

AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION SUBMISSION TO THE NATIONAL HEALTH AND HOSPITAL REFORM COMMISSION

Summary

The terms of reference of the National Health and Hospitals Reform Commission (NHHRC) include a number of points specifically addressing the challenges to the provision of education and training to the future medical workforce, and healthcare to Australia's rural and indigenous communities. The Australian Medical Students' Association's (AMSA) submission addresses items 2 f), g) and h) of the NHHRC's terms of reference:

- f) improve the provision of health services in rural areas*
- g) improve Indigenous health outcomes; and*
- h) provide a well qualified and sustainable health workforce into the future*

Within these terms of reference the NHHRC has identified a set of proposed performance benchmarks (see Appendix A) to address closing the gap in indigenous health status; improving distribution and equitable access to services; and ensuring enough, well-trained health professionals into the future. AMSA broadly supports these benchmarks, however proposes further measures to specifically ensure ongoing quality and capacity of medical education and provision of healthcare to underserved communities.

These benchmarks include measures to expand the medical teaching workforce, address increasing student numbers, grow training infrastructure especially in rural areas, diversify training settings for medical students and junior doctors, invest in innovative medical education initiatives, promote practice in rural areas, encourage more Aboriginal and Torres Strait Islander people into the medical workforce and improve Indigenous health education at medical schools.

Providing a well qualified and sustainable health workforce into the future

In an attempt to address the shortage of doctors in the Australian medical workforce the Federal Government has dramatically increased the number of medical student places at Australian Universities. The number of medical schools in Australia has nearly doubled from 10 in 2000 to 19 in 2008, with the number of domestic graduates each year predicted to increase from 1265 in 2002 to 2920 in 2012 (1-3). The dramatic increase in medical student numbers has placed significant pressure on the clinical training infrastructure within the Australian healthcare system.

Challenges

In the context of increasing student numbers the current challenges to ensuring the provision of a well qualified medical workforce into the future include:

- the changing nature of inpatient admissions, with reduced average length of stay reducing available teaching time (4,5);
- the reduction in outpatient clinics occurring in public hospitals;
- the increasing number of procedures performed, often exclusively, outside of the public hospital system (5);
- the static number of clinicians available as teachers (6);
- increased competition between medical, nursing and allied health students for access to clinical training opportunities and resources;
- the impingement of the work of delegated role healthcare practitioners on the availability of training opportunities for medical students and prevocational doctors;
- historically poor coordination between training providers including Universities, medical colleges and hospitals; and
- the maldistribution of increases in medical student numbers. (In Queensland the projected number of domestic and international medical graduates will increase by 255% (216 to 766) between 2003 and 2012 compared to South Australia which will have a 52% (194 to 296) increase during the same period)

Solutions

In order to ensure the ongoing provision of a well qualified and sustainable health workforce these issues urgently need to be addressed. The benchmarks outlined in the NHHRC's COAG submission (see Appendix A) are important measures. Other means of addressing these challenges in the context of the upcoming AHCA's include the following:

Addressing increased student numbers

- Any further increases in medical student numbers need to be balanced against available clinical training capacity to ensure that the current pressure on undergraduate training resources does not increase;
- Expansion of the role, and resourcing, of the Medical Training Review Panel (MTRP):

- to ensure ongoing surveillance of clinical training capacity, and plan for the future influx of trainees accordingly;
- to define and monitor the quality of the education and training provided at all levels of the training continuum;
- Avoiding the introduction of alternative workforce models that perform delegated roles currently assigned to prevocational doctors and medical students, until training capacity can be guaranteed for existing healthcare students and health workers.

Expanding the teaching workforce

- Teaching time, separate to that allocated for service delivery, must be quarantined within the role expectations of senior medical staff to allow them to undertake undergraduate and junior doctor teaching;
- Those medical staff who choose to undertake teaching for a significant proportion of their clinical time (up to 0.5 full time equivalent) should be remunerated comparably to their full time clinical colleagues; and
- A defined vocational pathway into medical education, including specific qualifications and fellowship, must be created, both to build the available teaching workforce and to increase the skills of existing clinician teachers, directors of clinical training and medical education officers.
- Recognising the contribution made by clinical teachers through awarding academic title, points towards continuing professional development and other non-financial incentives
- Support, in the form of leave of absence and professional development allowance, for clinicians to attend educational activities to improve their teaching skills

Growing undergraduate clinical training settings and infrastructure

- Within the provisions of the AHCAs, there must be quarantined investment in infrastructure for education and training, in order to fund:
 - more traditional teaching facilities (tutorial rooms, resources for bedside coaching, libraries, computing facilities, consulting rooms in community settings);
 - an expansion of non-traditional teaching facilities (skills development centres, simulation training);
 - the recruitment of more clinicians to public posts that include provision for education and training as a core role responsibilities;
 - common administrative staff and facilities to co-ordinate and best utilise educational opportunities across educational institutions and disciplines that use clinical training facilities; and
- There must be a concerted effort to formally expand undergraduate clinical training into alternate settings including community and private facilities.

Growing clinical training capacity for junior doctors

- To accommodate the influx of medical students moving through the system there must be dedicated investment in education and training within the provisions of the AHCA's to fund:
 - a number of high-quality intern places commensurate with graduating numbers of both domestic and international students both nationwide and within each state;
 - A sufficient number of high-quality, accredited pre-vocational positions;
 - An increase in vocational training positions throughout the specialties (including General Practice) which is commensurate with increasing graduate numbers; and
- There must be a concerted effort to formally expand pre-vocational and vocational clinical training into alternate settings including community and private facilities.

Providing innovation in the delivery of medical education

- There must be recognition of and support for the development of simulated training and innovative teaching programs, for example "Teaching on the run", Queensland Health's "More Learning for Interns in Emergency" (MoLIE), and the CPMEC's "Professional Development for Registrars", so that teaching time is used more efficiently, freeing up time to teach medical students and junior doctors; and
- Medical students and junior doctors should be encouraged to undertake research through funding of research initiatives and allocated course and clinical time.

Improving the provision of health services in rural areas

The rural health workforce in Australia is decreasing and is in a state of overall shortage (7,8). If this trend continues by 2012 the shortfall of doctors in rural and remote areas could reach 1182 (7). This shortfall poses significant problems for the provision of health services in rural areas. Current understanding is that the best predictors of medical graduates going on to practice in rural areas are rural origin plus early and repeated positive experiences with rural medicine and rural lifestyle (9,10).

Challenges

In the context of rural workforce decline and increasing medical student numbers the current challenges to improving the provision of health services in rural areas include:

- the decrease in the available pool of teachers for current medical students;
- the increased patient care requirements and longer working hours of the remaining practitioners as the size of the workforce diminishes (11);
- competition for limited training resources between an increasing number of medical students (both students undertaking compulsory rural placements through the RUSC program and students in rural clinical schools), medical graduates and bonded junior doctors;
- the negative perception of rural practice, visible to students, through the loss of workforce and the increasingly demanding practice requirements on those that remain;
- the long term detrimental impact of negative perceptions of rural practice created through state and federal bonding of medical graduates to rural areas;
- the lack of accommodation and transport facilities in many rural communities that preclude their use as teaching sites; and
- a lack of incentive for junior doctors to practice in rural areas.

Solutions

Addressing many of the challenges facing the health status of regional, rural and remote populations will require a number of short and long term initiatives to increase the available medical workforce in these regions. Sustainable solutions to address the rural medical workforce shortage include:

Building clinical teaching capacity in rural areas

- Completing a comprehensive evaluation of the available clinical training opportunities in regional, rural and remote communities to ensure that existing training opportunities are being adequately utilised;
- Increased funding for rural clinical schools which:
 - is indexed to increasing student numbers;
 - allows the development of rural clinical schools at all Australian medical schools, particularly new medical schools;

- funds the provision of accommodation and transport at rural clinical sites; and
 - allows the expansion of teaching infrastructure at rural clinical sites.
- Increased funding to provide support and incentives for senior doctors who become preceptors for students in rural areas; and
- Making greater use of multidisciplinary teaching from nurses, nurse practitioners, allied health professionals and paramedics in rural areas.

Increasing the recruitment of rural origin students

- Ensuring there are entry schemes (quotas, targets or transitional pathways from undergraduate study) for students of rural origin at every medical school in Australia;
- Developing initiatives such as rural high school visits and the Queensland Health "Health Careers in the Bush" program in every jurisdiction; and
- Increasing the number of RAMUS scholarships commensurate with increased student numbers.

Ensuring exposure to early, positive rural experiences

- Ensuring the number of places within schemes which expose medical students to early, positive rural experiences, such as the John Flynn Placement Program, remain commensurate with increasing medical student numbers;
- Increasing the number of Medical Rural Bonded Scholarship (MRBS) commensurate with increased student numbers; and
- Adding incentive for the current cohort of bonded medical students by introducing a scholarship component to the scheme.

Incentivising practice in rural areas

- Reducing reliance upon, with a view to abolishing, bonded medical schemes without scholarships which foster negative perceptions of rural practice among the medical student body; and
- Improving promotion of incentive schemes such as HECS/HELP reimbursement to medical students.
- Subsidising training fees for those junior doctors undertaking training in outer metropolitan, regional and rural areas.

Closing the Gap in Indigenous Health Status

There are currently an estimated 90 Indigenous doctors in Australia. They represent 0.18 percent of the medical workforce, despite the Aboriginal and Torres Strait Islander population accounting for 2.4 percent of the Australian population (12). Growing the number of Indigenous doctors in Australia is an important strategy for closing the gap in health status between Indigenous and non-Indigenous Australians. Another important means of addressing this issue is increasing the exposure of medical students to Indigenous health during medical school.

Challenges

The challenges to growing the Indigenous medical workforce in Australia include:

- poor recruitment of Aboriginal and Torres Strait Islander people into medicine;
- access barriers to medical school entry for Indigenous Australians; and
- high levels of non-completion of medical school among Indigenous students (12).

The challenges to improving the suitability of non-indigenous medical graduates for the provision of healthcare to Indigenous Australians include:

- the lack of availability of placements in Indigenous health services and Aboriginal and Torres Strait Islander communities;
- poorly co-ordinated and integrated Indigenous health curricula at some medical schools; and
- the difficulty in recruiting of medical graduates to work in areas of workforce shortage after graduation.

Solutions

Sustainable solutions to improving the delivery of healthcare to Indigenous Australians in the context of medical workforce recruitment include:

Increasing the number of Indigenous medical graduates

- Encouraging Indigenous students in their early high school years to aspire to tertiary education through the provision of information about, and role models within the health service;
- Increasing applications to medical school through targeted recruitment campaigns such as the Indigenous health careers camps offered by Health Workforce Queensland's "Health Careers in the Bush" program;
- Introducing Indigenous student entry schemes (quotas, targets or transitional pathways from undergraduate study) to every medical school in Australia;
- providing academic mentoring and social support for students, for example in the form of an Aboriginal Liaison Officer as is in place at Newcastle University School of Medicine;

- making prospective Indigenous medical students aware of the financial, social and academic supports available while they are at medical school; and
- investigating the sustainability of a medical school in Darwin and the delivery of other health courses in rural and remote areas.

Improving exposure of students to Indigenous health at medical school

- Improved utilisation and ongoing funding of the Leaders in Indigenous Medical Education (LIME) network;
- Promoting higher level positions for Indigenous Health academics within medical schools to strengthen the discipline;
- Completing a comprehensive evaluation of the availability of placements within Indigenous health services; and
- Auditing the implementation of the Medical Deans of Australia and New Zealand (MDANZ) Indigenous health curriculum framework for medical schools.

Conclusions

These solutions, while by no means exhaustive, are the product of extensive consultation with medical students and medical student bodies across Australia. While some of these solutions are novel, many are drawn from existing initiatives and programs which require improved implementation, funding and support.

As members of the future medical workforce who will be primarily responsible for implementing the reforms to come out of the NHHRC and AHCA, we hope that there can be further consultation with medical student groups, including AMSA, regarding strategies to strengthen medical education, increase training capacity and improve workforce recruitment to meet the needs of the Australian population.

In the ongoing consultative process the NHHRC will be conducting in the coming months AMSA, as a key stakeholder group, would be pleased to further discuss the items in this submission and more broadly the implications of the reform agenda for medical education and training.

Glossary and Terminology

AHCA- Australian Healthcare Agreements

AMSA- The Australian Medical Students' Association

COAG- Council of Australian Governments

HECS/HELP- Higher education contribution scheme/loan program

NHHRC- The National Health and Hospitals Reform Commission ('the commission')

RAMUS- Rural Australian Medical Undergraduate Scholarship

RUSC- Rural Undergraduate Support and Coordination

Clinical training- the proportion of medical student training which is undertaken in the hospital setting, normally the last 2-3 years.

Domestic graduate- Australian citizens graduating from an Australian medical school

International graduate- Australian medical school graduates who are not Australian citizens

Junior doctor- a medical graduate who is yet to complete their specialist training

Prevocational- a junior doctor who is yet to begin training in a specialty

Rural clinical school- clinical teaching sites remote from their parent medical schools where some students undertake one or more years of their clinical training

Undergraduate- a student in a medical program

References

1. Joyce CM, Stoelwinder JU, McNeil JJ, Piterman L. Riding the wave: current and emerging trends in graduates from Australian university medical schools. *Medical Journal of Australia* 2007; 186: 310-312
2. Medical Training Review Panel. 11th Report. December 2007.
3. Medical Deans of Australia and New Zealand. National clinical training review report to the Medical Training Review Panel Clinical Training Sub-Committee. 2008
4. Crotty B. More students and less patients: the squeeze on medical teaching resources [editorial]. *Medical Journal of Australia*. 2005; 183: 444-445.
5. Australian Institute of Health and Welfare. Australian Hospital Statistics 2006-2007. Canberra: AIHW, 2008 [Online]. Available at <http://www.aihw.gov.au/publications/hse/ahs06-07/ahs06-07.pdf> (accessed June 2008)
6. Australian Institute of Health and Welfare. Medical labour force 2003. Canberra: AIHW, 2005 [Online]. Available at <http://www.aihw.gov.au/publications/index.cfm/title/10153> (accessed May 2008)
7. Health Workforce Queensland and New South Wales Rural Doctors Network. Medical practice in rural and remote Australia: combined Rural Workforce Agencies national minimum data set report as at 30th November 2005. Brisbane: HWQ, 2006 [Online]. Available at http://www.healthworkforce.com.au/downloads/Publications/1698_MDS%20Report%202005_final_nocov.pdf (accessed Apr 2008).
8. Wilkinson D. Inequitable distribution of general practitioners in Australia: analysis by state and territory using census data. *Aust J Rural Health* 2000; 8: 87-93.
9. Dunbabin J, Levitt L. Rural origin and rural medical exposure: their impact on the rural and remote medical workforce in Australia. *Rural Remote Health* 2003; 3: 212
10. Laven G, Wilkinson D. Rural doctors and rural backgrounds: how strong is the evidence? A systematic review. *Aust J Rural Health* 2003; 11: 277-284.
11. Australian Institute of Health and Welfare. Medical labour force 2004. National health labour force series no. 38. Canberra: AIHW, 2006. (AIHW Cat. No. HWL 39.)
12. Lawson KA, Armstrong RM, Van Der Weyden MB. Training Indigenous doctors for Australia: shooting for goal. *MJA* 2007; 186 (10):547-550

Attachment A

Benchmarks in the NHHRC Beyond the Blame Game Report, April 2008

1. Closing the gap in Indigenous Health Status

- 1.1 Comparative life expectancy at birth
- 1.2 Birth weight
- 1.3 Rates of rheumatic heart disease

9. Improving distribution and equitable access to services

- 9.1 Indigenous rate relative to the non-Indigenous rate (each indicator)
- 9.2 Rate in lowest quintile by socio-economic status of area relative to highest quintile rate (each indicator)
- 9.3 Rural and remote rates relative to the metropolitan rate (each indication)

12. Ensuring enough well trained health professionals and promoting research

- 12.1 Number of graduating students in health professions relative to requirements
- 12.2 Number of new graduates employed in their field of training immediately post-graduation
- 12.3 Number of accredited and filled clinical training positions for all professions
- 12.4 Number of undergraduate placement weeks for medicine, nursing and other health service professions per 1000 population relative to national average
- 12.5 Research performance