Joint Statement

AMA Medical Training Summit

Australian Medical Association
Australian Medical Students' Association
Medical Deans Australia and New Zealand
Confederation of Postgraduate Medical Education Councils

ACTION ON MEDICAL TRAINING

Background

Australians have access to a world-class health care system that is the envy of many other countries. According to the Australian Institute of Health and Welfare, life expectancy in Australia is amongst the highest of all OECD countries[1].

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 general practice, 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 accredited, supervised training positions which enables them to get the experience they need to provide high quality care to the community.

Data from the former National Health Workforce Taskforce (NHWT) suggests that there is now a shortage of approximately 6300 medical practitioners across the country[2]. This

[1] Australia's health 2010. Australian Institute of Health and Welfare, Canberra, Cat. no. AUS 122
[2] Health Professions Entry Requirements, 2009 – 2025. Macro Supply and Demand Report. National Health Workforce Taskforce. 2009.

shortage has developed over the course of the last 15 years, largely as a result of policy decisions and inadequate workforce planning.

Since 2004, the Commonwealth has responded to medical workforce shortages by taking several steps to significantly increase the number of medical school places across the country. It increased the numbers of Commonwealth Supported Places at existing medical schools, provided funding to open eight new medical schools and temporarily lifted caps on domestic full fee paying places.

The Australian health system is highly reliant on the contribution made by international medical graduates (IMGs). At any one time there are around 6100 IMGs working in Australia on temporary resident visas. Many work in rural Australia and other areas of workforce need, as well as in the public hospital system. Additional investment in prevocational and vocational training positions will help ease this reliance and ensure better access to locally trained medical practitioners.

In 2002, as part of its efforts to address medical workforce shortages, the Commonwealth Government announced a specific policy measure to allow international full fee paying medical students to stay in Australia after graduation in order to complete an intern year and achieve full registration as a medical practitioner.

This policy has helped to encourage a significant increase in the number of international students studying medicine in Australia and the NHWT report referred to above suggests that in order to meet our future medical workforce needs, Australia should make every attempt to retain these students once they graduate.

By 2014, the number of domestic graduates from medical schools will grow to 3108pa – which compares to 1287pa in 2004[3]. Taking into account international full fee paying students, the total number of graduates from Australian medical schools in 2014 will be 3786. This presents Australia with a real opportunity to not only reduce overall medical workforce shortages, but to also address more specific workforce issues such as the lack of access to medical care in rural and remote areas.

Increasing the number of medical school places is only the first stage in the process of training more doctors to meet health delivery requirements. Graduates go on to complete one to two years of generalist (prevocational) training and then three to eight years of specialty training in one of a range of specialties, including general practice. Increasing the number of medical school places will be ineffective in addressing medical workforce shortages unless there is a coordinated increase in:

- clinical training places for medical students;
- intern and prevocational training places; and
- vocational (specialist) training places.

[3] Medical Training Review Panel, Thirteenth Report April 2010.

Some steps have already been taken towards meeting these challenges. In 2008 the Council of Australian Governments (COAG) announced a $1.64 billion package to support undergraduate clinical training for the health workforce. More recently, the Commonwealth committed $640m to support a significant expansion in prevocational and vocational GP training positions as well as additional specialist training positions in the private sector. There has also been a commitment to increase training positions in Emergency Medicine.

However, the above investments will not be enough to ensure that Australia's future medical graduates can progress through prevocational and vocational training and realise their full potential as medical practitioners. To illustrate the challenge ahead, in 2009 there were 2243 intern places in Australia, which falls well short of the more than 3700 positions that will potentially be needed for domestic and international graduates in 2014. If current rates of expansion continue there will only be 3200 positions in 2014

Through the COAG processes, State and Territory governments have committed to guarantee an intern place for all domestic Commonwealth funded medical graduates. They have also set a goal to provide *all* Australian medical graduates, including full fee paying graduates, with an intern place to allow them to complete their training.

Reliable data on the remaining prevocational training years is not currently available, although we understand that Health Workforce Australia (HWA) is working to improve data collection in this area. In addition, no formal process is currently in place to assess how the provision of places will be matched to the additional number of medical graduates progressing through prevocational training towards vocational training.

First-year vocational training positions have been growing at a rate of around 8.2% pa since 1999. This historical rate of growth falls short of the expected growth in graduate numbers. Vocational training programs are generally three to eight years in duration and this means that not only will we require around an additional 1200 first year vocational training places by 2015, we will also need to support the ongoing provision of new training posts over several years to allow these trainees to complete their training.

This statement reflects the consensus view of our respective organisations on the key steps that need to be taken in order to ensure that the community does not face a situation where it has supported the training of more medical students only to see them fail to get the training and clinical experience needed to provide high quality care to the community in the long term.

Action needed

We believe that Commonwealth and state/territory Governments must deliver more resources to support medical workforce training and create a framework that delivers the right number of medical practitioners to the community, working in the disciplines and regions where they are needed so that the community's health needs are properly served. This will require significant commitments and funding, better planning and coordination,

and better utilisation of private and community settings – within an appropriate accountability framework. We will commit to working in close partnership with Government to ensure the best possible outcomes are achieved.

Improving planning and coordination

Planning

Health Workforce Australia (HWA) is funded to undertake a variety of functions including health workforce planning. In our view, the complexities and breadth of medical training, warrant the establishment of a planning forum to work closely with and advise HWA.

In this context, we call on HWA to establish a specific Medical Workforce Planning Advisory Committee (MWPAC), which includes representatives of all key stakeholder bodies in the medical education and training sector, as soon as possible.

Once formed, MWPAC should be commissioned and appropriately resourced to oversee and complete the following key medical workforce studies by the end of 2011:

- *an analysis of community demand for medical services through until 2025 and the associated medical workforce requirements – broken down according to specialty area and location;*
- *an analysis of medical school intakes and graduate numbers through until 2020 and the associated need to increase the available number of medical prevocational and vocational training places to match the growth in medical graduate numbers; and*
- *an analysis of the projected demand for, and desirable level of, international medical graduates through until 2020, taking into account increases in local graduate numbers.*

These studies should form the basis of advice to health ministers on the number of prevocational and vocational medical training places required and should inform decisions on the creation of additional medical school places or new medical schools in the next five to ten-year period.

Cooperation between the Commonwealth and the states and territories

We call on the Australian Health Ministers' Conference (AHMC) to convene a specific meeting prior to the end of 2010 to develop plans for additional prevocational and vocational medical training places.

We also call on the members of the AHMC to agree to work together cooperatively to ensure that the total number and location of training places is matched to the growing number of medical graduates and to ensure that bodies such as the Medical Training Review Panel (MTRP) and HWA are able to access all available data on projected training positions to inform their medical workforce planning activities.

The AHMC, in early 2012, should meet to consider and adopt the recommendations from the above HWA studies and guarantee to provide the number of prevocational and vocational training positions recommended by HWA (covering both public hospitals and other settings such as general practice and private hospitals).

The Commonwealth should develop an effective mechanism to ensure that the number of medical school places across the country is determined by robust workforce modelling and a proper assessment of the resources that will be needed to provide not only the required undergraduate clinical training places, but also sufficient downstream prevocational and vocational training places. This process should be undertaken in full consultation with medical schools and other stakeholders.

In the interim we do not support the creation of new medical schools or any significant increase in medical student numbers until it has been established that there are sufficient training posts and clinical supervisors to provide prevocational and vocational training for the increased numbers of students currently enrolled Australian medical schools. Any expansion of medical school places should be consistent with the recommendations of the above HWA studies.

National cooperation on intern allocation

Existing mechanisms to allocate intern numbers across the country are inefficient and often result in medical graduates applying for positions in multiple states. Under these arrangements some states have difficulty filling all the intern positions that they offer, while others are unable to provide enough places for all applicants.

We propose that the AHMC supports the ongoing work of stakeholders to develop nationally consistent intern allocation processes and to allow jurisdictions to share information on intern applications and acceptances in order to better inform the recruitment and selection processes in each state/territory. This would include a national "wash-up" process that identifies those graduates that accept more than one offer of an intern position and asks them to confirm a final choice to free up places that can be accessed by other applicants.

Better coordination through Commonwealth funding arrangements

The Commonwealth generally funds medical training in private and community settings. In addition, the Commonwealth has agreed, through the National Health and Hospitals Network Agreement (NHHNA), to fund 60 percent of the recurrent costs of medical training in public hospitals in future years.

Under current arrangements the Commonwealth is responsible for determining the number of medical school places and can increase these in response to community need. It can also determine the number of prevocational and vocational training positions in areas such as general practice, the private sector and other community settings.

However, the Commonwealth does not exercise any control over the majority of prevocational and vocational training places that are provided in each state/territory health system. States and territories generally determine the number of training places they provide based on the service delivery needs of public hospitals with limited consideration of the broader healthcare needs of the community.

This disconnect should be addressed through the proposed new NHHNA funding arrangements.

We call on the Commonwealth to make its 60 percent funding contribution to teaching conditional on the states and territories funding and delivering the prevocational and vocational training places recommended by HWA and agreed to through the AHMC process outlined above.

The Commonwealth has overseen the recent expansion of medical school places and we believe that it carries a responsibility to ensure that graduates can complete the accredited intern year they need to achieve full medical registration. The intern year is, in reality, the final year of basic medical education. The Commonwealth should take a proactive role in ensuring the provision of intern positions for graduates.

Based on the projected workforce needs outlined by the NHWT we call on the Commonwealth and States/Territories to provide intern places for currently enrolled international full fee paying medical students. We also call on both levels of government to work in partnership with medical schools to determine the number of international full fee paying students that should be provided with postgraduate training to meet continuing workforce needs.

Accountability through better monitoring by the Medical Training Review Panel

The MTRP was established in 1996 to ensure that junior doctors could access sufficient numbers of vocational training places. It brings together all relevant stakeholders in medical education and enjoys broad stakeholder support.

Since then the MTRP has played an important role in monitoring the expansion of vocational training places. There has been a 90% increase in the number of first year vocational training positions from an estimated 1369 in 1998 to an estimated 2598 in 2009.

In February this year the Commonwealth Government agreed to a continuing role for the MTRP, including expansion of its data collection and interpretation functions. We believe that the MTRP is well placed to monitor the performance of the Commonwealth and the states and territories in delivering the number of prevocational and vocational training positions recommended by HWA and agreed by AHMC.

We call on the Commonwealth to commission the MTRP to monitor the expansion of prevocational and vocational training positions supported by HWA. We also call on the Commonwealth to adopt Recommendation 4 of the 2009 Review of the MTRP:

'The MTRP conduct a biennial review of clinical training places across the spectrum of medical training which will include identifying any gap between actual places and the perceived need for places.'

A biennial review will be able to collect stakeholder feedback, identify bottlenecks, and provide expert advice on how to boost the number of available prevocational and vocational training places.

Making the system more sustainable

Reducing Australia's reliance on international full fee paying medical students

The higher education system in Australia is heavily reliant on income generated from overseas students. This is particularly true for medical courses with 17% of current students being international full fee paying students.

Funding arrangements for undergraduate medical training must be reviewed as a matter of urgency so that the quality of training of domestic students is not reliant on the income from overseas students.

Protected teaching time

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 the same resources.

We call on the Commonwealth, as part of NHHNA reforms, to ensure that the funding provided to the states and territories for teaching includes a component that specifically recognises the costs of protected teaching time for clinicians and requires the states and territories to set aside quarantined funding to support hospitals to meet appropriate benchmarks in this regard.

Funding innovative programs that expand training capacity

While there is no substitute for supervised hands-on clinical experience, there is scope to move towards more structured use of time and resources. Simulated training and "structured off the floor teaching" can play a positive role in improving the quality of teaching and enhancing teaching capacity. HWA has significant funds for this purpose and a number of projects are currently underway in this area.

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 two half-day sessions per week, teaching capacity in emergency departments can be increased by around 20 percent without changing on-the-floor supervision ratios.

We encourage HWA to continue to work with stakeholders to identify, develop and fund innovative training programs.

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 percent. There is no information on the amount of teaching provided by prevocational doctors.

In 2009 there were 2,226 interns and almost 13,000 vocational trainees. These junior doctors could be much better utilised in the delivery of medical training.

To harness this untapped potential their role needs to be better recognised and supported through the provision of appropriate professional development programs, which could be funded through HWA.

We call on HWA to work with stakeholders to identify, develop and fund training programs that give junior doctors the skills they need to help teach and train medical students and other junior doctors.

Continued support for training in general practice, private and other community settings

Over recent years, the Commonwealth has allocated significant additional funding to expand prevocational and vocational GP training, as well as specialist training in private and community settings.

We welcome this investment and highlight the need for the Commonwealth to maintain its effort in this area and to work with HWA, MTRP and stakeholders to fully utilise opportunities for clinical experience that are available in these environments.

Improving and better supporting current accreditation arrangements

Robust accreditation arrangements are one of the strengths of medical education in Australia. It is important that Postgraduate Medical Education Councils (PMCs) are properly resourced to accredit the extra prevocational training positions that will be required in the future. It is also important to recognise the significant pro-bono contribution of PMC accreditors and College fellows to accreditation of prevocational and vocational training positions.

There is duplication in current accreditation arrangements and hospitals and general practices are required to host multiple accreditation visits.

We believe that there is significant room to improve the sustainability of current accreditation arrangements and call for:

- *PMCs to be properly funded so that they can accredit the number of prevocational training positions that will required into the future;*
- *the Australian Medical Council (AMC) to review current accreditation arrangements for prevocational training and harmonise current standards into a nationally consistent framework; and*
- *a profession-driven process in which the AMC works with medical colleges and prevocational medical education bodies to review hospital and general practice accreditation arrangements to identify areas where these can be streamlined.*

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