

The Roma Agreement: changing the face of rural generalist training in Queensland

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Introduction

Queensland Health's Rural Generalist (RG) Pathway commenced as a new stream of rural training in 2007. This pathway, which has changed the face of rural medical recruitment and training across the jurisdiction, arose from a number of sentinel events relating to workforce recruitment and retention, work practices, and industrial progresses, culminating in a forum in the rural town of Roma in 2005.

This seminal meeting of Queensland Health, Colleges, educational providers, rural doctors and other stakeholders led to the so-called *Roma Agreement*, which agreed to:

Develop and sustain an integrated service and training program to form a career pathway supplying the Rural Generalist workforce that the bush needs.

The principles expressed in the *Roma Agreement* (Table 1) underpinned the educational principles and outcomes of the RG Pathway. The success of the Pathway in Queensland has been associated with a broader enunciation of the concept of a *Rural Generalist*, and similar approaches being adopted in other states,

Table 1 The Roma Agreement

1. All career pathways will be easy to understand, responsive to needs, well promoted, well supported, well resourced and involve key stakeholders.
2. 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.)
3. The educational standards of the training program will be set externally by the appropriate college.
4. 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 Practitioners (RACGP).
5. The program markets and provides a supported career path from medical school to rural generalist practice.
6. Vocational training will be provided by General Practice Education and Training (GPET) Training Providers and will be rural centric.
7. 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.
8. All providers and funding sources commit to the process and to provide timely decision making and action.
9. 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.)

This paper will briefly outline the antecedent events that led to the development of the *Roma Agreement* and explores the central role of this agreement in the Rural Generalist pathway in Queensland. The success of the Pathway in Queensland invites speculation about the applicability of this model in other jurisdictions and in other disciplines.

Background

The well documented events within Queensland Health in the early part of the 21st century produced an opportunity for change. The 2005 Foster Review and related Inquiries into the events at Bundaberg Hospital identified that significant cultural shift was required within the Health department and noted that rural hospitals cannot be ignored. With a background of an ageing and diminishing rural Senior Medical Officer workforce, the risk of skills being lost, and an evidently limited supply of appropriately qualified international graduates came the realisation that it was better to staff hospitals with local graduates with good training and clear understanding of scope of practice. These events provided the opportunity to develop a specialist career pathway for Rural Generalists.

A pivotal meeting in Roma, southwest Queensland in October 2005 attended by key stakeholders agreed to establish the so-called *Roma Agreement*. This agreement, which fulfilled the State government's promise of a specialist career pathway for rural generalists, provided a framework for junior doctors (including government scholarship holders with return-of-service obligations), which integrated training and industrial recognition. The framework had been devised in consultation with key stakeholders and endorsed by rural medical superintendents. A pivotal survey of rural senior medical officer workforce in 2001 provided justification and design evidence. The training program developed with a jurisdictional focus and supplies Rural Generalists to both public and private sectors. The nine principles articulated, which underpin the pathway, are still relevant today, with similar approaches being adopted in other jurisdictions as the pathway is rolled out nationally.

One key component of this reform was the recognition by Queensland Health of the concept of a *Rural Generalist* as a rural medical practitioner credentialed for:

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 & community-based public health.

These reforms had significant industrial implications for rural doctors and trainees embarking on a rural career. There was now recognition and definition of the role of the Rural Generalist with a specified scope of credentialed practice. A salary scale was devised with near-equivalence to a Staff Specialist and Senior Staff Specialist. In addition, Training Pathways were developed to support and supplement vocational training to the endpoints of Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) and/or Fellowship of Australian Rural General Practice (FARGP). Flexible career pathways were devised to allow trainees with appropriate training and experience in Emergency Medicine to practise as Generalists in Emergency Medicine (GEM), recognising that many trainees may have several careers and multiple practice locations in their working life.

These developments occurred in the setting of considerable growth in rural medical education. The increase in medical schools in Queensland from one to four was accompanied by a rise in numbers of medical students, many of whom had rural backgrounds, adopted rural scholarships, or were otherwise committed to a rural career. The development of University Departments of Rural Health and Rural Clinical Schools allowed many more students to undertake rural placements in their basic medical training. Together with growth in postgraduate training opportunities in rural medicine, these developments ensured an increased supply line of graduates interested in rural practice.

Discussion

The principles enunciated in the *Roma Agreement* have served the Queensland Rural Generalist Pathway well. But does everyone need such an agreement? Multidisciplinary fora such as the National Rural Health Conference provide an opportunity to consider questions such as:

- Would similar agreements be useful in other contexts? How would they work?
- Who are their stakeholders and communities of interest?
- What are the key lessons from this experience?

In the definition of a Rural Generalist provided above, the role of hospital practice in primary and secondary care is mentioned. This is underpinned in the principles of the *Roma Agreement*:

Principle 2. 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.)

In Queensland, the rural medical hospital services provide a unique model of care in Australia, with salaried doctors providing services across public and private domains. For a long time, those within the system have known that these positions are excellent training and career opportunities. To meet this opportunity, hospital posts needed to be re-designed in some instances to meet the accreditation standards of the various Colleges. The need to meet existing standards was clearly stated in the *Roma Agreement*:

Principle 3. The educational standards of the training program will be set externally by the appropriate college, and

Principle 6. Vocational training will be provided by GPET Training Providers and will be rural centric

Interestingly, in the majority of cases, meeting the standards for accreditation of hospital vocational training posts has not been difficult. Mature and functioning networks with Regional Training Providers (RTPs) in the most part have facilitated this. Solutions to challenging accreditation sites have been worked out with the goodwill between the hospitals, the pathway, and the RTPs. The Remote Vocational Training Scheme (RVTS) has been another option for more remote sites.

The Queensland RG pathway has been clear not to request anything other than fair and equitable accreditation by RTPs. Where this has not been possible, sites have not been made available as training locations. Instead, the RG pathway has worked to assist localities to move towards accreditation with an RTP or develop a relationship with RVTS.

Training in hospital environs and hospital based primary medical care may be unique in Queensland. However, the principle of provision of rural primary medical practice and hospital based secondary practice has applicability across all jurisdictions.

Similar approaches to training are already happening in many rural areas on an *ad hoc* basis as was the case in Queensland prior to the pathway. Indeed, there is a distinct trainee group preferring to make their own way outside the RG pathway. This group is able to meet an equal vocational outcome (Fellowship of the relevant College) to trainees in the RG pathway. The RG pathway team frequently engages this group to assist them in ensuring their vocational training and preparation is pitched at an equivalent level.

The wider applicability of the pathway across other states is further supported by key aspects of the pathway in both marketing and retention areas. The RG pathway aims to be supportive and facilitative, which is frequently fed back as a major benefit to trainees. The *Roma Agreement* specifically addresses issues relevant to training:

Principle 5. The program markets and provides a supported career path from medical school to rural generalist practice, and

Principle 7. 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, and

Principle 8. All providers and funders commit to the process and to provide timely decision making and action.

Principle 8 notes the recognition of RG medicine in Queensland. The appropriate remuneration of trainees and vocationally trained doctors was a work in progress at the time of the *Roma Agreement* in 2005. This work has provided an appropriate remuneration package for these rural doctors which recognises the importance of rural primary care, advanced practice roles played in specialised practice areas, the broad generalist skills needed to function in secondary practice in a rural location, and the issues of maintenance of skills for rural doctors practicing across a number of areas.

The industrial changes which occurred in parallel have brought equity to this group of doctors and had a significant effect on retention. These principles could be considered in any jurisdiction considering a systematic approach to RG training.

Finally, the importance of each jurisdiction having their own *Roma Agreement* cannot be overstated. While many operational aspects must be local, many of these principles may well be generic across the country. However, the negotiation and details of what is needed where and how is a state function and all states are different. The Rural Generalist management team has regularly revisited the *Roma Agreement* document. It is with pride in the moment and some relief that these principles remain relevant in their entirety at present. The team will continue to revisit and rely on this seminal document into the future and hope that other jurisdictions can develop similar blueprints for rural training into the future.

Future directions

A major review of the Rural Generalist Pathway undertaken on behalf of Health Workforce Australia highlighted some areas for further development. Ongoing dialogue and consultation with stakeholders suggested some of the principles of the *Roma Agreement* may need to be reviewed or updated. These included the need for the RG Pathway to continue to work collaboratively with specialty colleges to ensure that the Advanced Skills Training offered through the Pathway is appropriately recognised and endorsed by all relevant Colleges (Principle 3); the respective roles of ACRRM and the RACGP (Principle 4); and the priority access of RG trainees to appropriate accredited Queensland Health training positions (Principle 9).

Conclusion

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 Queensland Rural Generalist Pathway was founded on embedding into Queensland medical workforce planning processes four key transformational characteristics, which are likely to be applicable in other settings:

- recognition of rural generalist practice
- practice value for its true worth
- a supply line/pathway to vocational practice
- responsiveness to workforce redesign.

The greatest divergence of opinion amongst other jurisdictional stakeholders, vests with the pillars that focus on the recognition of the rural generalist. The divergence in opinion is philosophically based and focuses on the debate of whether:

- Rural Generalist workforce strategy should be principally focused on addressing general practice workforce needs, specifically from a primary health care / community based office workforce perspective; OR
- whether the Rural Generalist workforce strategy is a hospital focused workforce solution.

Debate then arises as to whether Rural Generalists should be considered as specialists in their own right or continue to be deemed as general practitioners with advanced skills.

Further work needs to be undertaken to address how best to manage the competing priorities, roles and functions of the respective parties, particularly in terms of managing training placement be commissioned as outlined in principle 9. Important stakeholders include Regional Training Providers, General Practice Education & Training, the RG Pathway and Queensland Health.

The principles enunciated in the *Roma Agreement* have served the Queensland Rural Generalist pathway well in the early years of the program. Other jurisdictions could consider adopting similar approaches in their own settings to address their requirements for a Rural Generalist workforce.

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