



SUPPORTING PREVOCATIONAL AND VOCATIONAL TRAINING THROUGH HEALTH WORKFORCE AUSTRALIA

Background

Australians have access to a world-class health care system that is the envy of many other countries. Our health system gives patients choice and provides a safety net to ensure that disadvantaged people are not left behind.

One of the keys to the success of the Australian health care system is that patients have access to a highly skilled and motivated medical workforce working in both community and hospital settings. Australian doctors are held in the highest regard throughout the world. Medical workforce training in Australia follows rigorous, independently set standards that require students and junior doctors to work in high-quality training positions – which allows them to get the experience they need.

While our doctors are among the best in the world, we do not have enough of them. Medical workforce shortages are a key topic of community discussion and 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.

Policy response to medical workforce shortages.

The Commonwealth has responded to medical workforce shortages by significantly increasing its investment in medical school places since 2004. By 2012, the number of domestic graduates from medical schools will grow to 2920pa – which compares to 1287pa in 2004¹. The number of international students graduating will be 517pa by 2012. Many of the latter group are likely to stay in Australia to complete their intern year and ultimately go on to seek permanent residency².

With proper planning and support, these increases will help address overall medical workforce shortages

Over time, this surge in medical student numbers will address overall medical workforce shortages. However, this is subject to a fundamental caveat. A significant investment will need to be made to ensure that these students get a full medical education – during medical school and in the years beyond when they become a junior doctor, progress through their intern year and then subsequently enter a specialist training program. This requires the creation of:

- adequate numbers of clinical places for medical students
- adequate numbers of accredited prevocational medical training places
- adequate numbers of accredited specialist training places (including general practice)
- adequate numbers of supervisors to teach and train the next generation of doctors

¹ Medical Training Review Panel, Twelfth Report February 2009.

² International full fee paying students are permitted to work in Australia for up to 2 years after completing medical school. This allows them to complete the intern year.

To illustrate the challenge faced, the number of intern places in 2008 was 2030 while the number of first-year vocational training places was 2479³. These numbers fall well short of anticipated 2920 domestic graduates 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.

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.”*⁴

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”.

2008 COAG Health Workforce Training Package

The Council of Australian Governments in November 2008 announced a \$1.64b funding package to support clinical training across the whole of the health workforce encompassing:

- \$500m additional Commonwealth funding to support undergraduate clinical training;
- 212 additional GP training places by 2011;
- 73 additional specialist training places in the private sector;
- Funding to train 7000 medical supervisors;
- Funding to establish a national health workforce agency and health workforce statistical register;
- \$175.6m to fund capital infrastructure to expand teaching and training opportunities, particularly in major regional hospitals.

This is strong package by any standard, but it has a significant focus on undergraduate clinical training. Despite additional private sector specialist training positions and GP training positions, it does not adequately address the immediate and growing need to better support prevocational and vocational training as graduate numbers continue to grow.

Health Workforce Australia (HWA)

HWA has been established as a statutory Commonwealth authority and is intended to have a number of functions including:

- Supporting health workforce research and planning;
- The provision of financial support for undergraduate clinical training;
- The provision of non-financial support for clinical training (eg matching students with clinical placements);
- Workforce redesign and reform; and
- The provision of advice to health ministers.

³ Medical Training Review Panel Twelfth Report, February 2009

⁴ Page 80

The Minister for Health and Ageing at the 2009 Royal Australian College of General Practitioners Conference also stated that the Commonwealth hoped “to work with states through this agency to expand intern training places, including into community settings like general practice.”

The states/territories and the Commonwealth jointly fund HWA. It will have a budget under its administration in excess of \$1.2b (over 4 years).

The AMA believes that the HWA can play a significant role in providing funding support to increase available resources for teaching and training prevocational doctors and vocational trainees. It is widely recognised that medical education and training is most effective when it is integrated across the full continuum of medical education. This means that the provision of funding for specific programs to support prevocational and vocational training will have clear flow on benefits for undergraduate clinical training as medical students learn in an environment that encourages interaction with peers and the sharing of skills and knowledge.

The AMA notes that the HWA may not be fully operational in the immediate future. With this in mind it may well be appropriate, particularly in 2010, for the HWA to pilot some of the proposals in this paper with a view to a broader rollout in the years beyond.

Pressures on medical education and training

The AMA has already identified that growing graduate numbers will overwhelm existing resources and infrastructure for teaching and training at all levels including the prevocational and vocational years. In addition, we know that the system is already under pressure because of factors including the:

- Lack of time for teaching and training due to service pressures in public hospitals;
- Insufficient recognition and support for the role played by junior doctors in the provision of teaching and training; and
- Under-utilisation of available clinical settings.

Teaching and training versus service delivery

There is a constant tension between the demand for service delivery in public hospitals and the need to teach and train the next generation of doctors in the same setting at the same time. In its report, *Beyond the Blame Game*, the National Health and Hospitals Reform Commission discussed this tension and said:

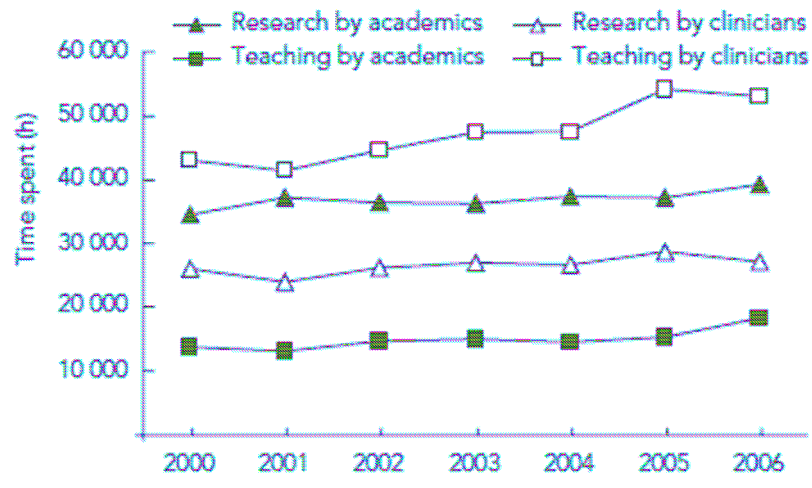
Research, education and training are sometimes seen as an afterthought by health services which are focused on service delivery. Clinicians who have clinics and operating lists cancelled at short notice are denied their responsibility to teach. Trainees are expected to provide service while the commitment to their own training and that of students can be ignored in the interest of service provision.

Inadequate access to protected time for research, teaching and training and the supervisors to provide this, is short-sighted and must be remedied.

The following graph (taken from the Medical Journal of Australia) illustrates the problem to some extent and shows that despite growing numbers of medical school students and graduates, the total time spent on medical teaching by clinicians fell between 2005 and 2006⁵.

⁵ Joyce C, Piterman L, Wesselingh S. The widening gap between clinical, teaching and research work. Medical Journal of Australia 2009. Volume 191 Number 3. 3 August 2009.

2 Total time spent on medical teaching and research by academics (medical educators and researchers) and clinicians in Australia, 2000–2006*



*Data were derived from references 8, 12 and 21–25. See also footnote to Box 1. ♦

Insufficient recognition and support for the role played by junior doctors in the provision of teaching and training

The role of junior doctors in teaching and training other junior doctors and medical students is barely recognised in any formal way and only very limited support is provided to junior doctors to effectively assist them in this role.

A 2004 study commissioned by the Medical Training Review Panel that looked at the Confederation of Postgraduate Medical Education Councils (CPMEC) Professional Development of Registrars Supervising Junior Medical Officers program demonstrated that providing registrars with additional skills in this area is highly effective, not only equipping them to pass on “technical skills”, but also helping them to provide leadership, foster teamwork, and provide effective feedback.

Under-utilisation of existing clinical settings

The Commonwealth, through specific funding programs, has already recognised the benefits of expanding specialist training into the private sector and other community settings. The 2008 COAG health workforce package will also provide improved funding arrangements to support clinical placements for medical students in such settings. In addition, the Commonwealth has established the Prevocational General Practice Placements Program (PGPPP) to provide prevocational doctors with up to three months experience in general practice environment.

While these are important initiatives, they do not go far enough – particularly when it comes to prevocational training. There is no doubt that the private sector and other community settings could be much better utilised to supplement the public hospital system and provide prevocational doctors with valuable clinical experience.

Addressing these challenges

Given the many different funding streams that currently support medical workforce training and the various responsibilities that each jurisdiction has for the provision of medical workforce training places, the AMA believes that HWA can play a significant role in the coordination and provision of additional funding to support prevocational and vocational training - *supplementing* (not replacing) the resources provided by the Commonwealth, states and territories.

Funding dedicated teaching and training time

To give senior clinicians the time they need to train the next generation of medical practitioners, they need improved access to protected time for teaching and training. The AMA has a benchmark for clinical support time, which includes teaching and training. This benchmark specifies that at least 30% of a public hospital senior clinician's time should be set aside for clinical support work.

Current evidence suggests that while medical student numbers are growing rapidly, the number of supervisors in our public hospitals remains relatively static and the time allocated for teaching, training and assessment activities remains unchanged. In other words, we are trying to do more without the extra resources required.

Specific funding should be made available through HWA to support the provision of protected teaching time in Australia's public hospital system. The AMA proposes that the HWA fund a KPI-based grants program for eligible public hospitals that will support them to fund additional dedicated teaching and training time for senior clinicians and clinical academics.

These monies could be made available to support backfilling, improved coordination of clinical training, remuneration incentives for clinical academics and other similar initiatives that free up time for teaching and training.

Estimated cost: *Based on a program of 1000 grants per year of up to \$50,000 per clinician, the estimated cost of this program would be up to \$50m pa.*

Funding innovative programs that expand capacity

While there is no substitute for supervised hands on clinical experience, simulated training and "structured off the floor teaching" can play a positive role in improving the quality of teaching and enhancing available teaching capacity.

A good example is the More Learning for Interns in Emergency (MoLIE) program. By providing interns working in emergency departments with structured off the floor teaching that equates to around 2 half-day sessions per week, available teaching capacity in emergency departments can be increased by around 20 percent without changing on-the-floor supervision ratios.

Specific funding should be made available through HWA to support access to and/or the development of innovative programs such as MoLIE.

Estimated cost: *Providing 1000 interns each year with access to a program such as MoLIE is estimated to cost \$9m pa.*

Recognising the role that junior doctors can play in teaching and training

In 2006 it was estimated that clinicians provided around three quarters of total medical teaching hours, with specialists providing almost half of total teaching time. Specialists in training contributed an estimated seven

percent⁶. No similar figure for the teaching and supervision contribution of prevocational doctors is publicly available.

There are around 14,000 junior doctors across the country in prevocational and vocational and training and there is no doubt these junior doctors could be much better utilised in the delivery of medical workforce training. To harness this untapped potential their role needs to be better recognised and supported through the provision of appropriate professional development programs.

Estimated cost: *Providing 2000 junior doctors in prevocational and vocational training with access to professional development programs, similar to the CPMEC program referred to earlier, is estimated to cost \$1.5m pa.*

Better utilising community settings including the private sector

The AMA agrees with the Minister for Health and Ageing that, with appropriate funding support, community settings could be much better utilised in order to build the capacity of Australia's medical workforce training system. Such arrangements must supplement (not replace) essential training in the public sector and recognise the scope for training to take place in community settings such as general practice, private hospitals, residential aged care facilities and the like.

The AMA proposes that in addition to existing programs, such as the highly successful PGPPP, funding should be made available to support 500 full-time equivalent prevocational training positions, that are accredited by the relevant postgraduate medical education council, in community settings each year.

Estimated cost: *Providing 500 FTE accredited prevocational training positions each year in community settings is estimated to cost around \$75m pa.*

The role of the states and territories – keeping COAG commitments

Medical workforce training is a joint responsibility of the Commonwealth and the states and territories. The package of measures outlined in this paper is not intended to provide the states and territories with an excuse to divest themselves of some of their responsibilities to provide adequate numbers of training positions in our public hospitals.

The states and territories gave a clear commitment to support medical workforce training at the July 2006 Council of Australian Government's meeting, with the relevant COAG Communiqué stating:

The States and Territories have agreed to guarantee to provide high-quality clinical placements and intern training for Commonwealth-funded medical and nursing students. States and Territories have also agreed to continue to invest significantly in on-the-job and post-graduate training for these health professionals.

At the very minimum, the states and territories need to honour these commitments and need to be held accountable for doing so. In this regard, the AMA believes that the Medical Training Review Panel (MTRP) must be given an expanded role in monitoring the progress of the states and territories in providing medical workforce training places and providing appropriate policy advice and solutions to address any shortfall in available training positions. The MTRP should also continue to be funded to develop pilot programs that promote best practice training and supervision models.

Evaluation

The AMA proposes that there should be annual evaluation of programs funded by HWA, which include robust trainee feedback.

⁶ Joyce C, Piterman L, Wesselingh S. The widening gap between clinical, teaching and research work. Medical Journal of Australia 2009. Volume 191 Number 3. 3 August 2009