	50.6% 39	13.0% 10	1.3% 1	1.3% 1	77
Reputation of the program	18.2% 14	46.8% 36	22.1% 17	11.7% 9	1.3% 1	77
Recognition of the program and proceduralist skills	62.3% 48	29.9% 23	5.2% 4	1.3% 1	1.3% 1	77
Remuneration packages available at the end of the program	44.2% 34	39.0% 30	13.0% 10	2.6% 2	1.3% 1	77
Support provided by QRGP staff for the duration of the program	26.0% 20	46.8% 36	19.5% 15	6.5% 5	1.3% 1	77
Ability to pursue interests in AST	66.2% 51	24.7% 19	5.2% 4	2.6% 2	1.3% 1	77
Other factors, please specify below	10.4% 8	5.2% 4	40.3% 31	1.3% 1	42.9% 33	77

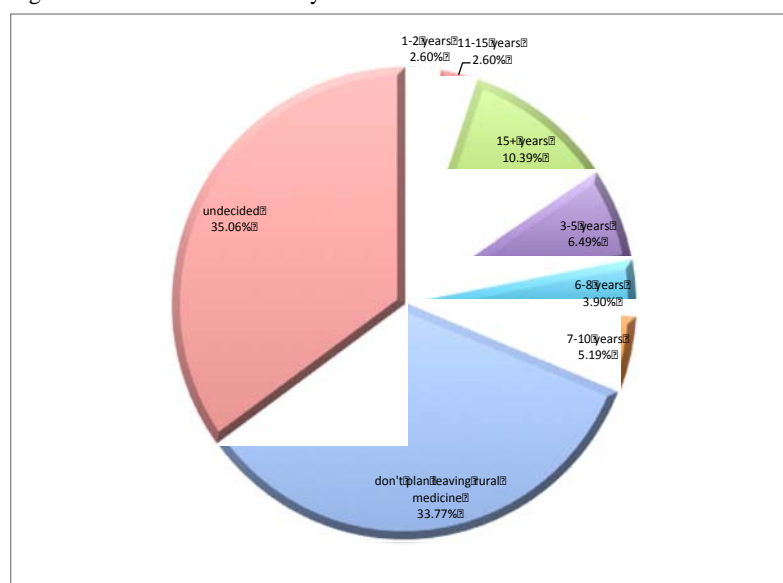
Source: QRGP Trainee Online Survey September 2012

5.4 Factors influencing time spent practicing rural medicine

5.4.1 Intention to stay in rural medicine

Respondents to the online survey were asked to identify how long they intended to stay working in rural medicine. Slightly more than a third of the respondents (35%) were uncertain as to how long they intended to stay in rural medicine. Of the respondents who gave a time frame for their expected tenure in rural medicine, the vast majority intend to remain for a long period of time, near half of the total stating they intend to stay anywhere from 15+ years to indefinitely.

Figure 35: Time intended to stay in rural medicine



Source: QRGP Trainee Online Survey September 2012

The majority of respondents (42.9%) were undecided whether they would work in one or multiple locations (refer Table 27) and this likely reflects the fact that the majority of respondents to date were in their early years of QRGP training.

Table 27: Planned location for work

Value	Count	Percent %	Statistics	
one location for this period?	19	24.7%	Total Responses	77
multiple locations over this period?	25	32.5%		
undecided at this stage	33	42.9%		

Source: QRGP Trainee Online Survey September 2012

Table 28 shows that partners' employment is considered a significant factor in determining the trainees choice of practice location, followed by the reputation of the existing practice/ hospital and then the existing infrastructure of the practice/hospital.

Table 28: Factors influencing choice of practice location

Item	Total Score ¹	Overall Rank
Partners' employment	622	1
Reputation of existing practice/hospital	604	2
Environment	535	3
Existing connection to a town	485	4
Children's education facilities	441	5
Available infrastructure	440	6
Known colleagues	437	7
Personal invitation	395	8
Sporting/special interest	392	9
Cultural communities	314	10
Other	267	11
Religious facilities	259	12
Total Respondents: 76		
¹ Score is a weighted calculation. Items ranked first are valued higher than the following ranks, the score is the sum of all weighted rank counts.		

Source: QRGP Trainee Online Survey September 2012

Personal factors such as children's education, pressure of work, and lack of professional support from Queensland Health or professional colleagues were deemed to be likely factors that would influence trainees and graduates to leave rural practice. This is consistent with findings in the literature.

Table 29: Factors influencing decision to leave rural practice

Value	Count	Percent %	Statistics	
Children's education	47	61.8%	Total Responses	76
Pressure of work	41	54.0%		
Personal factors based on social/family situations	44	57.9%		
Personal factors based on spouse/partner situations	53	69.7%		
Concerns about medico-legal issues	12	15.8%		
Personal health	31	40.8%		
Lack of professional support from Queensland Health	42	55.3%		
Lack of professional support from colleagues	40	52.6%		
Declining infrastructure in place of employment	32	42.1%		
Availability of suitable housing	27	35.5%		
Other, please specify	9	11.8%		

Source: QRGP Trainee Online Survey September 2012

5.5 Expected Practice Setting Post QRGP

Respondents to the online survey were asked to nominate their preferred practice environment once graduating from the QRGP. Whilst a small percentage (16.9%) indicated that they would prefer to remain working in their current location, the overwhelming majority (58.4%) indicated that they would seek to work in a rural or regional location with a large regional

hospital. This suggests that a significant cohort of QRGP trainees are keen to pursue a career as a rural generalist working in a secondary care setting rather than solely as a rural general practitioner. This preference also influences the trainee's choice of College in terms of pursuit of fellowship.

Table 30: Preference of practice environment

Value	Count	Percent %	Statistics	
Remain working in current location	13	16.9%	Total Responses	77
Work in metropolitan location	1	1.3%		
Work in outer metropolitan location	5	6.5%		
Work in rural or regional centre with a larger regional hospital	45	58.4%		
Work in small rural or remote town with no hospital	3	3.9%		
Other, please specify	10	13.0%		

Source: QRGP Trainee Online Survey September 2012

5.6 Satisfaction with QRGP

The overwhelming majority of respondents consider that the QRGP is “well” to “extremely well” supported.

Table 31: Level of support from QRGP staff

Value	Count	Percent %	Statistics	
Extremely well supported	19	24.7%	Total Responses	77
Well supported	35	45.5%		
Somewhat supported	20	26.0%		
Not supported very well	3	3.9%		
Not supported at all	0	0.0%		

Areas where greater support could be provided largely centred on improved communication, particularly post PGY 1 and 2 years and greater information about AST opportunities and requirements. Specific feedback included:

- ▶ *Getting things sorted with hospitals and payment issues*
- ▶ *Contact earlier in the year about placement preferences*
- ▶ *Improved communication between TMT, ACRRM, Qld Health and QRGP*
- ▶ *Pay entitlements*
- ▶ *Applying for AST training, getting SMO position (the list produced each year is sent out too late) Workshops are great Not always clear what roll QRGP staff have*
- ▶ *Facilitating more supervised training*
- ▶ *Vocational direction - providing advice*
- ▶ *Continuing medical education Courses post PGYs 1 and 2. More info regarding completion exams and requirements*
- ▶ *More communication. I felt after I had completed my prevocational time (intern, RMO and AST) there weren't enough contacts from the team. There were times where it would have been nice to be followed up with a call or email.*
- ▶ *Discussing options for placements*
- ▶ *Overall Communication*
- ▶ *Flexibility of AST timing/further training*
- ▶ *More clarification of pathway, requirements and steps involved. Also more insight to the different AST pathways.*
- ▶ *Choosing AST*
- ▶ *There is significant disparity between staff members concerning knowledge and information I want/need to know.*
- ▶ *Support and information for availability of rural positions and facilitating this No help during AST year*

The role and function of the RTPs in providing trainees information about AST requirements needs to be considered before assuming that the response to these requests vests with the QRGP administrators. Close collaboration between the RTPs and QRGP administrators to facilitate an appropriate integrated and streamlined response is warranted.

Recommendation 5.4: The RTPs and QRGP collaborate to develop an appropriate response to the needs of the QRGP trainees in terms of obtaining information about AST opportunities and requirements.

The large majority (89.6%) of the respondents who were satisfied with the placement process, as depicted in Table 32.

Table 32: Satisfaction with placement process

Value	Count	Percent %	Statistics	
Yes	69	89.6%	Total Responses	77
No	8	10.4%		

Source: QRGP Trainee Online Survey September 2012

The majority of respondents (65%) stating that they were either satisfied or extremely satisfied with their supervisors (refer Table 33).

Table 33: Satisfaction with supervisors

Value	Count	Percent %	Statistics	
Extremely satisfied	15	19.5%	Total Responses	77
Satisfied	35	45.5%		
Somewhat satisfied	21	27.3%		
Not really satisfied	5	6.5%		
Not satisfied at all	1	1.3%		

Source: QRGP Trainee Online Survey September 2012

There was an extremely positive response amongst respondents to the perceived level of support being provided to trainees at the training facilities as evidenced in Table 34.

Table 34: Satisfaction with support at training facilities

Value	Count	Percent %	Statistics	
Extremely satisfied	20	27.0%	Total Responses	74
Satisfied	43	58.1%		
Somewhat satisfied	9	12.2%		
Not really satisfied	2	2.7%		
Not satisfied at all	0	0.0%		

Source: QRGP Trainee Online Survey September 2012

The overwhelming majority of QRGP trainees (87%) indicate that they are satisfied to extremely satisfied with the overall training program.

5.7 Overall Experience on the QRGP

The evidence gathered in this survey shows that the trainee's overall experience to date with the QRGP is positive with over 87% respondents stating that they were either "satisfied" or "extremely satisfied"(refer Table 35).

Table 35: Overall experience with the QRGP

Value	Count	Percent %	Statistics	
Extremely satisfied	17	22.1%	Total Responses	77
Satisfied	50	64.9%		
Somewhat satisfied	8	10.4%		
Not really satisfied	2	2.6%		
Not satisfied at all	0	0.0%		

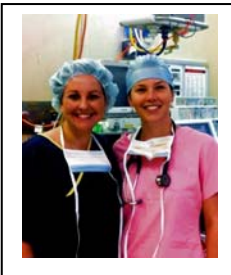
Source: QRGP Trainee Online Survey September 2012

Areas where further improvements could be made to the QRGP were suggested by the survey respondents and heavily focussed on AST. Again the role of RTPs in this process was raised

by some of the trainees who indicated that they were unclear whether the responsibility for providing support and assistance with AST placement and requirements falls to the QRGP administrators or the RTPs. An illustration of the comments provided by respondents is provided below.

- ▶ *Queensland Health needs to foster placements in small hospitals in the Central Queensland area. Very limited options post*
- ▶ *Clearly define roles. Ongoing contact from QRGP when not doing Workshop. Eg online modules or something*
- ▶ *As I did RACGP and FARGP, my concerns were with proving I had done enough women's health to satisfy requirements. It was all a bit vague. I think some clear criteria need to be created and implemented at the start of the program so there is something to work towards.*
- ▶ *More support/contact*
- ▶ *More formalised programmes; better access to training opportunities especially in the RMO years. More surgical AST places. More recognition to non-proceduralist ASTs - paediatrics, adult internal medicine etc.*
- ▶ *Mainly communication and contact in the later stages of the program.*
- ▶ *? role of RTPs in the program*
- ▶ *Flexibility in pathways for achieving AST and reinforcing skills*
- ▶ *Need to talk more to the specialists in prospective AST departments in Brisbane to ensure they support trainees and there should be a financial incentive to the departments that take you on in the AST in Brisbane*
- ▶ *Supporting research development and support*
- ▶ *Obviously more specialised training would be beneficial. I am satisfied with the training thus far but would always love more even though I know it is restricted by costs.*
- ▶ *Further support during advanced skill year. More information about districts and positions for post skill time*

5.8 Case Study



The following case study provided to the study team by the James Cook University (with the express consent of the two doctors depicted) illustrates the experiences of medical graduates on the QRGP. It is presented as a mini-case study giving further validation to the feedback received via the on line survey and individual trainee interviews conducted by the study team.

The information was provided in an email dated 27th March (the names have been removed) and reads:

Just thought I would share this photo with you both to show what JCU medicine graduates are up to- that all the rural, remote, indigenous and tropical health teaching in those 6 yrs we spent with you all did pay off!!

Dr X (in pink) and myself (in navy) graduated in 2008 from the JCU SoM. We are QLD Health scholarship holders on the Rural Generalist Pathway. We are both ACRRM registrars, and last year completed our Advanced Skills Training- Dr X in Hervey Bay in Anaesthetics, and myself in Rockhampton in Obstetrics. It has worked out that we have now both taken jobs out in Longreach to complete our last 2yrs of ACRRM training, as well as continue our return of service for QLD Health. We have been here for nearly 8 weeks, and it so happened that this morning we were "top and tail" for our first emergency caesarean section together. It was rather a surreal experience for us- definitely didn't think we would be looking at each other over a surgical drape in this manner when we first rocked up as starstruck and naive 1st yr students in 2003!!

I wanted to share this experience with you both- mainly to let you know that us JCU kids have "made good" and are out here in the real world doing the exact kind of work that you hoped we would be motivated to do when the SoM was first started with it's emphasis on Rural, Remote, Indigenous and Tropical health!! I wanted to send this to you, because I know you recently wrote an editorial for Rural Doctor about rural workforce and getting skilled doctors back into country areas with the "rebirth" of the proceduralist generalist and ACRRM curriculum. Well, Dr X and I are living the dream out here in Longreach!!!

We have great support from our colleagues and supervisors out here- [they] are absolute gems and the epitome of capable, confident proceduralist generalists who are actually making a huge difference to the community that they belong to. We only hope that we will be that lucky. Enjoy our little piece of history!! Go Team JCU!!!

6 The making of the QRGP – Underpinning Pillars and the Roma Agreement

The defining document that led to the development of the QRGP is the Roma Agreement outlined below. It clearly states that the initiative was developed in response to the need to establish a sustainable rural generalist workforce. The key principles underpinning the Agreement (and thus the QRGP) are listed in the Roma Agreement, and one of the key considerations of this evaluation is to determine the currency of the Agreement and the underpinning principles.

Roma Agreement October 2005

1. Goal

To develop and sustain an integrated service and training program to form a career pathway supplying the rural generalist workforce that the bush needs.

2. Principles

- I. All career pathways will be easy to understand, responsive to needs, well promoted, well supported, well resourced and involve key stakeholders.
- II. Key outcomes of the training program are eligibility for vocational recognition (for the purposes of the Health Insurance Act 1973 (C'th)) and appropriate credentialing. (The program incorporates training in hospital-based (public and private) and community-based (private and public) settings.)
- III. The educational standards of the training program will be set externally by the appropriate College.
- IV. The professional standards and vocational requirements of rural generalist practice are those prescribed by the Australian College of Rural and Remote Medicine, whereas those of rural general practice are prescribed by the Royal Australian College of General Practitioners.
- V. The program markets and provides a supported career path from medical school to rural generalist practice.
- VI. Vocational training will be provided by General Practice Education and Training, Regional Training Providers and will be rural centric.
- VII. The program is underpinned by mentoring and individual learning and career planning. The personal and professional and career needs of trainees and their families are accommodated within the workforce.
- VIII. All providers and funders commit to the process and to provide timely decision making and action.
- IX. Rural generalist trainees have priority access to appropriate accredited Queensland Health training positions. (Queensland Health integrates service placement with prevocational and vocational training in partnership with training providers.)

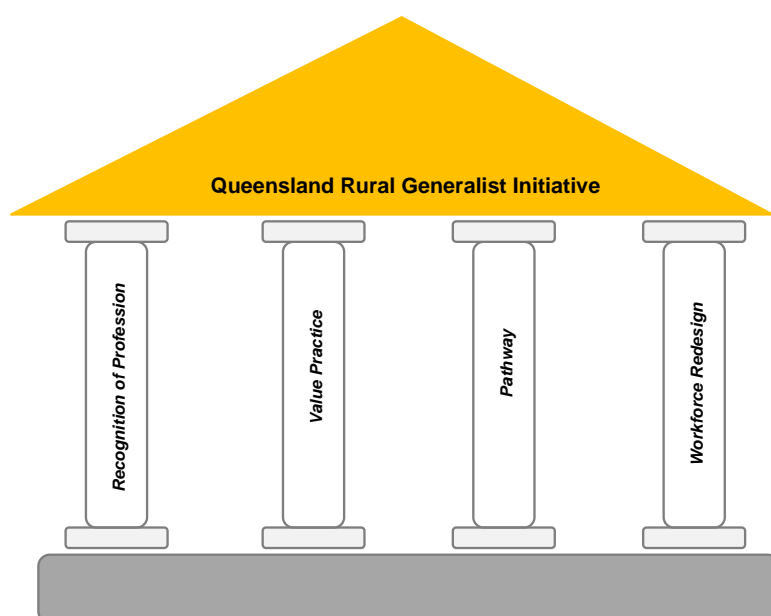
In

reviewing the Roma Agreement, due consideration needs to be given to the characteristics of the QRGP encapsulated by the respective principles. Specifically, the ability to implement the QRGP in the Queensland context related to initially ensuring that three key pillars were embedded in the Queensland Health system. With the program now moving to a state of maturity, a fourth pillar – namely workforce re-design - has been added.

6.1 Pillars of the QRGP

The QRGP is founded on embedding into the Queensland medical workforce planning processes four key transformational characteristics, namely: recognition of rural generalist medicine; practice value for its true worth; a supply line/pathway to vocational practice; and responsiveness to workforce re-design.

Figure 36: Four Pillars of the Queensland Rural Generalist Pathway



6.1.1 Recognition of Profession

Recognition of Profession occurs on multiple levels. It occurs nationally and at a professional level; through the medical profession giving due recognition to the rural generalist as a qualified specialist. It occurs industrially; with the State or employer giving due recognition to the rural generalist as a recognised discipline/specialist through appropriate and equivalent employment structures to that accorded to other medical specialities. It occurs locally; with health services ensuring appropriate credentialed scope of practice is clearly defined through the appropriate specification of requisite set of qualifications contained within relevant position descriptions.

National recognition

Over the past five decades, there has been a trend towards sub-specialisation within the medical profession that has had an adverse impact upon the availability of medical professionals supporting or working in rural and remote locations.⁵² There is evidence that greater investment in generalist medical services, as well in primary health care, may be more

⁵² Senate of Australia, Inquiry into factors affecting the supply of health services and medical professionals in rural areas, August 2012, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/rur_hlth/report/b02.htm accessed October 2012

A review of the current national processes and methods adopted in managing the overall general practice training pathways to appropriately accommodate the needs of rural generalism will represent a significant milestone in rural generalism achieving national recognition as a profession/discipline

cost-effective, efficient and equitable for rural communities compared with specialist and sub-specialist medical service providers.⁵³ Accordingly future policies and strategies focusing on rural medical workforce initiatives should take into consideration relevant investment in supporting generalist medical services.

Nationally, rural generalism has, for a range of reasons, struggled to gain acceptance and recognition as a discipline/specialty in its own right. The role of the rural generalist within the medical profession is again gaining considerable focus with proposals being generated by peak bodies such as the Rural Doctors Association of Australia (RDAA) for the development of a national advanced rural training program tailored specifically to the development of skills and expertise required of rural generalists; through to the Senate Inquiry on the “Factors affecting the supply of health services and medical professionals in rural areas.”

The Senate Inquiry has provided the impetus for rural generalism to garner national recognition as a profession, with the Inquiry concluding that:

- ▶ specialisation is causing a reduction in generalist training pathway
- ▶ there needs to be a significant increase in rural generalist GPs.

Major change processes will be required to implement the recommendations made by the Senate Inquiry. Some of the resistance to the recognition of rural generalists originates from a genuine concern that this will reduce the number of general practitioners working in rural communities. It is important to note that there is no evidence to support this perception.

For too long there has been an adherence to rigid demarcation of roles and scopes of practice inherent in ‘mono-professional’ approaches to health labour needs, and these have been shown to work against efficiency, effectiveness and sustainability of health care⁵⁴, doing little to serve the needs of rural and remote communities. There is a need now to review scope of practice issues and training requirements such that they fit with new and emergent service delivery models, of which rural generalism plays a significant role.

Rural generalism falls within the broader professional standing of general practice. The professional standards required of general practice are the remit of the Royal Australian College of General Practice (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) respectively. Accordingly, the training programs, professional recognition and ongoing professional development required by rural generalists must align with the respective training pathways and professional standards of these Colleges. A rural generalist can seek fellowship with one or both of the Colleges.

At a national level, the infrastructure associated with general practice training is complex with multiple stakeholders including the Colleges, training providers and GPET (the national body auspiced to co-ordinate and manage general practice training pathways across the country). There is little evidence to date that this overall infrastructure (and the operations associated with the management of general practice training pathways) has been reviewed, re-engineered or modified in any significant way to cater for the specific needs of those pursuing vocational training as a rural generalist. Nor is there any evidence to suggest that the contemporary status of this infrastructure has been reviewed in terms of its alignment with emergent general practice service delivery models. Rather, it appears that to date, rural generalist training pathways such as the QRGP have had to be shoe-horned to fit the existing general practice training framework. A review of the current national processes and methods adopted in managing the overall general practice training pathways to appropriately accommodate the needs of rural generalism will represent a significant milestone in rural generalism achieving national recognition as a profession/discipline. In the health system, one size does not fit all, and the challenge of maldistribution underscores the need for different and flexible training models and skill requirements⁵⁵. Accordingly, giving due recognition to rural generalists as a viable workforce solution for rural health needs and establishing recognised training pathways for this cohort of medical practitioner is critical in ensuring the sustainability of programs such

⁵³ Faculty of Medicine, Health and Molecular Sciences, James Cook University Senate Inquiry Submission, December 2011

⁵⁴ Duckett SJ. ‘Health Workforce Design for the 21st Century. Australian Health Review. 2005. 29(2).

⁵⁵ Faculty of Medicine, Health and Molecular Sciences, James Cook University Senate Inquiry Submission, December 2011

as the QRGP.

State recognition

Prior to the implementation of the QRGP, Queensland Health acknowledged that solely relying on local community based general practitioners to meet the health needs of rural and regional communities as a workforce solution was not effective nor practical. Neither was the continued reliance on a fly in fly out medical workforce. Consequently a blended workforce strategy that addressed hospital based and primary medical workforce needs was developed. In so doing, Queensland Health recognised the rural generalist from both a vocational and professional perspective.

Vocational recognition was provided when the State government announced its recognition of rural generalists in 2005 and defined a rural generalist as:

1. Hospital-based and community-based primary medical practice AND
2. Hospital-based secondary medical practice:
 - in at least one specialist medical discipline (commonly, but not limited to obstetrics, anaesthetics and surgery) AND
 - without supervision by a specialist medical practitioner in the relevant disciplines
3. AND possibly, hospital and community-based public health practice – particularly in remote and indigenous communities

The State Government then moved to establish a formal mechanism that enabled the state to recognise industrially disciplines that were deemed to be non-specialist under pre-existing arrangements. The drivers for this change were to ensure that recognition of profession would safe guard the quality of care delivered to patients, ensure continuing improvement in patient outcomes and represent a value for money solution to the existing workforce demands.

As a result a professionally constituted State Recognition of Practice Committee was established and facilitated the recognition process. The processes adopted by the State Committee were adapted from those used by the Australian Medical Council for recognition of medical specialties and accreditation of specialist education and training programs and professional development respectively. Upon examination of nominated practice in a non-specialist area, the Committee assigns (or declines):

1. professional recognition of non-specialist disciplines – thereafter referred to as Recognised Disciplines
2. professional recognition of non-specialist qualifications (including professional development programs) for each recognised discipline – the qualifications thereafter referred to a Recognised Qualifications.⁵⁶

Medical practitioners with qualifications assigned by the committee as a “recognised qualification from these recognized disciplines” are then paid on a scale equivalent to those specialist medical practitioners. There has been considerable conjecture that the remuneration provided by Queensland Health through implementation of this pillar results in the public health system incurring a significant cost of a magnitude that would dissuade other jurisdictions making similar investments in order to implement a program similar to the QRGP. A comparison of the base level salary of a salaried medical officer level 18 (the level paid to rural generalists before the recognition pillar was implemented) to that of a specialist salaried medical officer (advanced credentialed) level 21 indicates (the current level paid to rural generalists since the implementation of the recognition pillar) shows that the differential in payment is of the order of \$12,150. When incidentals and benefits are added the

⁵⁶Lennox D., Brief History of the Rural Generalist Pathway, August 2007

comparative difference is in the order of \$23,800. This figure represents a relatively modest investment, and is exclusive of the administration costs associated with the program. The cost implications are discussed further in Section 9.

6.1.2 Value of Practice

This pillar focuses on establishing a practice value for its true worth. Whilst originally this pillar was considered closely aligned to the recognition of the profession and valuing the rural generalist as a specialist medical practitioner, it has evolved to represent the philosophical approach driving medical practice namely one that promotes re-investment back into the profession and community.

Local recognition

At the local level there has been a recognition of the value of practice associated with the QRGp with strong professional investment and commitment of time by clinicians involved in the establishment and continued operations of the QRGp training pathway. The majority of senior clinicians and supervisors involved in the program indicated that they willingly give of their time, as they considered that they are investing in the next generation of rural medical practitioners; setting an example and building a workforce that would provide the next set of supervisors and mentors. It is evidenced by the broader workload undertaken by the clinicians above and beyond the individuals contracted and remunerated hours.

Examples of this pillar and the commitment displayed by clinicians within the program are documented in Section 8.

6.1.3 Pathway

The ability to address the medical workforce shortages experienced by rural Queensland has been contingent upon designing an appropriate supply of trained medical practitioners suited to rural and remote medicine. The literature^{57 58 59} abounds with evidence that shows a well supported and well structured training pathway, providing early immersion in rural communities and rural medicine will attract candidates that are more likely to remain practicing in rural locations for a longer period of time. The QRGp was founded on these principles. The strong support and the early immersion into rural medicine are two of the most valued features of the QRGp (refer to feedback from the trainees, graduates and supervisors provided in Section 5). The quality of training and training experiences provided through the QRGp reflect the strong support and well defined structure of the program and are highly valued by clinicians associated with the program and the trainees participating on the program. Feedback from trainees indicates that the reputation of the program and the quality of the training pathway are key determinants that attracted individuals to pursue a career as a rural generalist in the first place.

6.1.4 Workforce Redesign

This last pillar represents a recent addition to the underlying design of the QRGp. It reflects the programs evolution as it matures and produces the first set of graduates. This pillar recognises the need to link the overall training pathway to medical workforce planning and clinical services redesign.

The pillar instils the need for the program to be proactive and responsive to the diverse ways in which health services are delivered to rural communities and to ensure that the profession of rural generalism is not rigid in construct.

⁵⁷ r2rgp Road to rural general practice, The Rural Doctors Workforce Agency Report on the Rural Pathway Project, RDWA June 2011

⁵⁸ Eley D., Young L., Baker P., Wilkinson D.; Developing a Rural Workforce Through Medical Education: Lessons From Down Under, Teaching and Learning in Medicine: An International Journal Volume 20, Issue 1, 2008

⁵⁹ Maley M., Worley P., Dent J.; Using rural and remote settings in the undergraduate medical curriculum: AMEE Guide No. 47 <http://informahealthcare.com/doi/abs/10.3109/01421590903111234> accessed September 2012

It gives due recognition to the fact that the QRGP represents the supply component of the workforce cycle and that there needs to be corresponding mechanisms embedded into the program that provides timely information about the demand for medical workforce numbers and configuration of skill sets required by the respective HHSs in order to ensure that the training pathway is sufficient robust and flexible to respond to these needs in a timely manner.

This pillar represents a systemic approach to workforce and service delivery planning that shares the responsibility with both supplier (QRGP) and purchaser (HHS). Appropriate monitoring and systems need to be in place to determine the long term contribution this pillar has upon the overall success of the program.

6.2 Re-affirmation of the Roma Agreement

The Roma Agreement of October 2005 continues to have currency to the existing medical workforce needs of rural Queensland

The evaluation assessed the relevance and currency of the Roma Agreement to today's medical workforce needs in Queensland.

Feedback from stakeholders indicates that *the overall principles contained in the Roma Agreement continue to be contemporary and relevant to the medical workforce needs of today and as such should be re-affirmed.*

The following section identifies specific areas where refinements or updates may be warranted.

6.2.1 Principle iii – Educational standards

Principle iii of the Roma Agreement states:

The educational standards of the training program will be set externally by the appropriate College.

With the program focussed on ensuring trainees undertake advanced skills training in at least one discipline, this principle ensures that appropriate certification and credentialing for advanced skills involves the input of the relevant Colleges.

The Australasian College for Emergency Medicine (ACEM) provided specific commentary about principle iii of the Roma Agreement as it relates primarily to the discipline of "rural generalist emergency medicine".

The following comments were made in the written submission provided by the College:

ACEM believes that appropriate advanced training and credentialing is required for non-specialists (general practitioners and rural generalists) who undertake aspects of emergency medicine practice.

ACEM would expect that any program of advance skills training in emergency medicine must involve:

- *A formalised curriculum*
- *A transparent process of supervised clinical training*
- *Demonstration of clinical competency and form credentialing, and*
- *Formalised continuing professional development program.*

ACEM is aware that the Generalist Emergency Medicine (GEM) post-Fellowship program offered by the ACRRM is recognised as 'specialist qualification' in terms of salary classification within Queensland Health facilities. While individual FACEMs may have assisted ACRRM in developing the GEM curriculum, ACEM has not been asked to formally review, nor has the College endorsed, this training program.

The College contends that, as the relevant specialist college, it has an important collaborative role in establishing the standards of training and criteria by which trainees are assessed in advanced skills emergency medicine through the QRGP and, that this is consistent with Principle iii embodied within the Roma Agreement.

There is an imperative that the QRGP work collaboratively with ACEM and ACRRM to ensure that the AST in emergency medicine offered through the program is supported by ACEM. Further, QRGP should work jointly with ACEM to ensure that the Diploma program offered by ACEM is available to QRGP trainees wishing to pursue advanced skills training in emergency medicine. This activity should be given high priority.

Recommendation 6.1: QRGP work collaboratively with ACEM and ACRRM to ensure that the AST in emergency medicine offered through the training pathway is appropriately recognised and endorsed by ACEM.

Recommendation 6.2: QRGP work collaboratively with ACEM to ensure the Emergency Medicine Diploma offered by ACEM is included in the QRGP training pathway and offered as an AST to program trainees.

6.2.2 The nexus between Rural Generalism and Rural General Practice - Principle iv

Section 6.1.1 discussed the differences between rural generalism and general practice and noted that the rural generalist is not identified professionally as a unique specialty but is embodied within the specialty of general practice. Whilst it is not within the scope of this evaluation to raise the appropriateness or otherwise of this decision, the philosophical perspective of what is entailed by the specialty of general practice influences the various views expressed by respective stakeholders and continues to impact upon operational aspects of the QRGP particularly in terms of AST placement.

The phrasing of Principle iv seeks to distinguish between the expectations made of a rural generalist and a rural general practitioner. Specifically, the QRGP is based on a training pathway where the professional standards and vocational requirements of rural generalist practice are those prescribed by ACRRM, whereas those of rural general practice are prescribed by RACGP or the ACRRM.

Trainees on the QRGP can seek to obtain fellowship with either or both Colleges.

Representatives from RACGP perceive the current phrasing of Principle iv has the capacity to introduce bias and potentially unduly influences the trainees's decision as to which College they propose to seek fellowship with. Specifically the RACGP suggested the wording of this principle infers that RACGP does not have standards and vocational requirements of a rural generalist and that as a consequence of this wording, trainees are more likely to pursue fellowship with ACRRM.

Discussions with trainees indicated that their choice of which College to pursue fellowship with was largely influenced by their long term career aspirations. During the interviews there were a range of opinions expressed, which largely fell into the following broad categories:

- ▶ a cohort of trainees indicated that they had no intention of working predominantly as a community or office based general practitioner, and they had elected to train on the QRGP because they wanted to work in rural Australia, in a hospital based setting, for a substantive amount of their professional time. Accordingly, this cohort had indicated that they were seeking to gain fellowship with ACRRM as there was a perceived closer synergy with the overall philosophy and services offered by this College and their career aspirations
- ▶ another cohort of trainees indicated that they had always wanted to work as a general practitioner in rural Australia and that the training pathway offered a fast track to gaining the requisite qualifications as well as the ability to diversify their skill set. This cohort indicated that they were more likely to pursue a career as an office/community based general practitioner in rural settings interspersed with some hospital based work. This cohort were more likely to pursue fellowship with the RACGP as they perceived this College's standards, services and philosophy resonated better with their career aspirations
- ▶ a third cohort, albeit in the minority, indicated that they envisaged their career pathway would be a blend between hospital based practice and office based general

practice. Specifically, this cohort indicated that they had joined the pathway because it offered a fast track to their career as well as diversity not necessarily perceived as being available on the more “traditional” general practice pathways. This cohort of trainee indicated that early in their careers they were more likely to work in both a hospital based and community/office based setting with greater time being dedicated to the hospital based work. However, this same cohort indicated that, over time, when family dynamics (such as children commencing high school) came in to play, they planned on changing this mix pulling back from hospital based services to more community/office based general practice. This change was also likely to be accompanied by a change in residential location to a more regional location. For this cohort a number of respondents indicated that they were considering pursuing fellowship with both Colleges, although a few had indicated that they were pursuing with ACRRM in the first instance and would review their position at a later stage.

The evidence base to date suggests that the wording of Principle iv has limited impact upon the decision made by trainees as to which College they would seek fellowship with. Rather, it is the long-term career aspirations and the alignment of these aspirations with the overall messaging, services and communications emanating from the respective Colleges that influences or drives their decisions.

Given that Principle iv includes both Colleges and both career pathways of rural generalist and general practitioner there does not appear, at this stage, to be any need to update or modify this key principle.

6.2.3 Priority Access to Training Posts – Principle ix

The allocation of trainees to general practice training positions is a complex process that involves GPET and the training providers. Access to advanced skills training posts adds another layer of complexity with the respective Colleges also involved in this process.

Key principle ix identifies:

Rural generalist trainees have priority access to appropriate accredited Queensland Health training positions. (Queensland Health integrates service placement with prevocational and vocational training in partnership with training providers.)

The implementation of this principle is considered to be a cornerstone of the QRGP. Trainees and supervisors associated with the program view this as being one of the key strengths of the program. It has also been identified in the feedback to the online survey (refer Section 5) as a significant marketing feature that attracted the interest of prospective trainees and was an influential determinant in deciding whether to nominate for the program. Both parties strongly advocated that the ability to access quarantined training positions in rural hospitals across Queensland continue to be maintained as an integral and unaltered feature of the QRGP.

The implementation of this key principle has however resulted in a perceived overlap in the responsibilities associated with the management of general practice training placements in Queensland. For example, in most other states, the Regional Training Providers (RTPs) manage the placement of trainees. This is not the case in Queensland, with Queensland Health mandating where the QRGP places are to be located thereby directing where trainees are placed. Whilst this process serves the immediate needs of Queensland Health, this is seen to create a challenge for the RTPs. Specifically the RTP is required by GPET (the national body responsible for general practice training) to manage training positions across the state. Accordingly each RTP has a number of trainees who are registered with their organisation and for whom they must find appropriate training posts. With a number of training posts being made unavailable through the quarantining process for RGTs and some training posts located in sites that are deemed by Queensland Health as unsuitable/undesirable for generalist training, RTPs are finding it difficult to place some of their trainees. A potential risk mitigation strategy where training providers begin to limit the number of rural generalists they accept on their programs was mooted in discussions with the study team.

Stakeholders clearly recognise the QRGP has been successful in placing doctors into rural locations, particularly areas that previously faced difficulties in attracting medical practitioners. However, the competing roles and functions of the various stakeholders involved in general practice training creates potential challenges when instituting the intent of key principle ix.

Recommendation 6.3: A work program investigating how best to address the competing priorities, roles and functions of the respective parties, particularly in terms of managing training placement be commissioned. Stakeholders to be involved in the work program include the RTPs, GPET, the administrators of QRGP and Queensland Health.

7 Processes underpinning the QRGP

In discussing the overall process efficiency of the program, it is important to note that the QRGP has reached an important stage of the maturity cycle. Specifically, the QRGP has moved from its embryonic stage of being a concept, through the development stages giving rise to the overall training pathway and attracting trainees to the program, to now attaining maturity as a workforce solution, yielding graduate rural generalists ready to take up positions in the workforce. Not surprisingly, the processes to date have focussed largely on establishing the program. This section of the report focuses on the assessment of the program's process efficiency.

7.1 Existing Processes

The evaluation consulted with the administrators of the QRGP and established a process map that identifies the range of activities involved in administering the program and the interface the program has with multiple stakeholders along the pathway. Figure 37 overleaf depicts the QRGP process map.

Whilst the evaluation is not intended to be a process evaluation, key issues have been identified along the pathway that may need further refinement or enhancement to improve the overall operations and effectiveness of the pathway and these are identified below.

7.1.1 QRGP Information Management System

As previously referred to, the existing information management system used to underpin the administration of the program and the case management of trainees is not purpose built. The current system used by Cunningham Centre staff is based on an adaptation of the system used to manage and monitor the Queensland Health Rural Scholarship Scheme (QHRSS). Whilst expedient at the time, the database is based on old systems architecture and is no longer supported. As a result, less than ideal database administrative practices have had to be adopted to enable the system to capture data necessary for the tracking of QRGP trainees and the overall management of the program. Interchangeable data fields have been utilised in some instances that have created challenges when utilising or interpreting the data.

The evaluation team concludes that the current system used by Cunningham Centre to manage the QRGP is still heavily biased and focussed on the management and monitoring of the QHRSS. It is not appropriately configured or structured to focus on the needs of the QRGP.

Discussions are currently in place between Cunningham Centre and a metropolitan based HHS to develop and maintain a new database specific to the needs of the program. However, it is the understanding of the evaluation team that the specification development appears to be based more on system architecture requirements rather than reporting functionality and management requirements.

The development of functional specifications should be driven by the Cunningham Centre. Any specification for the development of a suitable information management system (and associated database) underpinning the performance monitoring and reporting requirements of the QRGP should give due recognition to the reporting requirements of the program.

The information management needs of the program are not complex and would not require investment in a major software solution or sophisticated and complex hardware architecture. Modest investment is likely to be required to equip the program with a customised management information system. This investment is needed in the immediate future and relevant resources should be committed to the project to facilitate this process.

Recommendation 7.1: A business plan, identifying the appropriate level of investment needed to develop a robust information management system that is needed to support the management, performance monitoring and reporting functions associated with the QRGp.

Recommendation 7.2: The investment for the purchase of appropriate hardware and software development be made available within the 2013/14 financial year.

Recommendation 7.3: Functional specifications for the QRGp management system be driven by Cunningham Centre.

Recommendation 7.4: The functional specifications for the QRGp management system be extended from system specifications to incorporate reporting and user requirements.

7.1.2 Policy and Procedure Documentation

Discussions with the Cunningham Centre indicate that a range of materials describing the overall pathway exist in various forms and documents, but have yet to be consolidated. Further there is no clear policy and procedural documentation in place and this is needed from an organisational, administrative and leading practice perspective. To date, staff have focussed energies on establishing the program and managing the trainees on the pathway. With the program now reaching a steady state, focus should also be given to ensuring core administrative infrastructure and documentation is in place. This will ensure that the administrators of the QRGp are operating in an environment that would be readily accredited and recognised as representing a leading practice organisation.

Recommendation 7.5: The administrators of the program focus on consolidating relevant policy and procedures into a central document.

7.2 Future Administrative and Management Directions

7.2.1 Succession Planning

The professional investment and commitment of time provided by a range of individuals from within Queensland Health, the Cunningham Centre and general practitioners living and working in rural communities across Queensland is one of the major enablers of the QRGp. The vision of the program was vested with a few key individuals who have worked tirelessly to bring the program from a concept to reality. They continue to be heavily involved in the overall promotion and operations of the program to this day.

There is an ongoing need to promote the program amongst upcoming medical trainees, and the benefits of having a clinician driving this marketing strategy is not to be underestimated.

There is now also a need to commence a new form of marketing of the program, one that targets the rural HHSs and ensures that appropriate communication and processes are in place between Cunningham Centre and the HHS to support local workforce planning. This marketing should also promote the utilisation of RGP's as a viable medical workforce solution. The success of this marketing strategy will be reliant on using senior recognised clinicians and professionals associated with the QRGp and developing individual relationships with the respective HHSs.

Accordingly, in the short term, continued utilisation of the knowledge and standing of some of the key individuals associated with the program is warranted, however a transition or

succession plan needs to be developed recognising that these individuals will be exiting the workforce in the future.

There is little doubt that having a key figurehead to whom strategic questions can be directed is of benefit to the overall program. However, it should not be the sole feature of any future proofing strategy devised for the program. The consolidation of policies and procedures; the development of contemporary marketing and recruitment materials; effective communication provided to rural HHSs on how the QRGP can best support their workforce needs; the establishment of appropriate communication and governance structures that facilitate ease of information transfer between the QRGP and stakeholders involved in the delivery of the training pathway and in workforce planning, attraction, recruitment and retention should all underpin the succession plan and will form valuable inputs into the future proofing of the overall program.

The program has now reached a state of maturity that requires the development of such a plan.

Recommendation 7.6: A succession plan be developed for the QRGP to ensure the future proofing of the program.

7.2.2 Workforce Planning

As previously discussed, the focus of the QRGP has, until recently, been focussed on establishing the training pathway and in recruiting and retaining trainees on the pathway. Accordingly, the role of the rural HHSs has been relatively limited to working with the QRGP to ensure that local facilities are of a sufficient standard and accredited as teaching and training facilities and nominating the number of QRGP trainee posts that could be accommodated at respective facilities.

The QRGP is now producing graduates from the program, and the other part of the workforce equation, namely planning, attraction recruitment and retention now have to be actively integrated into the overall program.

In the absence of establishing this integration of the QRGP into proactive workforce planning activities, there is a potential risk that the program will yield an oversupply of rural generalists with AST in a particular specialty at the risk of undersupply of skills that are in shortage.

With the restructuring of Queensland Health and the introduction of HHSs, each HHS is now responsible for workforce planning for their health service. The construct of the HHSs is a relatively new advancement in Queensland and as such most of the health services have had to deal with governance issues and basic operational issues. Formalised communication channels to facilitate the integration of the QRGP into workforce planning processes have not been set up to date, and the Cunningham Centre needs to establish the mechanisms to support these processes into the future.

In establishing the communication channels, it would be prudent for Cunningham Centre to develop relevant materials that promotes the role of RGP as a viable medical workforce solution. The second phase of this study focussed on the development of a set of tools for rural HHSs to utilise in medical workforce planning activities, and how to factor in RGP into the HHSs medical workforce solutions. There will be a need to provide support and education to the rural HHSs in the utility of these tools; advise them on how their workforce planning activities and outputs will be utilised by the QRGP and how their workforce needs should be communicated to Cunningham Centre in the future.

Recommendation 7.7: The Cunningham Centre, in conjunction with the rural HHSs, establishes a mechanism through which rural HHSs can formally inform the program of their future medical workforce needs.

Recommendation 7.8: The Cunningham Centre establishes a mechanism through which the QRGP can be moderated in the future to meet the rural medical workforce needs as identified by the respective rural HHSs.

Recommendation 7.9: The Cunningham Centre develops an information session for individual rural HHSs that outlines the workforce planning guide developed as part of this study.

7.2.3 Attraction, Recruitment and Retention of the Medical Workforce

In addition to the responsibility of undertaking workforce planning, rural HHSs are vested with the role and responsibilities associated with recruiters and employers of their respective health workforce. As such, whilst it is the responsibility of the QRGPs to attract and recruit trainees to the training pathway, it is the rural HHSs responsibility to attract, recruit and retain graduates of the program to their respective facilities. This has not necessarily been promoted by the program to date, given that it has focussed on establishing the training pathway and ensuring a steady supply of trainees are attracted to the program. Investment in the development of a promotion/communication strategy that raises the awareness of the rural HHSs that the QRGPs is now generating graduates may be warranted. The Cunningham Centre, as administrators of the QRGPs, will in all likelihood be expected to support the respective HHSs as recruiters/employers of program graduates. This can be achieved by establishing communication channels between trainees, prospective graduates and the respective HHSs. Cunningham Centre should plan how best to fulfil this function without assuming the role and responsibilities of recruiter/employer that is clearly vested with the respective HHSs.

The strongest attraction, recruitment and retention strategies engage with potential employees whilst they are still on their training pathway, and the potential exists for those HHSs offering training placements to retain the QRGPs graduates, potentially at the detriment of those locations most needing access to RGP. As the program now reaches this state of maturity, the establishment of appropriate communication strategies and processes that mitigate against this risk should be undertaken involving Cunningham Centre and the rural HHSs.

Recommendation 7.10: Consideration be given to investing in the development of a promotion/communication strategy that raises the awareness of the rural HHSs as to the number and skill sets of each years QRGPs graduate cohort.

Recommendation 7.11: The Cunningham Centre explore how best to support rural HHSs attraction, recruitment and retention strategies and processes.

7.2.4 Support Services

The feedback from trainees on the support provided by the Cunningham Centre was largely positive although there were some areas where the introduction of further improvements or supports would be considered beneficial and valuable.

Online survey respondents indicated that the overall interactions with the Cunningham Centre were of a high standard. The trainees from Mackay, Longreach and Kingaroy interviewed by the evaluation team echoed the same sentiments. This feedback was however, largely in relation to the quality of the conferences convened by the Centre. Trainees readily identified the benefits these conferences presented to participants in terms of facilitating networking opportunities and information sharing.

Trainees indicated that they have had positive experiences in terms of the support they receive in their first two years of post-graduate studies. The Cunningham Centre is highly visible in these early years and the support is tailored and targeted suiting the general needs of the trainees. However the presence of the Cunningham Centre is perceived to reduce considerably after these first two years, a phenomenon not too dissimilar to experiences quoted by trainees training on other general practice training pathways, albeit the observations by these cohorts relate to their RTPs. The perception held by the trainees does not align or resonate with the perception held by the Cunningham Centre, namely one of providing ongoing case management services to the QRGPs trainees. This needs to be investigated further.

Trainees interviewed by the evaluation team also indicated that they found navigation through the training pathway difficult, particularly in terms of being aware when to submit various applications and forms, and in some instances what expectations exist in terms of training requirements and placement processes amongst the respective training providers. Confusion in

the early years between what constitutes rotations and advanced skills training also needs to be addressed by the Cunningham Centre and reinforced by the RTPs.

Focusing on activities and strategies that improve communication between the Cunningham Centre and QRGP trainees, particularly in PGY3-5 years is warranted. In order to identify and design appropriate supports catering to the needs of the PGY3-5 year trainee cohort, a formal process needs to be established through which PGY3-5 year trainees and graduates of the program can provide advice to the Centre on the specific support requirements of this cohort. The process could be in the form of quarterly meetings in which needs identification and progress on support designs can be discussed.

Recommendation 7.12: A formal mechanism be established that enables PGY3-5 trainees and graduates of the program to advise the Cunningham Centre on the type of supports they require.

Feedback from trainees both via the online survey and direct interviews indicated that there was a degree of confusion as to what role and function the RTPs have in the way of assisting the trainees to navigate through the complex training pathway and how, if any this differs from the role Cunningham Centre. Universally, respondents indicated that when they contacted the Cunningham Centre for information the response was positive and timely and in many instances trainees acknowledged that they would approach either the Cunningham Centre or their supervisor to address questions rather than approach the training providers. The trainees were looking for timely responses and a simplified way to navigate through the training pathway. The interface between the Cunningham Centre, as administrators of the QRGP and the RTPs in terms of addressing these specific needs of trainees as well as providing a seamless and unified support is warranted.

Recommendation 7.13: A review of the roles and responsibilities, and the interface between RTPs and the QRGP be undertaken with a view to simplifying information access by trainees and improving the overall supports provided to trainees participating in the QRGP.

Areas where further supports could be provided, or where improved communication is warranted (as identified by trainees in the online survey and consultations) include:

- ▶ Contact earlier in the year about placement preferences
- ▶ Improved communication between TMT, ACRRM, Qld Health and QRGP
- ▶ Applying for AST training, getting SMO position (the list produced each year is sent out too late) Workshops are great Not always clear what roll QRGP staff have
- ▶ Assisting with securing more supervised training.
- ▶ Vocational direction - providing advice
- ▶ Overall Communication – e.g. More clarification of pathway, requirements and steps involved. Also more insight to the different AST pathways
- ▶ Flexibility of AST timing/further training
- ▶ Assistance with choosing AST
- ▶ Greater presence during AST year.

Other issues relating to the overall pathway raised in the consultations are discussed in the following section

8 Feedback from the Consultations and Submissions to the Evaluation

The following presents some of the key issues raised with the evaluation team during the consultations held in the conduct of the study. It should be noted that some of the issues that have arisen reflect the fact that, notwithstanding Queensland Health's recognition of the profession, rural generalists are not recognised professionally by key stakeholder organisations as a specialty in their own right, but rather as part of the general practice specialty which is heavily biased towards office based community service delivery models of care. Inherently these tensions between what is a rural generalist and what is a general practitioner abound in the commentary and feedback provided. Of particular note is the concern that a workforce strategy built on rural generalists will be implemented at the detriment of the general practitioner workforce and primary care in remote and rural locations will be adversely affected. Whilst there is no evidence that this will occur, close monitoring over the next few years, particularly as the QRGP is now producing graduates is warranted. Specifically, due to the age and construct of the program, the expectation was one of providing an immediate solution to hospital based medical workforce needs in rural locations. As the program matures and graduates of the program seek permanent employment, the impacts of the program on the community office based general practice workforce can only now start to be monitored.

The feedback presented below identifies areas that will require continued negotiation, communication, monitoring and management by the QRGP administrators and Queensland Health.

Commencement of Advanced Skills Training (AST)

The current structure of the QRGP expects the majority of trainees to commence advanced skills training by the third year of post graduate studies. A number of trainees interviewed during site visits, (as well as supervisors and hospital staff) indicated that they felt that this may be too early into the training pathway. Whilst it is recognised that the QRGP is aimed at fast tracking the trainees, the overall view expressed by stakeholders was to seek to make the third year of training a further rural generalist training year enabling the trainee to gain in confidence and experience. This then enables AST to commence in the 4th year of post graduate training.

This may also extend the years of service hospitals can currently expect of the trainees (approximately two to three currently) as AST is required further into the training program.

Emergency Medicine Advanced Skills Training (AST)

Trainees uniformly acknowledged their need to maximise their exposure to emergency medicine training, recognising that throughout the years of practice in rural locations they will be calling on these skills more often than not. This was best illustrated in a written submission to the evaluation that stated:

“Emergency Medicine is somewhat unique, in that, no matter where you are in the country, from a tiny nursing outpost to a major metropolitan referral centre, just about anything can come through the door at any time, and you are expected to deal with it. I have worked on aboriginal communities where I have been called to a “spear in the chest” presentation, and the following patient is a premature labour in a 28 week pregnant woman with pre-eclampsia. All in a less than ideal setting, but I have been expected to apply a first world standard of emergency medical care, with little in the way of resource, right here and right now, with back-up being a long flight away. So, while other Rural Generalist Disciplines (such as Surgery), might be able to teach a limited repertoire of procedures to achieve a Rural Generalist standing, there is no such luxury for Emergency Medicine. One has to walk the walk,

not just talk the talk. One must have the knowledge and reach the standard, not just have the piece of paper.”⁶⁰

Throughout the consultations, trainees and supervisors indicated that access to a one year Diploma course in Emergency Medicine (similar to that offered by RANZCOG for obstetrics) would be highly desirable and should be considered a compulsory component of the overall QRGP training pathway. The Australasian College of Emergency Medicine is in the process of finalising the requirements of the Diploma in Emergency Medicine. In light of comments presented above regarding extending AST requirements into the fourth/fifth year, and while waiting for ACEM to finalise the Diploma course, QRGP should take the opportunity to review the overall construct of the training pathway both in terms of the time at which AST is expected to commence, as well as the need to make certain elements of the training pathway compulsory.

Recommendation 8.1: A review of the training pathway also consider whether the training pathway should be extended or modified to enable AST training to take place post PGY3 years. The impacts upon trainee uptake of the program as well as workforce impacts should be considered within this review.

Scope of Practice – Advanced Skills

Discussions with trainees has highlighted a reluctance to pursue AST in disciplines such as surgery largely due to issues associated with scope of practice which are largely driven by the respective Colleges.

Feedback specific to the surgical AST indicates that trainees are concerned that their scope of practice will be severely limited and that they may end up doing little more than endoscopic and laparoscopic based surgery. This perception is largely based on the fact that this form of surgery constitutes the bulk of the work these trainees are exposed to during their AST. Access to sufficient blocks of supervised surgical time in theatres is proving to be problematic (preference is given first to those trainees on the Royal Australasian College of Surgeons pathway, subspecialties and then rural generalists).

The risk to the QRGP is one of attrition of trainees to the surgical training pathway specified by RACS; or having extremely few trainees opting to pursue a surgical AST. Ongoing discussions with the respective Colleges and enhanced dialogue with the trainees during their AST years is worth pursuing by the Cunningham Centre.

Range of Specialties pursued via Advanced Skills Training

Data presented in previous sections of the report highlight that to date trainees have pursued AST largely in the disciplines of anaesthetics and obstetrics. Submissions from Colleges such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) indicates that there is a growing shortage of skilled specialists in rural, regional and remote locations of the country, and that within Queensland the QRGP has the capacity to address this shortage through an innovative workforce solution.

Of note, all Colleges agree that the QRGP has been successful in attracting trainees and a potential workforce to rural Queensland. The quality of the graduates is dependent upon the program being able to provide appropriate levels of supervision and credentialed AST training programs. RANZCP noted in their submission that the College “*has received some feedback from our members in Queensland who report that the development of an advanced training capacity in psychiatry for generalist medical practitioner in Queensland has stalled. In principle, some regional Queensland mental health services which currently provide training for psychiatrists would also be willing to provide training in psychiatry for generalists. However, to date, the requisite processes involving a consistent pathway into such training with clear training requirements have not been developed or, if developed, not disseminated more widely.*”

Principle iii of the Roma Agreement clearly recognises that the relevant Colleges have responsibility for the setting of standards associated with respective AST training and that

⁶⁰ Submission to the QRGP evaluation, Director of Emergency Medicine Bundaberg Hospital

these same Colleges are responsible for certifying a candidate as demonstrating skills at a recognised and appropriate level. Accordingly, Cunningham Centre will need to liaise with RANZCP and work with them in shaping the QRGP such that it can offer AST in psychiatry. The development of the actual clinical training program vests with the College.

Recommendation 8.2: The Cunningham Centre liaises with RANZCP and work with them to shape the QRGP such that it can offer AST in psychiatry, recognising that the responsibility for the development and specification of the actual advanced skills clinical training program vests with the College.

Capacity to Access Training Positions

Feedback from trainees and also from stakeholder submissions indicates that QRGP trainees face some challenges in terms of being able to be released from hospital responsibilities in order to complete training requirements in general practice. This situation is exacerbated with not all hospitals being RACGP or ACCRM accredited training facilities. Some trainees reported difficulty accessing their professional development leave, whilst others indicated that they had difficulty accessing training places for advanced skills training due a shortage in these places.

Queensland Health should consider developing a program that seeks to support hospitals used by QRGP for trainee placements to gain ACCRM and/or RACGP training facility accreditation.

Recommendation 8.3: Queensland Health considers developing a program that supports hospitals used by QRGP for trainee placements to gain relevant teaching accreditation status with the respective Colleges (ACCRM and/or RACGP).

Rostering Practices

Once HHSs have employed trainees and graduates of the program, it is incumbent on the respective organisations to ensure that there is sufficient volume of cases and opportunities for the rural generalist to maintain their advanced skills. Examples where this has potentially broken down were cited by some of the trainees and supervisors. For example, rostering practices at some hospitals were such that some of the trainees with advanced skills in anaesthetics were limited in their capacity to utilise these skills. This then introduced additional pressure on the trainees to quarantine blocks of time to go off site and work at another location with sufficient workload and volume in order to re-establish their skills.

The onus is on the employing facility to ensure that there is sufficient volume and opportunity for the rural generalist to maintain their advanced skills and this needs to be considered as part of the overall workforce planning process as well as part of the operational framework and responsibility of the employing hospital.

Specification of Supervisors Requirements

Feedback from the trainees on the program shows that the program participants highly value the quality of supervision and mentoring provided on the QRGP. Supervisors indicated that they considered their role in the training pathway to be a component of how medicine should be delivered in the rural setting, reinvesting both into the profession and community. They indicated that they would benefit from further networking between QRGP supervisors. For those supervising trainees in smaller hospital locations access to documentation that outlines the training syllabus, topics to be covered, expectation of the level or standards expected to be attained by trainees, overview of the program etc. would be welcomed. More regular communication between the Cunningham Centre and these supervisors and increased opportunities to network with other supervisors were all considered as areas where further improvements could be made.

It is unclear whether all of the information and support needs of the supervisors rests with the administrators of the QRGP or whether some of these needs would be better addressed by the RTPs. Further work is required in this area.

Recommendation 8.4: Cunningham Centre reviews the information needs of supervisors associated with the QRGP to determine what supports should be provided directly through the program and what supports would be best provided by RTPs.

Vocational individualised plans

As part of the QRGP, trainees undergo counselling sessions that give rise to an individualised vocational plan (VIP) being written for each trainee. These plans are typically completed by the Director of Rural Generalist Training (DRGT) who, in many instances, is the trainees supervisor. The trainees are often unaware of the fact that they have formally completed a VIP, which may undermine the intent of the overall process. Supervisors did not consider this to be an issue, however the administrators of the program have implemented the process for a specific purpose and it is unclear if the VIPs are achieving their intended purpose.

Recommendation 8.5: A review of the utility of the Vocational Indicative Planning (VIP) against its intended purpose should be undertaken.

Directors of Rural Generalist Training

The Directors of Rural Generalist Training (DRGT) are funded positions within the program and located at training facilities. The positions are funded at 0.2FTE and the role of the DRGT is to provide a mentoring and case management role for a set number of trainees. The amount of time and workload involved in providing these services anecdotally exceeds the 0.2FTE allocated time. The services however continue to be provided as part of the broader workload assumed by the clinicians appointed to DRGT roles. Importantly, at no time during discussions with these individuals was the issue additional remuneration raised. Rather the clinicians indicated that they valued and believed in the training program and as such were prepared to continue to invest their time into the program.

Whilst this level of commitment is note worthy, it can place the sustainability of the program at risk as new DRGTs are appointed and current incumbents replaced. A review of the time required to complete the role of a DRGT to the standard desired by the QRGP should be undertaken.

Recommendation 8.6: A review of role and function of the DRGT and time required to complete the requisite duties be undertaken by the Cunningham Centre.

Impact on general practice workforce

A number of stakeholders continue to view the QRGP as a workforce solution that will have deleterious impacts upon the community office based rural general practitioner workforce in rural Queensland. There is concern, that the value of remuneration package offered by Queensland Health will not be able to be matched in the community setting and will therefore significantly influence the decision of rural generalists to remain practicing in a hospital setting rather than transitioning to community based general practice at some point in their career. This perception has yet to be tested.

As outlined in previous sections, trainees and graduates of the program indicated that they joined the program not for the remuneration attached to the positions, but because they always wanted to work in rural settings and the position of a rural generalist offered them greater diversity and career options than that offered by the traditional general practice training pathway.

Further, the HHSs are expected to assume the role of employer and to undertake the necessary workforce planning to determine the medical workforce needs of the local community. Working in conjunction with Medicare Locals, the HHSs will have the capacity to shape the workforce by specifying within the job descriptions the balance of work that is expected to be completed in hospital based versus community/primary care based settings.

Longitudinal tracking of the QRGP graduates along with close monitoring of the general practice workforce in rural Queensland and the manner in which recruitment and workforce planning is undertaken will need to be implemented to build the evidence base to refute or

validate this pervading perception.

Community Based Placements

Trainees have diverse expectations in terms of the proportion of time they expect to invest in working in a community based/office based practice compared to working in a hospital. Whilst primary care clinics within many of the hospitals, together with some emergency department based work enables trainees to gain exposure to general practice skills, most trainees recognised that the skill set required of office based general practice is different to that gained through hospital exposure.

A number of trainees had not undertaken office based placements, and were finding that some RTPs were less likely to facilitate such a placement. For those seeking fellowship with the RACGP this was considered problematic. For those who were seeking fellowship with ACRRM, but planning on pursuing an office based career further into their career pathway this was also seen as an area that could be improved upon within the overall construct of the training program.

RACGP expressed a view that exposure to office based community general practice should occur earlier in the overall training program. Trainees and supervisors did not express a view either in support or against the sequencing of clinical placements in general practice settings. With a request to extend the training program to enable AST to commence in PGY4 there would be scope to gain early exposure for QRGP trainees to community based general practice through an early rotation in the PGY3 year. This should be investigated further.

Recommendation 8.7: The capacity to gain earlier exposure to community based general practice for the QRGP trainees be explored further.

Balance between General Practice and Secondary Care

Submissions made by a number of stakeholders identified that there is a delicate balance between the general practice and secondary care components of the QRGP, and that the program has the potential to create doctors that could be more hospitalists than generalists. Further, stakeholders noted that the RACGP has recently released comments in the medical media about the need to adhere to their definition of what constitutes a general practitioner. Feedback via the submissions gives due recognition to the fact that primary care is delivered in rural areas in ways that conform to available facilities in specific areas (e.g. primary care centres, aged care facilities, multi-purpose health services, small rural hospital outpatients) and that there should be negotiation between the Colleges nationally to determine what are the acceptable settings that meet the recognised definition of general practice. This may have future implications for the QRGP particularly in terms of the pillar centred on the recognition of profession.

Fundamentally, the workforce and delivery models by which services are delivered to communities (particularly in rural locations) is changing, and there is a need to ensure that the profession is flexible enough to cater to these changes. Adherence to too rigid a definition or concept may diminish the contemporaneous nature of the profession. Many of the issues raised in submissions relate to how the respective Colleges value a rural generalist compared to a general practitioner, and whilst a critical pillar of the QRGP, the essence of this debate is one that is considered to be outside of the control and remit of the QRGP.

Critical Success Factors

The respective stakeholders involved in the evaluation identified a number of critical factors contributing to the overall achievements of the QRGP. In no order of importance, these included:

- ▶ early immersion in rural medicine during the prevocational years
- ▶ due recognition being given to the profession of rural generalist by Queensland Health and the associated industrial and remuneration packages that accompany this recognition
- ▶ the fast track nature of the program is both attractive to trainees but also addresses the workforce needs of rural communities in a timely fashion

- ▶ the quality of the training and supervision offered on the pathway
- ▶ the effective quarantining of training placements in rural locations and the preference given to QRGP trainees
- ▶ career opportunities presented at the end of the training period, albeit currently perceived as limited to within Queensland.

The majority of participants in the evaluation process consider the QRGP to be a successful program. It is considered to have made significant inroads in addressing the rural medical hospital workforce needs of the state and in, what many consider to be, a sustainable fashion. There is some concern amongst a broader set of organisations as to what the effect on office or community based general practice will be within the state, and this will require careful monitoring over time is warranted.

There are elements of the program that appear to have relevance to other pathways, strategies and workforce initiatives being trialled or considered in other jurisdictions. Most of these are listed in the above set of critical success factors. However, given that each jurisdiction faces its own distinct challenges in terms of population distribution, training facility capacity and workforce configuration, it is highly unlikely that the QRGP can be readily transferred into other jurisdictions in its current format without some form of customisation being required.

9 Cost Comparison

The terms of reference required the evaluation undertake a comparative cost analysis for a Clinical Services Capability Framework level 3 site of the various available models of medical service delivery.

9.1 Administrative Costs of the Program

The administrative costs associated with the program since inception totals \$10,156,590 (including the 2012/13 budget allocation). This represents an average annual commitment to the program by Queensland Health of approximately \$1,450, 940. The investment covers both salary and non-salary costs of administering the program. Based on the number of trainees that have enrolled in and participated in the QRGp (including deferrals and withdrawals), the average cost of administration per trainee per annum is approximately \$5,315. This modest investment not only includes the costs associated with case managing the individual trainees, it also includes the costs associated with marketing the program, providing networking opportunities through conferences etc. and the general supports provided to trainees by the Cunningham Centre.

It represents a relatively modest investment per trainee.

9.2 Cost Impacts of the Program: A Case Study

Limitations in data availability and the capacity to undertake appropriate linkages across differing datasets restricted the capacity to undertake a comparative cost analysis for a Clinical Services Capability Framework level 3 site of the various available models of medical service delivery. However, based on feedback from a region, a case study and cost modelling exercise against this case study was able to be completed.

Feedback from a regional HHS identified that since the implementation of QRGp 57 additional deliveries were able to be performed locally in the last year which otherwise would have been delivered either at another regional location or in Brisbane.

Assuming that 50% of these deliveries in the past may have been emergency presentations and the other 50% represented planned complex cases; a model that identified the costs incurred by Government for travel, out of hospital accommodation and additional accrued beddays was calculated.

The medical team composition associated with these deliveries in the past was assumed to involve:

- ▶ 1.0 FTE L23 DMS
- ▶ 2.0 FTE L18 non-specialist
- ▶ 1.0 FTE L14 SMO/CMO
- ▶ 1.0 FTE L13 GP registrar
- ▶ 1.0 FTE L5 RMO

The medical team composition associated with these deliveries once the QRGp had been introduced was assumed to involve:

- ▶ 1.0 FTE L23 DMS
- ▶ 2.0 FTE L21 medical officer advanced credentialed practice
- ▶ 1.0 FTE L14 SMO/CMO
- ▶ 1.0 FTE L13 GP registrar
- ▶ 1.0 FTE L5 RMO

The additional investment associated with the remuneration of the team involving advanced skilled credentialed medical officers totalled \$47,660.

Savings in travel costs borne by the government (ambulance and helicopter) and accommodation costs covered by the patient assistance transport scheme (PATs) were identified together with an estimated 42.5 bedday efficiency gain. The total estimated savings was approximately \$104,600 which represents a return on investment ratio of 1.2. This implies that for every \$1 investment the QRGp returns a saving of \$1.20.

This estimate is conservative as it does not include expected savings to the system in reduced VMO services or changes to locum arrangements. Equally the costs of administration of the program have not been included in this modelling exercise.

9.3 Recognition Costs

The Queensland Government elected to give due recognition to the profession through changes to the industrial award and remunerating rural generalists as specialists. There has been considerable conjecture that the remuneration provided by Queensland Health results in the public health system incurring an additional cost that is significant and likely to be prohibitive in terms of other jurisdictions capacity to implement a similar program. The reality is somewhat different.

The award structure in Queensland Health already made provision for the employment of non-specialist senior medical officers – which is the position rural generalists were previously appointed to. By providing recognition for advanced skills training, and deeming the rural generalist position as a specialist discipline, the differential in payment (i.e. moving from non-specialist award rate to specialist award rate) on the base salary represented an additional cost injection of \$12,150 by the state government. This additional cost represents an annual figure for each rural generalist appointed to a salaried position in a rural hospital. The differential increases to approximately \$23,800 when differences between the overall packages are considered. This represents a modest additional investment incurred by Queensland Health for the recognition of rural generalists and as further illustrated by the case study above.

10 Comparison of QRGP to Other Comparable Programs

The following provides a synopsis of comparable medical workforce strategies adopted in other jurisdictions most of which have not been evaluated or produced comparable data from which to draw any meaningful comparisons.

10.1 Models Across Different Jurisdictions

Ensuring a steady health workforce is the joint responsibility shared by the Australian Commonwealth, States and Territory governments. Strategically, the Commonwealth government is in charge of policy relating to, and financial support to, university education for medical students. State and Territory level governments are accountable for the delivery of health services, in addition to being main employers and trainers of medical practitioners, essentially through the public hospital system⁶¹.

10.1.1.1 New South Wales

New South Wales Health medical training models are predominantly based on a hospitalist model. The models typically have been focused on development of hospital-based doctors who have the capacity to assist with the management of patients in major metropolitan hospitals by ensuring patients receive continuity of care and treatment⁶².

Recently, NSW has increased the number of initiatives through programs such as the NSW Rural Generalist Training Program to build a sustainable medical workforce⁶³. The program offers 15 positions in 2013 for PGY2 JMOs to apply for entry into Procedural Training in PGY3 (anaesthetics or obstetrics) and then advance on a supported pathway that is aligned with the curriculum of their preferred General Practice Training requirements whilst having the opportunity to use their advanced skills at a rural health facility⁶⁴. However there have been concerns pertaining to the structure of training packages as well as the absence of administrative supports to assist trainees to navigate and train via this initiative⁶⁵.

This program supersedes an earlier program developed in 2003 which experienced difficulties in coordination of and alignment of GPs with procedural skills to positions within the Rural Local Health Districts (LHDs).⁶⁶

Dual trained physicians – Royal Australasian College of Physicians

The RACP is currently working with the New South Wales government to introduce a training program for dual trained physicians, through a general practice pathway that will focus on addressing the chronic disease management issues arising as a result of the ageing population profile of the state. In its early stages of planning, the program is likely to be rolled out in metropolitan locations in the first instance.

10.1.1.2 Victoria

Since 1 July 2010, through the Rural Workforce Agency of Victoria (RWAV), 95 GP training positions were offered in rural, regional and Indigenous health services. The program also included relocation, matching, placement and continuous support services for GPs as well as assisting in professional development, marketing of rural general practice, academic research and policy

⁶¹ The Parliament of the Commonwealth of Australia (2012). *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors, March 2012*. Canberra: House of Representatives Standing Committee on Health and Ageing

⁶² Australian Government Department of Health and Ageing (2008). *Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008*. Commonwealth of Australia, Canberra.

⁶³ HETI Rural Directorate (2012) Rural Generalist Training Program <http://www.ruralhetti.health.nsw.gov.au/_documents/initiatives/rural-generalist-training-program/rural-generalist-information-fact-sheet.pdf> viewed 22 August 2012

⁶⁴ Moynihan, M. Brief Submission to the Senate Inquiry 6.1.12. Factors affecting supply of health services and medical professionals in rural areas. Rural doctors Association of Victoria <http://www.rdav.com.au/documents/Indexpage/Senate%20Rural%20Medical%200112.pdf> viewed 24 August 2012

⁶⁵ NSW Department of Health (2011) *Securing a stable medical workforce for rural communities: a discussion paper*. Workforce Development and Innovation. August 2011

⁶⁶ Ibid, pg. 1

recommendations⁶⁷. The program was more focussed on addressing community/office based general practice workforce needs rather than supplying an advanced skills trained general practice workforce.

10.1.1.3 Western Australia

In 2007, Western Australia Country Health Service (WACHS) reviewed the Queensland RGP model with the intention of replication. However, due to the vast difference in WA's geographical and population dispersion, as well as availability of infrastructures and facilities, the QRGP model in its existing format was deemed unsuitable for the Western Australian environment. WACHS has since worked closely with GPET, the Rural Clinical Schools (RCS) and the Communities Residencies Program to develop the WACHS RGP model. The model targets trainees who have completed their PGY3 and are ready to move to a College training program, whether ACRRM, RACGP or another specialist College.

10.1.1.4 South Australia

South Australian rural health facilities operate on a Visiting Medical Officer (VMO) model, with an estimated 430 GPs across South Australia receiving a fee for service to provide emergency and procedural services. Much like Western Australia, the QRGP in its current format does not fit well within the overall medical workforce strategy of the state nor is it able to be supported with the existing infrastructure in rural, regional and remote South Australia. The focus in this state is very much on building the community based general practitioner workforce, supplemented with a smaller number of general practitioners with proceduralist training.

10.1.1.5 Northern Territory

The Northern Territory Department of Health and Families (NTDHF) have commenced negotiations with Queensland with the intention to collaborate, adopt and adapt the QRGP model to create viable pathways for rural and remote generalist and proceduralist training in the Northern Territory⁶⁸.

10.1.1.6 Tasmania

The generalist model is likely to be of most use in places such as the North West coast because trends suggest it will become harder to attract specialist consultants to the area. The North West region has about 1/3 of the population of Tasmania (about 120,000 people) and it currently has difficulty attracting specialists. Workforce solutions are also stretched through low medical workforce numbers and pressures being felt with locum and on - call arrangements. The region has not yet fully explored the generalist model but may eventually do so.

10.2 International Models: North America, Japan and Switzerland

Programs from overseas typically have focussed on how to improve overall medical workforce retention in rural locations. Strategies that addressed the backgrounds of trainees and selection processes into medical training were explored first as a means of addressing retention issues.

A shortage in medical practitioners was identified in the 1960's; prompting the US government to develop medical schools that specifically recruited trainees with rural backgrounds. *The Washington, Wyoming, Alaska, Montana and Idaho Program (WWAMI)* was developed 1971 by the University Of Washington, School Of Medicine. The program is based on a preferential system and recruited trainees from rural and remote backgrounds as well as trainees returning prevocational and vocational experience. Since then, empirical evidence has shown that rural background is the strongest predictor in trainees' decision to continue to practice in rural locations post training⁶⁹.

⁶⁷ RWAV (2011). Submission to Finance and Public Administration References Committee for Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA). <<https://www.rwav.com.au/upload/rwav/Publications/RWAV%20Senate%20Submission%20-%20AHPRA.pdf>> viewed 24 August 2012

⁶⁸ NOVA Public Policy (2010), pg. 19

⁶⁹ Cooper, J.L., Heald, A. & Samuels, M. (1977). Affecting the supply of rural physicians. *American Journal of Public Health*, 67, 756-759; Rabinowitz, H.K (1988). Relationship between US medical school admission policy and graduates entering rural practice. *Family Practice*, 5, 142-144.

The *Rural Physicians Associate Program* (RPAP) was established in 1971 at the University of Minnesota. The program included a 9-month, scholarship funded elective that allowed forty 3rd year medical undergraduates to study in rural community settings. A review into the program showed it was effective in producing higher numbers of rural practitioners in comparison to non-participating cohorts⁷⁰.

The Jichi Medical School in Japan and the University of Tromsø, School Of Medicine in Norway also have developed successful programs. The model is based on a decentralised medical school curriculum that provides continuous training experiences in rural and remote settings. Follow-up studies in 1996 revealed that approximately 42% of graduates continued practicing in rural and remote communities, post-training⁷¹.

⁷⁰ See Dunbabin, J. & Levitt, L. (2003) pg. 2-5.

⁷¹ *ibid*

11 Conclusions

The QRGP has been recognised by all stakeholders as an effective and sustainable training pathway that is providing a solution to rural medical workforce issues faced in Queensland. Due to the model construct, implementation and stage of development, it has been more successful in providing a hospital focused medical workforce solution. As it now moves to a state of maturity with ongoing supply of graduates ready to join the workforce, the impact of the program on addressing rural general practice workforce needs can only now begin to be monitored.

Figure 38 provides a summary rating of attainment against some of the more critical domains of inquiry posed by the evaluation.

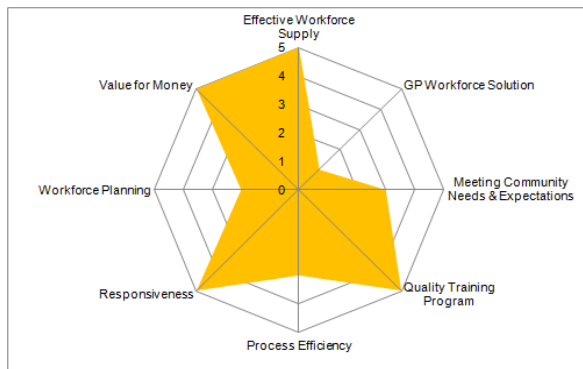


Figure 38: Rating of attainment of the QRGP

The evaluation concludes that the QRGP has:

- ▶ Provided an exceptionally high quality training program valued by trainees and graduates and reflects the commitment of senior clinicians to the program through high quality supervision and support
- ▶ Operated at an efficient level, but can be significantly improved upon through investment in relevant information management systems; consolidation of policies and processes; construct of appropriate communication protocols with key stakeholder organisations
- ▶ Demonstrated high degree of flexibility and responsiveness to the needs of the trainees
- ▶ Yet to realise its potential to support workforce planning activities undertaken by HHSs
- ▶ Met the needs of local communities through the reduction of critical shortages in medical workforce numbers; the enabling of health services to expand service delivery making services more accessible and affordable to local residents
- ▶ Represented value for money investment for the Queensland government with a return on investment ratio conservatively estimated to be in the vicinity of 1.2.

Work now needs to focus on refining the program to improve process efficiency and quality as well as moderating the program to fit with the individual workforce planning requirements of the respective rural HHSs.

Appendix A Stakeholders involved in the Evaluation

Stakeholders
Australasian College for Emergency Medicine (ACEM)
Australian College of Rural and Remote Medicine (ACRRM)
Australian Medical Association Queensland (AMAQ)
Australian New Zealand College of Anaesthetists (ANZCA)
Cunningham Centre
General Practice Education and Training (GPET)
General Practice Queensland (GPQ)
Griffith University
Health Workforce Queensland
James Cook University
Kingaroy Hospital <ul style="list-style-type: none"> • Trainees • Supervisors • Administrators
Longreach Hospital <ul style="list-style-type: none"> • Trainees • Supervisors • Administrators
Mackay Hospital <ul style="list-style-type: none"> • Trainees • Supervisors • Administrators
Queensland Health
Queensland Rural General Pathway trainees and graduates
Regional Training Providers (RTPs): <ul style="list-style-type: none"> • Tropical Medical Training • Central & Southern Queensland Training Consortium • Queensland Rural Medical Education
Remote Vocational Training Scheme (RTVS)
Royal Australasian College of Physicians
Royal Australasian College of Surgeons (RACS)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZOG)
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
Royal Australian College of General Practitioners (RACGP)
Rural and Remote Medical Services
Rural Doctors Association of Queensland
Rural Medical Panel Statewide (RuMPS)
University of Queensland

Appendix B Trainee and Graduate Online Survey

Evaluation of the Queensland Rural Generalist Program (QRGP) - Trainee & Graduate Survey

Introduction

The Queensland Rural Generalist Program (QRGP) was founded in Queensland as a generalist discipline in medicine in August 2005 by a group of key stakeholders who convened in Roma to develop the concept of a supported training pathway to a career in rural medicine. Intake into the program commenced in 2007, and in 2008, Queensland Health formally recognised "rural generalist" medicine as a specialist discipline and reformed the State's salary classification.

The achievements of the QRGP have been noted more recently both nationally and across a number of jurisdictions, with interest being expressed in terms of identifying key attributes of the program that can be readily transferred to other jurisdictions to address medical workforce issues. Of interest to Queensland Health (and other jurisdictions) is the identification of the successes, constraints, issues and benefits the QRGP program has on addressing rural/remote service delivery and workforce issues.

Queensland Health, through the Office of Rural and Remote Health, has recently engaged Ernst & Young (EY) to evaluate the Queensland Rural Generalist Program. The objectives of the evaluation include:

- the review of the current state of the QRGP focusing on stakeholder engagement and process efficiency
- undertaking a comparative cost analysis for a Clinical Services Capability Framework level 3 site of the various available models of medical service delivery
- giving due consideration to the extent to which the QRGP meets the needs and expectations of the rural communities
- undertaking a workforce analysis which maps workforce requirements and service elements, determines the future needs of the QRGP with specific mapping of advanced skills and identified pertinent population drivers
- developing a workforce framework which provides the principles, service guidelines and planning tool that will assist and inform Hospital and Health Services, training organisations and trainees in regard to training programs and pathways to meet future needs.

The evaluation team is keen to engage with trainees and graduates of the program to gain an appreciation of why you were attracted to the program, the experiences gained on the program and the factors that impact upon decisions of trainees to practice medicine in rural locations.

We are therefore inviting trainees and graduates of the QRGP to participate in the evaluation by

completing this survey. It should take approximately 10 minutes to complete and is structured such that you can save at any point and return to it at a later stage.

We recognise that not all questions may be relevant to you given where you may be along the QRGP pathway. As such we have included an option in most questions where you can indicate whether or not the question is pertinent to you at this stage of your training.

We request that you complete the survey by close of business ***Friday September 7th 2012***.

The survey asks you to present your experiences and perceptions relating to a number of aspects of the QRGP. Your participation in the survey is voluntary. Your response will be non-identifiable and there will be no repercussions of any type if you elect not to participate. If you do elect to participate, we request that you answer all possible questions.

The outcomes of the evaluation will be used to determine the future direction of the program and forms an important component of the overall quality assurance program of both the QRGP and the Department. To this end I encourage you to take this opportunity to participate in the evaluation.

Should you have any further queries about the evaluation please direct them to Rita Brewerton on either mobile phone: 0419 833 140 or via email at ritabrewerton2@bigpond.com.au.

We thank you in advance for taking the time to consider your participation in the study.

Demographic Data

1. Please identify your gender

- ☐ Female
- ☐ Male

2. Please identify your age

3. Have you ever lived in a rural or remote area prior to commencing your medical training? *

- ☐ Yes
- ☐ No

4. In total how long (in years) did you live in rural and/or remote towns?

5. Which rural and remote towns (and state) did you live in?

6. Has living in a rural location pre-medical training influenced your decision to pursue a rural medical career?

☐ Yes

☐ No

Give reasons for your answer

QRGP Training

7. Please identify whether you are currently a trainee on the QRGP or whether you have graduated from the program

- ☐ Current Active Trainee of the Program
- ☐ Currently a Trainee on the Program but Deferred
- ☐ Graduate of the Program and Fellowed
- ☐ Graduate of the Program awaiting Fellowship

8. What year of training are you currently involved in?

- ☐ PGY1
- ☐ PGY2
- ☐ PGY3
- ☐ PGY4
- ☐ PGY5
- ☐ Not Sure

9. Please identify when you commenced training in the QRGF

10. Please identify your estimated completion date

11. Please identify when you completed the program

12. Are you a recipient of a scholarship?

☐ Yes

☐ No

13. Please identify which scholarships you have received - tick all that are applicable

☐ Queensland Health Rural Scholarship

☐ John Flynn

☐ Other, please specify

14. Which College are you seeking Fellowship with?

☐ Australian College of Rural and Remote Medicine (ACRRM)

☐ Royal Australian College of General Practitioners (RACGP)

☐ Not sure yet

15. At which of the following locations are you presently training?

- ☐ Cairns
 - ☐ Townsville
 - ☐ Mackay

 - ☐ Rockhampton
 - ☐ Ipswich
 - ☐ Toowoomba
 - ☐ Nambour
 - ☐ Caboolture
 - ☐ Redcliffe
 - ☐ Logan
-

16. How were you made aware of the QRGP? Select as many options as relevant

- ☐ Presentation during O-week
 - ☐ Presentation nearing the end of my undergraduate years at University
 - ☐ Information obtained via student club
 - ☐ Internet
 - ☐ Colleagues
 - ☐ Other, please specify
-

17. Is it easy to find information about the QRGP?

- ☐ Yes
 - ☐ No
 - ☐ Not sure
-

18. How would you rate the information that is available outlining the QRGP?

- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Extremely
Useful | Very Useful | Useful | Not very
Useful | Not Useful at
all | Do not recall |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
-

19. How easy is it to interpret the information contained in materials describing the QRGP?

Extremely Easy Easy Somewhat difficult Difficult Extremely Difficult Do not recall

☐ ☐ ☐ ☐ ☐ ☐

QRGP Training Cont.

20. What attracted you to the Queensland Rural Generalist Program? *

21. Please rate from highest to lowest the factors that attract you to practicing as a rural generalist

Drag items from the left-hand list into the right-hand list to order them.

Prefer rural lifestyle
Commitment to specific community
Financial benefits/incentives
Enjoy the professional challenges
Close to family/friends
Diversity in practice
Other

22. If other was selected above, please specify

23. Rate the importance of the following in terms of influencing your decision to train on the QRGP

*

	Extremely Important	Somewhat Important	Neutral	Of little Importance	Not Important at all
Access to funds through scholarship program *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to work across primary and secondary health settings (office based and hospital based settings) *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Early immersion in rurally based medicine during pre-vocational years *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment opportunities within Queensland Health at the end of the program *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Location of training placements *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of the teaching provided on the program *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reputation of the program *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recognition of the program and proceduralist skills *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remuneration packages available at the end of the program *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support provided by QRGP staff for the duration of the program *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to pursue interests in AST *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other factors, please specify below *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you identified "other factors" above please specify what these factors are

24. In which specialty do you propose to obtain Advanced Skills Training (AST)?

- ☐ Anaesthetics
 - ☐ Emergency Medicine
 - ☐ Indigenous Health
 - ☐ Internal Medicine
 - ☐ Mental Health

 - ☐ Obstetrics and Gynaecology
 - ☐ Paediatrics
 - ☐ Surgery
-

25. Have you already commenced your AST?

- ☐ Yes
 - ☐ No
-

26. Which AST are you currently undertaking ?

- ☐ Anaesthetics
 - ☐ Emergency Medicine
 - ☐ Indigenous Health
 - ☐ Internal Medicine
 - ☐ Mental Health
 - ☐ Obstetrics & Gynaecology
 - ☐ Paediatrics
 - ☐ Surgery
-

27. Which AST have you already acquired?

- ☐ Anaesthetics
- ☐ Emergency Medicine
- ☐ Indigenous Health
- ☐ Internal Medicine
- ☐ Mental Health
- ☐ Obstetrics & Gynaecology
- ☐ Paediatrics
- ☐ Surgery

28. Why do you NOT/ did NOT want to pursue AST in any of the following (other than your chosen AST):

Anaesthetics	<input type="text"/>
Emergency Medicine	<input type="text"/>
Indigenous Health	<input type="text"/>
Internal Medicine	<input type="text"/>
Mental Health	<input type="text"/>
Obstetrics and Gynaecology	<input type="text"/>
Paediatrics	<input type="text"/>
Surgery	<input type="text"/>

Your experience on the QRGP

29. Please indicate how well supported you have been by the QRGP staff whilst on the QRGP pathway

- ☐ Extremely well supported
 - ☐ Well supported
 - ☐ Somewhat supported
 - ☐ Not supported very well
 - ☐ Not supported at all
-

30. Are there areas where you feel the QRGP staff could support you better?

- ☐ Yes
 - ☐ No
-

31. Please specify what these areas of improvement could be

32. Are you satisfied with the placement process/es?

- ☐ Yes
- ☐ No

33. If not, why not?

34. Please identify your level of satisfaction with the support being provided to you by your supervisor

- ☐ Extremely satisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Not really satisfied
- ☐ Not satisfied at all

35. Give reasons for the rating you have provided to the above question

36. Please identify your level of satisfaction with the support being provided to you by the facility at which you are currently training

- ☐ Extremely satisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Not really satisfied
- ☐ Not satisfied at all

37. Give reasons for the rating you have provided to the above question

38. Please identify your level of satisfaction with the support being provided to you by the Regional Training Provider (RTP)

- ☐ Extremely satisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Not really satisfied
- ☐ Not satisfied at all

39. Give reasons for the rating you have provided to the above question

40. If you have an issue with the Program, who do you go to see in the first instance ?

- ☐ Supervisor
- ☐ QRGP staff at Roma
- ☐ QRGP staff at Toowoomba
- ☐ RTP

☐ Other, please specify

41. Why do you seek this person's assistance?

42. Please rate your overall experience to date on the QRGP

- ☐ Extremely satisfied
 - ☐ Satisfied
 - ☐ Somewhat satisfied
 - ☐ Not really satisfied
 - ☐ Not satisfied at all
-

Give reasons for your answer

43. Could the QRGP be improved further?

- ☐ Yes
 - ☐ No
 - ☐ Not sure
-

44. Identify areas for improvement

45. Upon graduating from the QRGP, would you value having the opportunity to join a QRGP alumni?

- ☐ Yes
 - ☐ No
 - ☐ Not sure
-

46. What sort of services would you expect to access as a QRGP alumni?

Career Planning

47. When you have completed QRGP training, which of the following would be your preferred practice environment? *

- ☐ Remain working in current location
- ☐ Work in metropolitan location
- ☐ Work in outer metropolitan location
- ☐ Work in rural or regional centre with a larger regional hospital
- ☐ Work in small rural or remote town with no hospital
- ☐ Other, please specify

48. What specific town or region are you interested in working once you complete the QRGP?

49. Please rate from highest to lowest the factors that will influence your choice of practice location

Drag items from the left-hand list into the right-hand list to order them.

Partners' employment
Children's education
facilities
Sporting/special interest
Personal invitation
Existing connection to a
town
Cultural communities
Environment
Religious facilities
Known colleagues
Reputation of existing
practice/hospital
Available infrastructure
Other

50. If other was selected above, please specify

51. How long do you intend to practice in rural locations?

- ☐ 1-2 years
- ☐ 3-5 years
- ☐ 6-8 years
- ☐ 7-10 years
- ☐ 11-15 years
- ☐ 15+ years
- ☐ undecided
- ☐ don't plan leaving rural medicine

52. For the period selected above, do you envisage working in

- ☐ one location for this period?
- ☐ multiple locations over this period?
- ☐ undecided at this stage

53. What are the factors that could influence you to leave practice in a rural or remote town?

- ☐ Children's education
- ☐ Pressure of work
- ☐ Personal factors based on social/family situations
- ☐ Personal factors based on spouse/partner situations
- ☐ Concerns about medico-legal issues
- ☐ Personal health
- ☐ Lack of professional support from Queensland Health
- ☐ Lack of professional support from colleagues
- ☐ Declining infrastructure in place of employment
- ☐ Availability of suitable housing
- ☐ Other, please specify

Demographics - Marital Status

54. Please identify your current marital status

- ☐ Single
- ☐ Married/de-facto
- ☐ Divorced/separated/widowed
- ☐ Other, please specify

55. Has your partner ever lived in a rural or remote area?

☐ Yes

☐ No

56. In total how long (in years) did they live in rural and/or remote towns?

57. Which rural and remote towns (and state) did they live in?

58. Is your partner professionally qualified?

☐ Yes

☐ No

59. Please identify your partner's qualification

60. Rate the degree to which employment opportunities for your partner influences your decision in terms of where you are prepared to be placed for training and/or practicing medicine?

Very Significant Factor	Significant Factor	Somewhat Significant Factor	Marginal Factor	Not a Factor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

61. How satisfied are you with the work opportunities for your partner in the current town in which you are located?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied	Not relevant
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

62. How satisfied are you with the educational opportunities for your partner in the current town in which you are located?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied	Not Applicable
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Give reasons for your response

Demographics - Family

63. How many children do you have under the age of 18?

- ☐ None
 - ☐ 1-2
 - ☐ More than 3
-

64. Rate the degree to which educational facilities and opportunities for your children influences your decision in terms of where you are prepared to be placed for training and/or practicing medicine?

- | | | | | |
|----------------------------|-----------------------|-----------------------------------|-----------------------|-----------------------|
| Very Significant
Factor | Significant
Factor | Somewhat
Significant
Factor | Marginal Factor | Not a Factor |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
-

65. How satisfied are you with the educational opportunities for your children in the current town in which you are located?

- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Very
Satisfied | Satisfied | Neutral | Dissatisfied | Very
Dissatisfied | Not
Applicable |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
-

66. Overall from a family perspective how satisfied are you with the rural and remote training location?

- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Very Satisfied | Satisfied | Neutral | Dissatisfied | Very
Dissatisfied |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
-

Thank You!

Thank you for taking our survey. Your response is very important to us.

Appendix C Abbreviations

ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
ARST	Advanced Rural Skill Training
CSQTC	Central and Southern Queensland Training Consortium
DRGT	Director of Rural Generalist Training
EMST	Emergency Management of Surgical Trauma
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FARGP	Fellowship in Advanced Rural General Practice
FRACGP	Fellowship of the Royal Australian College of General Practitioners
GPET	General Practice Education and Training
GPRA	General Practice Registrars Australia
GPRIP	General Practice Rural Incentive Program
HHS	Hospital and Health Service
IP	Independent Pathway
LHDs	Local Health Districts
MRBS	Medical Rural Bonded Scholarships
NARTP	National Advanced Rural Training Program
NTDHF	Northern Territory Department of Health and Families
NRF	National Rural Faculty
ORRH	Office of Rural and Remote Health
QHRSS	Queensland Health Rural Scholarship Scheme
QCRD	Queensland Country Relieving Doctor
QRME	Queensland Rural Medical Education
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RGTP	Rural Generalist Training Program
RRMA	Rural, Remote and Metropolitan Areas classification
RCTS	Rural Clinical Training and Support
RTPs	Regional Training Providers
RuMPs	Rural Medical Panel Statewide
Rural LEAP	Rural Locum Education Assistance Program
RVTS	Remote Vocational Training Scheme
RWAV	Rural Workforce Agency of Victoria
SMO	Senior Medical Officer
TMT	Tropical Medical Training
VMO	Visiting Medical Officers
VIP	Vocational Indicative Planning
VPP	Vocational Preparation Pathway

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