

**SUBMISSION TO THE PRODUCTIVITY COMMISSION'S HEALTH WORKFORCE REVIEW
MEDICAL TRAINING AND EDUCATION COUNCIL OF NSW**

Background

This submission is confined to comments regarding doctors-in-training, ranging from intern to specialist registrar training. The comments represent the views of the Executive of the Medical Education and Training Council of NSW. The Medical Training and Education Council was established by the Minister for Health to work with stakeholders to develop a sustainable and high quality medical workforce by enhancing the efficiency and effectiveness of service based training in NSW¹.

Workforce planning

While AMWAC was established ten years ago to advise government on the future medical workforce requirements at a national and state level, there has never been an agreed method or best practice model for linking national requirements with local medical workforce planning activities. The latter tends to be historically based and driven by hospitals' reliance on specialist trainees for delivery of "front-line" acute medical care rather than the community's requirement for trained specialists. Added to this is the fact that individual clinicians operate in a free market in terms of their choice of specialty of clinical practice and the geographical location of their practice. These factors contribute to the chronic maldistribution of doctors across geographical locations and clinical specialties.

The lack of sufficiently detailed and accurate data on the medical workforce means that, at present, it is not possible to state with reasonable accuracy the number and location of doctors who are in specialty training programs at a given point in time. Without adequate data, planning cannot occur in any meaningful fashion. Local medical workforce planning is largely decentralised and reactive with the focus on filling immediate vacancies rather than directing energy to medium and long term workforce needs. There is no dedicated budget for training or training positions: the costs of training are hidden and are nominally included in the global budget allocations from central health departments to local health services.

Solution: The development of reliable and up-to-date workforce information systems, workload modeling and local workforce planning methods is required in order for meaningful workforce planning to occur. For example, a trainee workforce register which matches trainees to position (job) numbers would provide a powerful workforce planning tool for health services.

There are few levers available for governments to influence the supply and distribution of doctors. The Commonwealth determines the number of university medical student places and has attempted to influence the distribution of trainees for example, by using bonded scholarship schemes for medical students and through programs such as the "outer metropolitan" scheme for specialist trainees. State government health services employ doctors who are undertaking specialist training but have traditionally adopted an arms length position in relation to the delivery of medical training in public health services. Only recently have governments started to refer to medical training as a "core business" of public health services and medical training is still largely an activity that is managed through medical professional

¹ Further information about MTEC is available on the MTEC website www.mtec.nsw.gov.au

structures (Colleges and individual College Fellows who work in health services) rather than health service management structures.

Coordination of workforce planning across health services has been problematic with the exception of the early postgraduate years (PGY1 and PGY2) where there has been a successful distribution of workforce under the supervision of the Postgraduate Medical Council (PMC) of NSW. However, until recently in NSW, there has been no state-wide mechanism or governance framework to advise on how to set, fund, manage and monitor specialist training numbers and performance across the State. As a result, the creation and funding of new training positions in the public sector is haphazard and episodic. Individual public sector directors of specialist services must lobby their Area Health Service Chief Executive and make a case for new speciality training positions having priority over other Area-wide needs.

Solution: Effective workforce planning requires all relevant parties to be brought together in the planning stages. These include trainees, trainers (clinicians) and hospital administrators as the main groups with strong input from Colleges, Area Health Services, State Health Departments and relevant unions. This style of work underpinned the MTEC approach to the Basic Physician Training Program¹ which was successfully implemented in 2005. A new way of thinking about workforce planning and distribution was required i.e. recognising that the medical training system is complex² and that a “command and control” approach from any one body such as a College or Health Department will not work. What is needed is a collegiate approach brokered and supported by an organisation such as MTEC.

Each jurisdiction needs a state based mechanism for determining the desired number and distribution of specialist training positions balancing national and local workforce requirements. In NSW, the government has announced the establishment of a NSW Institute for Medical Education and Training which will have responsibility for oversight of this area.

The link between postgraduate medical training and the distribution of the medical workforce has been the focus of work undertaken recently by the Medical Training Education Council of NSW (MTEC) through the establishment of formal service-based training networks in medicine, surgery and psychiatry³. In 2005 a statewide basic physician training program was instituted which incorporated appointments to 8 training networks. This has provided an excellent example of how training and service needs can be matched but only if appropriate training and supervision and working conditions are provided in parallel with the provision of sufficient numbers of trainees in the system to enable a redistribution without causing unacceptable risks to the quality of care and the quality of training. Where there are insufficient specialist trainees to meet staffing needs an alternative to the training workforce is required and is usually sourced from more costly medical staff such as locum medical officers and senior non-specialist medical staff. In general however, the public health system is reliant on junior medical staff (doctors-in-training) and is constrained by the supply of these doctors.

Fundamental to the success of a program such as the Basic Physician Training Networks is high level leadership and support from the State Health Minister and Director General of Health. With their imprimatur and subsequent investment of resources significant change can be achieved.

² Downton SB, Stokes ML, Rawstron RJ et al. Postgraduate medical education: rethinking and integrating a complex landscape. *Med J Aust* 2005; 182: 177-180

³ Further information is available on the MTEC website www.mtec.nsw.gov.au

Education and Training

Until recently (apart from the first two post-graduate years overseen by Postgraduate Medical Council of NSW), there was little coordination amongst the range of entities involved in setting and delivering education and training in NSW Area Health Services.

Solution: The MTEC approach to Basic Physician Training has set a good example of how relevant groups and individuals can be brought together to improve the delivery of medical training in health services. A whole new approach to education has occurred through a new governance mechanism: local network governance committees which include trainees, hospital administrators, clinicians, trainers and a State Overnight Committee which includes College representatives and Department of Health Representatives amongst others. At the local level education is carried out across the network rather than just in a major teaching hospital and new aspects of education have been implemented such as professional development programs for example, teaching skills for registrars. At a State level a video-conferenced teaching program occurs on a weekly or twice weekly basis after hours and is therefore available to trainees at all rural sites as well as the major city hospitals. This means that trainees are not disadvantaged in their ability to access this teaching program regardless where they are working. An ultimate aim should be that training networks should each have a training and education committee, including College and Health Service and trainee representatives, rather than having the current layers of committees which occur specifically within College, then again in Area Health Services and so on.

Training is still occurring largely in acute hospital settings. This is not always appropriate particularly in areas where most of the care occurs outside the traditional teaching hospital for example in community settings and private practice. A limited amount of training does occur in the private sector but these are arrangements usually informal.

Solution: Training in the private sector should be encouraged but needs to be made explicit, with financial input from the private sector towards this training. The AMC College accreditation process will encourage the provision of training in the most suitable clinical settings including non inpatient settings.

There are many doctors working in senior roles in public hospitals but who do not have specialist qualifications. It is often difficult for these doctors to access structured or formal training and professional development.

Solution: There are plans in NSW to develop a hospital training program which will be specifically designed to enhance and credential the skills of doctors not in a specialised training program.

Regulation of the Health Workforce

The importance of an independent medical profession which has responsibility for determining professional standards free of government "control" underpins the medical training system and the self-regulation of the medical profession. Yet governments are ultimately responsible for ensuring adequate supply of the medical workforce and have some responsibility to ensure that there are systems in place to regulate the quality and safety of medical practice. A tension arises from the lack of clarity between the roles and responsibilities of government and medical professional groups in relation to the regulation of the medical training system (which is the "supply chain" for the medical workforce).

The current medical workforce shortages have focused attention on the length of medical training which is perceived by many to be too long especially when compared to the medical training systems in other parts of the world. There is also the problem of “bottle-necks”, or “holding patterns”, which result in trainees being “stuck” for a number of years before being able to progress to the next stage of their training. The length and progression of training needs review. Some have called for a move away from the current practice of requiring a minimum training time towards a competency and performance based assessment of trainees. The latter would allow trainees to progress according to their capability and performance rather than being limited by minimum training times. Assessing competence and performance requires valid and reliable methods of assessment and standard setting – something that is being targeted as an area for further development by the Colleges in association with the Australian Medical Council. While a shift to competency and performance based training may result in a shortening of training time (or lengthening in some cases), the main consideration should always be training quality and ensuring graduating specialists and general practitioners meet professional standards rather than seeking to reduce training time *per se*.

Workforce Participation

The key influences on work place participation are whether job satisfaction will be attained and this usually requires the job to be interesting, rewarding (not only financially) and allowing a degree of flexibility and development for the trainee. Feedback from trainees indicates that trainees do not object to their (extended) hours of work provided they feel valued for the work that is done. On the other hand, some trainees are “used” by the system with quite unrealistic on-call requirements resulting in a disproportionately large number of working hours.

Solutions:

1. Workforce participation can be increased, and the distribution of workforce to undersupplied metropolitan and rural centres enhanced, through the introduction of incentives such as differential remuneration and other package arrangements for doctors working in such centres.
2. Public hospital care should be consultant led. This means that in some instances, consultants need to take a greater share of the “first-on-call” duties to avoid untenable situations of trainees working a one-in-one or one-in-two roster for extended periods.
3. Workforce participation and distribution would be enhanced by a modern approach to compensation arrangements for trainees when working away from their “home base” hospital. Few sectors of the health workforce (or indeed other professional groups) are required to rotate to different hospitals as often as junior medical staff. It is not unusual for trainees to be rotated to 3 or 4 different training sites (hospitals) within a twelve month period. The cost and social dislocation that arises from frequent change of a trainee’s place of work is a barrier to recruitment and retention of staff.

A major issue for trainee participation in the workforce is their desire to have 'on the job' teaching and appropriate supervision. Trainees will seek out hospitals that have a reputation for delivering high quality teaching and appropriate consultant support. The public has the right to expect that all doctors-in-training receive high quality training and appropriate clinical supervision. Access to high quality training should be available to all trainees wherever they may be working in the public health system.

Solution: Introduction of performance appraisal for consultants who have teaching and supervision responsibilities for trainees on their team would reinforce the importance and value of teaching and supervision as part of the consultant's role.

Migration issues

Australia has a social responsibility to limit its recruitment of overseas trained doctors from developing countries. Australia should strive for self-sufficiency in the supply of medical practitioners rather than relying on the importation of these skills.

Solution: Increasing the number of local medical school graduates, with targeted recruitment and retention strategies in shortage specialist and geographical areas is a more appropriate long term solution.

Productivity

Productivity for all involved in health would probably be increased by better role delineation for trainee doctors, with abolition of large amounts of clerical work currently undertaken by doctors-in-training and other clinical staff. The less time trainees spend doing clerical tasks the more time they would have to care for patients. There have been few serious attempts to reform the work practices of trainees this over several decades. A positive step would be the development of more clinical support roles to manage the workload in hospitals. The Vocational Education and Training sector would be well placed to provide the training for clinical support roles.

Summary

Re-distribution and enhanced productivity of the hospital medical trainee workforce can only be achieved by ensuring that appropriate supervision and training are provided wherever the trainee doctor is working. This can be achieved, and has begun to happen in NSW, provided there is an investment in infrastructure and funding support for medical training. The experience in NSW has shown that an organization such as the Medical Training and Education Council in NSW can work with the many stakeholders in medical education to "broker" short and longer term solutions.