



## **AMA COUNCIL OF DOCTORS IN TRAINING SUBMISSION TO THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION**

### **Background**

This submission has been prepared by the AMA Council of Doctors in Training (AMACDT). The AMACDT represents junior doctors across the country and its membership encompasses prevocational doctors as well as doctors in specialist training programs. The AMACDT has strong links to the Australian Medical Student Association and Junior Medical Officer Forums in each state, along with a network of trainee representatives from each medical college training program.

The AMACDT is represented on many committees at both state and federal level and is well known for its constructive input into important health issues.

This submission seeks to address item 2(h) in the Commission's terms of reference:

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| <i>h. provide a well-qualified and sustainable health workforce into the future</i> |
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It should be noted that the AMA will lodge a submission that more broadly addresses the Commission's terms of reference.

### **The Problem**

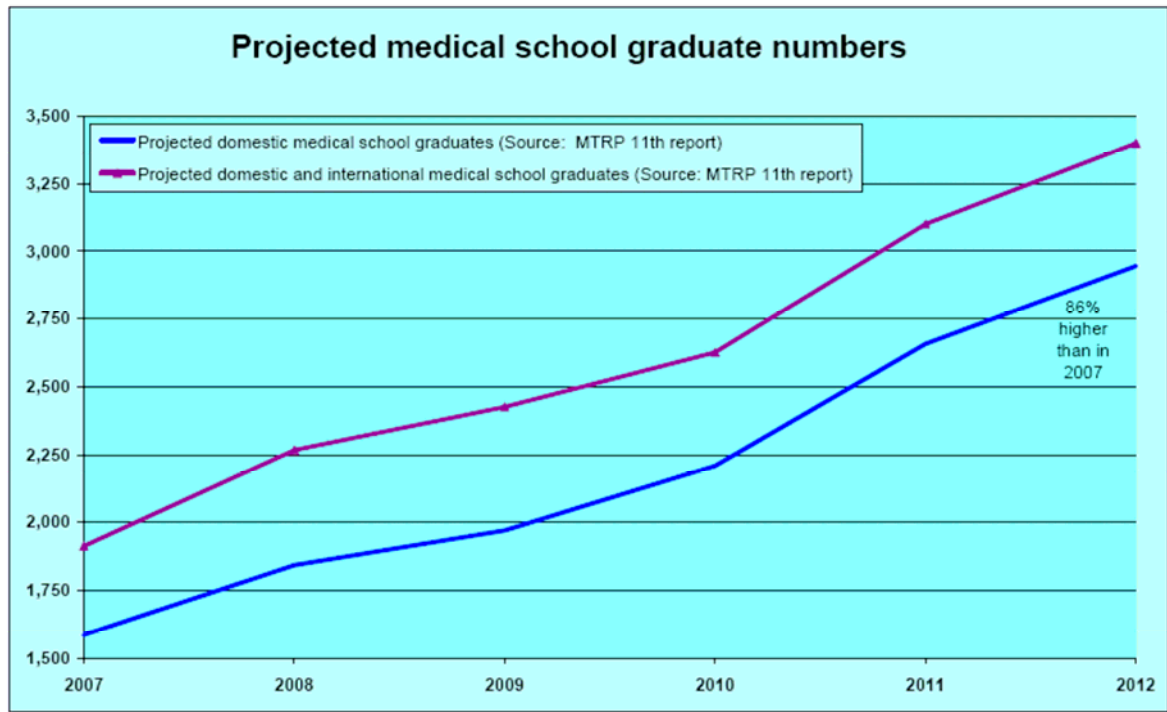
#### ***Delayed response to workforce shortages- The "flood" of medical students and graduates***

Medical workforce shortages have emerged as a growing problem over the course of the last 15 years as a result of poor policy decisions and poor workforce planning. At a time in the mid nineties when Australia was slipping into a situation of medical workforce shortage, policy makers decided to restrict the growth in medical school places.

To its credit, the Commonwealth has responded to medical workforce shortages by significantly increasing its investment in medical school places. By 2012, the number of domestic graduates from medical schools will grow to 2945pa – which compares to 1265pa

in 2002<sup>1</sup>. Figure 1 outlines the dramatic increase in undergraduate numbers over the next few years, including full-fee paying students (both domestic and international).

Figure 1



### ***Current and future training capacity***

There is little doubt that over time this surge in medical student numbers will address overall medical workforce shortages. However, this is subject to a fundamental caveat – similar investments will need to be made to support the creation of:

- adequate numbers of clinical places for medical students
- adequate numbers of intern places
- adequate numbers of vocational training places

<sup>1</sup> Medical Training Review Panel, Eleventh Report December 2007.

To illustrate the challenge faced, in 2007 there were 1582 domestic medical school graduates. The number of intern places in 2007 was 1776 while the number of first year vocational training places was 1957<sup>2</sup>. These numbers fall well short of anticipated graduate numbers in 2012. When full fee paying international students and graduates of the Australian Medical Council (AMC) exam are factored in, the challenge looks even more immense.

Figure 2

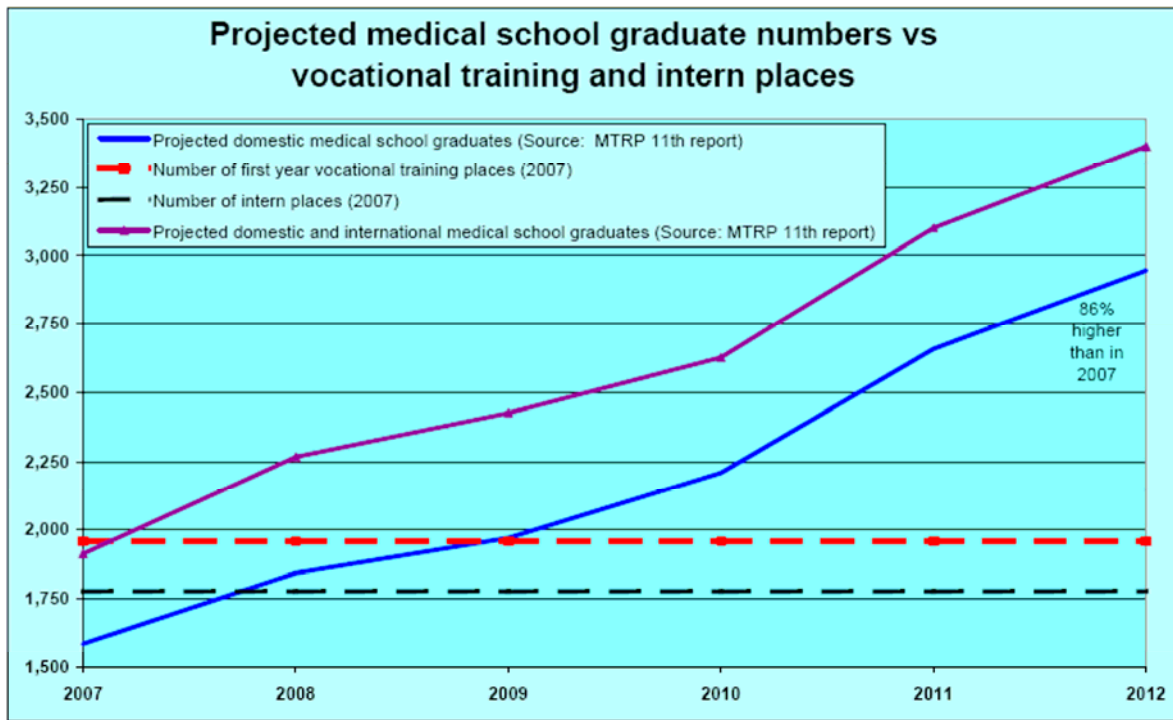


Figure 2 illustrates the projected expansion in the number of domestic and international medical school graduates and how this compares to available intern and vocational training places.

Despite best efforts, we do not have reliable data regarding the current medical education capacity in Australia. Although we have started to collect and publish some data<sup>3</sup> beyond the traditional Medical Training Review Panel Reports, there are still significant gaps in our recording and interpretation of medical training data.

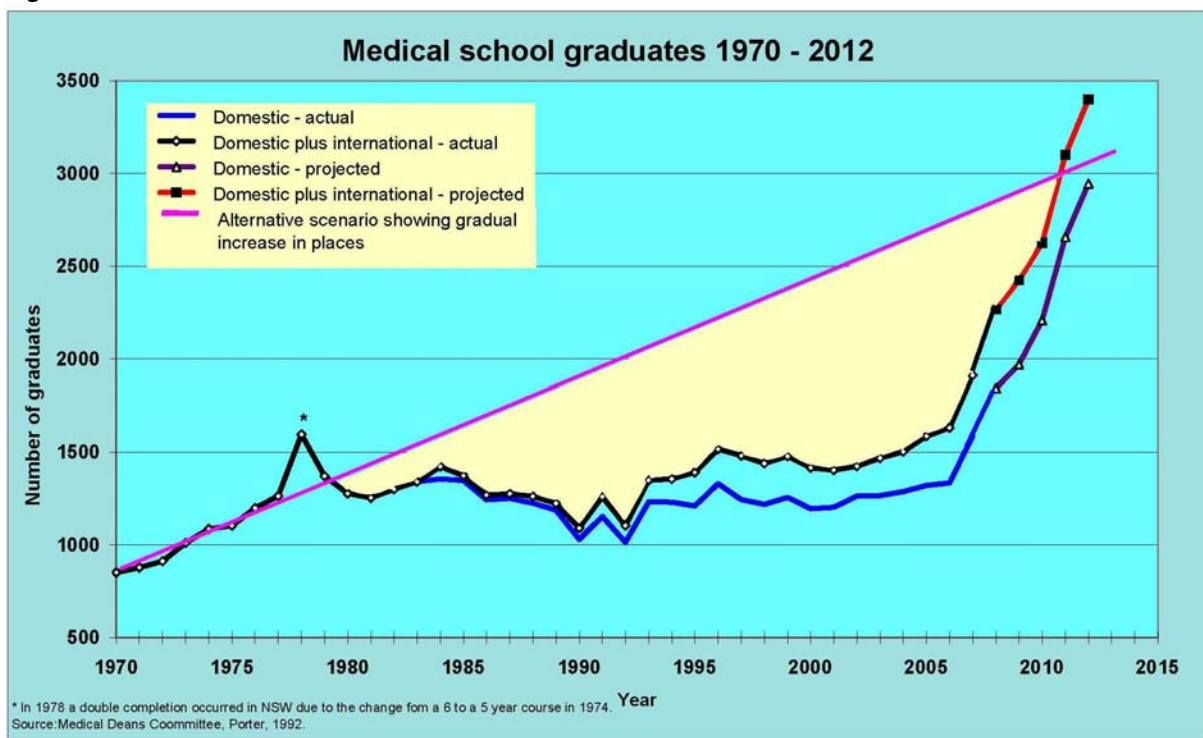
<sup>2</sup> Medical Training Review Panel Eleventh Report, December 2007

<sup>3</sup> Eg: Medical Deans of Australia and New Zealand, National Clinical Training Review, Report to the Medical Training Review Panel, Clinical Training Sub-Committee, February 2008; Confederation of Postgraduate Medical Education Councils, Clinical Training in Prevocational Years, Second Report to the Clinical Training Subcommittee of the Medical Training Review Panel, January 2008.

What data we do have (especially in states that have done analysis of their training capacity) indicates that there will be an enormous short-fall in terms of high quality training positions for medical students through to prevocational doctors and also for vocational training

Figure 3 illustrates Australian and international medical graduates, with projected graduate numbers included. The area under the projected line (had we increased medical student numbers steadily over the years) highlights the gap in locally trained doctors (and supervisors) Australia has tried to fill with international medical graduates. That strategy is not sustainable. One consequence of suppressing Australian medical school places is that we are now struggling to provide adequate training for students and graduates, and this will be compounded as more medical students are pumped into the system.

Figure 3



### Competition for training places

In the context of increased pressure for clinical experience, caution should be exercised with respect to the creation of new health practitioner roles. It does not make sense to flood the system with new medical graduates, only to find that they are unable to access quality clinical experience because of competition from other groups. Implementation of these new roles should be delayed until medical training capacity can be guaranteed.

### ***Lack of support for medical education and training***

In November 2006, the House of Representatives Standing Committee on Health and Ageing released its report on health funding – *“The Blame Game – Report on the inquiry into health funding”*.

The Committee’s Report made a number of relevant observations regarding health workforce training in general. In relation to current circumstances, the Committee highlights that the system is already under stress:

*“high levels of stress in the public hospital training environment that leaves less time for quality training. In an environment where staff are trying to respond to demands on service, there is little time to take on professional roles with students, or with other staff.”<sup>4</sup>*

The Committee’s report goes on to conclude at page 89 that

*“the rising numbers of medical graduates and allied health graduates will place significant pressure on universities and public hospitals to provide sufficient clinical training opportunities”*.

### **The Solution**

The AMCDT welcomes the acknowledgement of the importance of training in the NHHRC’s Report – Beyond the Blame Game<sup>5</sup>. The NHHRC has correctly identified significant issues in with respect to:

- the public sector’s focus on service delivery - at the expense of research, education and training;
- the impact that cancelling operating lists has on teaching opportunities;
- inadequate access to protected time for research, teaching and training in the public sector;
- inadequate access to supervisors;
- problems in accessing suitable clinical placements for medical students.
- the importance of better utilising training opportunities in the private sector, including general practice

The AMACDT believes that a multi-faceted response is required. We have outlined briefly below a range of solutions to our medical training concerns.

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<sup>4</sup> Page 80

<sup>5</sup> Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements. A Report from the National Health and Hospitals Reform Commission, April 2008

### ***Strengthen teaching and training culture***

We need to restore the balance of service delivery and medical workforce training in our public hospital system, to support a sustainable and well-trained medical workforce. We must give greater support to clinical academics and do much more to encourage doctors to become involved in teaching, training and research at all levels.

Protected training time, adequate clinical teaching opportunities, more resources for supervision and better infrastructure in the public sector are all extremely important factors in delivering a culture and an environment that encourages high quality medical education.

### ***Key Performance Indicators for Australian Health Care Agreements (AHCAs)***

We believe that it is possible to develop a set of suitable benchmarks that would provide credible, objective information on the progress of the Commonwealth, states and territories in ensuring that sufficient high quality training places are available.

Beyond the Blame Game proposes to include training performance benchmarks in the next set of AHCAs. The AMACDT welcomes this, but believes the NHHRC recommendations could go further. It is unclear, for example, whether performance indicator 12.3 on page 51 of Beyond the Blame Game concerns clinical training positions for medical students, or whether the recommendation extends to prevocational and vocational training. More detail indicators could include:

- Growth targets for clinical placements in public hospitals to match the requirements of medical schools in the relevant state/territory
- Growth targets for accredited intern places in public hospitals to match the increasing output of local medical schools
- Growth targets for college accredited vocational training positions in public hospitals
- Growth targets for medical school placements, prevocational and vocational training places in general practice
- Growth targets for prevocational and vocational training places in expanded settings such as the private sector

The AMACDT also believes that state jurisdictions should be required in the AHCAs to release junior doctors for specific training programs in general practice and the private sector. There is no doubt that some jurisdictions have been reluctant to release trainees even though there is an educational and long-term workforce benefit.

Some state health departments rarely look beyond the doors of their hospitals and do not sufficiently take into account the benefits of building the primary care workforce – which they see solely being a Commonwealth responsibility.

### ***Increased GP placements***

General practice is still a largely untapped environment for medical education and training across the continuum. To fully realise the available training opportunities in general practice there must be funding for infrastructure and supervision support.

The AMA has previously proposed the investment of an additional \$25m per annum for medical student GP placements. Up until 2008, the Commonwealth had funded 280 prevocational GP training places per annum. Unfortunately the most recent budget has significantly cut funding to this program, despite recommendations that the program be expanded to provide 1 000 prevocational training places in general practice.

In order to meet projected general practice workforce needs, vocational training positions must also be increased. The 2005 AMWAC report on GP workforce<sup>6</sup> estimated that Australia needed at least 1100 new GPs each year. The general practice training program intake is capped at 600 places per annum.

### ***Training in expanded settings***

There is significant medical training potential in the private sector, as well as other “expanded” setting such as community placements. Training in these settings (across the continuum) provides trainees with broader experience as well as increasing the capacity of the system generally.

The Commonwealth currently provides funding to support around 200 vocational training positions (excluding general practice) in expanded settings. The work of the Medical Specialist Training Steering Committee confirmed this potential. The AMA estimates that the total cost of such a program would be around \$200m per annum.

### ***The accreditation of medical workforce training***

Critically, as we explore new training opportunities, we must ensure that this process is underpinned by rigorous, independent, accreditation arrangements. The role of the Australian Medical Council, postgraduate medical education councils (PMCs) and the learned medical colleges must be preserved and, where appropriate, given greater recognition and support.

The AMACDT has supported the current proposal to bring PMCs within the remit of the AMC, which would allow the AMC to oversee accreditation of the whole medical workforce training continuum. This could potentially improve the delivery of medical education by encouraging improved links between university, prevocational and vocational medical education and training.

### ***Enhancing the role of the Medical Training Review Panel***

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<sup>6</sup>The General Practice Workforce in Australia, Supply and Requirements to 2013. AMWAC Report 2005.2 August 2005

The MTRP has played an important role in monitoring the progress of efforts to expand vocational training places and has overseen an increase in the number of first year vocational training positions from an estimated 1369 in 1998 to an estimated 1957 in 2007 – an increase of 43%.

This monitoring role is an important one and, in the context of significantly increased medical student places, the AMACDT believes the role of the MTRP should be enhanced. In addition to existing requirements, the Commonwealth, states and territories should be required to provide data to the Medical Training Review Panel on an annual basis in relation to areas such as:

- the number of public hospital clinical placements for medical students
- the number of accredited intern places, broken down according to discipline
- the number of GP pre-vocational training places and Commonwealth funded private sector training positions

Data such as this could then be used to determine whether or not individual jurisdictions were meeting training benchmarks set under the Australian Health Care Agreements. The Commonwealth and states should be also be required to report annually on activities in place to coordinate and/or provide additional training places.

It is recommended that the MTRP should be required to conduct a review every two years of the progress of efforts to provide extra clinical training places at undergraduate, pre-vocational, and vocational training levels. This would be similar to the Biennial Review of the Provider Number Legislation where a proper inquiry process is followed - leading to recommendations in response. It would be able to highlight where bottlenecks or training deficiencies occur and suggest suitable solutions.

## Summary

Past experience has shown that you cannot simply turn the tap on or off when it comes to medical workforce. It takes a long time to train a medical practitioner and it is not possible to conjure up new resources such as supervisors, rooms, facilities, new operating theatres etc overnight. It takes time to put all of the supports in place to ensure that a medical practitioner gets the level of training and education that they need.

Australia faces the real prospect of a training emergency. We need to ensure students get the right clinical experience, and that once they graduate they can progress through their training in a timely fashion. This training must be overseen by an appropriate, independent accreditation process.

The prospect of a training bottleneck is rapidly approaching. The Medical Deans of Australia and New Zealand (MDANZ) has reported that *“medical students are undertaking up to three years of supervised full-time clinical placements and the impact of the increased numbers will be felt as early as 2009”*<sup>7</sup>.

The clock is clearly ticking and to that extent, above all else, our message to the Commission is that this issue needs to be tackled as a matter of urgency.

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<sup>7</sup> Medical Deans of Australia and New Zealand, National Clinical Training Review, Report to the Medical Training Review Panel, Clinical Training Sub-Committee, February 2008

## **Glossary**

### ***Junior medical officer (JMO)***

Also known as a junior doctor or doctor-in-training, a doctor who is undertaking postgraduate (prevocational or vocational) medical training.

### ***Intern***

A graduate of an Australian Medical Council (AMC) accredited medical school who is undertaking the year of supervised clinical training. The intern year, also known as the postgraduate year 1 (PGY1), is undertaken primarily in a public hospital.

### ***Prevocational training***<sup>8</sup>

Broadly the first two years of postgraduate training for junior doctors.

*Postgraduate year 1 (PGY 1):* the year of supervised clinical training completed by graduates of an Australian Medical Council (AMC) accredited medical school. Also known as the intern year.

*Postgraduate year 2 (PGY 2):* the year of structured rotations through supervised clinical training placements, mostly in public hospitals, completed once medical practitioners have completed their internship, and gained general medical registration. Also known as 1st year Resident Medical Officer year or Hospital Medical Officer year.<sup>9</sup>

### ***The continuum***

Medical education continuum – the continuous process of medical education from undergraduate, prevocational and vocational training progressing through to continuing professional development throughout a doctor's career.

### ***Vocational training***

The necessary training for a chosen medical specialty.

***Prepared by the AMA Council of Doctors in Training – June 2008***

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<sup>8</sup> Eleventh Report of Medical Training Review Panel, Australian Government, 2008, p.113.