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POSITION STATEMENT

Commonwealth Supported Places and Medical Workforce Supply and Distribution

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Australia's medical workforce is maldistributed both geographically and by specialty, experiencing fluctuations of over and under supply. These workforce inconsistencies have a direct impact on the provision of quality patient centred care. Interlinking factors are driving medical workforce inconsistencies, key among these is the increase in university medical school places - both Commonwealth Supported Places (CSPs) and domestic and international full fee-paying places - and an absence of long-term medical workforce planning.

Increases to the number of CSPs available for medical training without a commensurate investment in specialist medical training places, determined by national need geographically and by specialty, has caused a bottleneck in the Australian medical training pipeline and increased competition between doctors in training to enter specialist training. CSPs must be allocated according to community needs, and accountability mechanisms developed to ensure medical schools deliver sustainable outcomes. To ensure consistency across the medical training pipeline the Commonwealth must invest in an independent health workforce modelling and planning body to inform future medical graduate, prevocational, and speciality training numbers, that is resourced and able to ensure accountability for implementation of medical workforce strategies developed.

1. Background

1.1. Since the 1970's successive Australian Federal Governments have undertaken medical workforce planning initiatives in a reactionary, ad-hoc, and cyclical nature.[i] Various reports, committees, and inquiries noted the lack of data and medical workforce planning without implementing long-term solutions. Since this time a parade of health planning and analysis bodies were appointed including Medical Workforce Data Review Committee in 1991, the Australian Medical Workforce Advisory Committee in 1995, the Australian Health Workforce Advisory Committee in 2000, Health Workforce Australia in 2008, National Medical Training Advisory Network, and the Medical Workforce Reform Advisory Committee. The lack of a permanent planning and analysis body has led to inconsistent planning cycles and an over and under supply of medical professionals.[ii]

1.2. Commonwealth Supported Places are a recent tool for medical workforce development and planning at the beginning of the medical training pipeline. More recently there have been calls to increase CSPs for up to 1,000 additional medical places to secure a sustainable and self-sufficient medical workforce.[iii] However the AMA's position is that Australia can deliver better patient access to medical services right now by looking more closely at opportunities to bolster prevocational and specialist training places around the country rather than diverting funding to additional university places.

1.3. Recent policy, including limited redistribution of university medical places in favour of regional universities, has focused on redistributing existing resources to address chronic geographical shortages.[iv] The allocation and distribution of CSPs must be informed by robust medical workforce data and analysis in line with medical workforce and community needs. Further, the AMA recommend that medical schools be held more accountable for delivering on those workforce needs.

1.4. As CSPs are funded by Australian taxpayers, accountability to the taxpayer should be determined such that vocationally-ready doctors are distributed by specialty and geography, necessitating pairing of introduction of additional medical school CSPs with downstream workforce mechanisms to incentivise and distribute medical workforce to national needs.

2. Medical Schools and CSPs

2.1. Commonwealth Supported Places (CSPs) are commonwealth subsidised undergraduate degrees for domestic students paid directly to the educational provider.[v] Medical school's CSPs are set and restricted within funding agreements between the Commonwealth and the university.[vi] Universities can also offer domestic and international full fee-paying places in addition to CSPs; these are uncapped and as such there is effectively no cap on overall medical student enrolment numbers. The limited and finite number of CSPs are currently distributed between primary medical schools and are intended as a means to address geographic shortages of medical graduates and doctors, and any other needs identified by the Ministers and departments of health and education.

2.2. Australia has increased medical school intakes dramatically over the last 15 years and graduates medical students at a rate well above the OECD average. Australia in 2019 delivered 15.9 medical graduates per 100,000 inhabitants, compared to the UK with 13.1, the USA 8.1and Canada 7.1.[vii] Further, there has been almost doubling of medical school graduates from 1,544 domestic graduates in 2007 to 3,066 domestic graduates in 2020.[viii] These increases have not resulted in better access to medical professionals in rural and remote areas and within specialties in under supply. Instead, multiple factors continue to drive medical practitioners to practice in metropolitan locations and there has been a trend of oversupply in some specialties and increased subspecialisation.[ix]

2.3. Medical schools which offer full fee-paying places for both domestic and international students must provide education and training that benefits the medical workforce and the learning cohort, including full fee-paying students. Medical schools which offer full fee-paying places must also ensure they are appropriately resourced to meaningfully provide quality medical training experiences for graduates. This includes ensuring that students and graduates have experience in clinical settings and have access to intern training should the graduate wish. The Commonwealth Government should consider regulating the number of full fee-paying places provided by primary medical programs to ensure quality training experiences are provided to all medical students.

2.4. Increases or greater redistribution of CSPs must also consider the capacity and resourcing of the medical school to maintain a high-quality medical training experience. There is a risk that increasing medical school numbers can lead to overcrowded training environments diluting clinical experiences and overwhelming supervisory capacity.

2.5. The AMA proposes accountability measures be developed to ensure medical schools are delivering medical graduates that meet community and workforce needs. Additional or continued allocation of CSPs should be extended to medical schools that actively facilitate students to have quality learning experiences in rural, remote, and community settings; and have curriculums and processes providing career guidance and support for students to enter specialties that are undersubscribed such as general practice. Universities and their outcomes should be evaluated to create a well-distributed and sustainable medical workforce, address undersubscribed medical specialities, and existing inequities.

3. Australia's Medical Training Pipeline and Medical Workforce Data

3.1. Inefficiencies in the training pipeline and medical workforce are driven in large part by a lack of coordination between stakeholders such as primary medical schools, specialist medical colleges, hospitals, and governments. This is amplified by a lack of data driven decision making in medical workforce planning and training policies.

3.2. This current bottleneck and mismatch in supply and demand of doctors has occurred because of historical concerns regarding an undersupply of doctors in Australia. To address these concerns, the Federal Government significantly increased CSPs in the early 2000s without consideration for the whole of training pipeline.[x] While not occurring immediately, intern places were similarly expanded to accommodate the growth of medical graduates.

3.3. However, a lack of attention to specialist training capacity since the 2000s has led to a limited number of specialist medical training positions being available for doctors in training. This inaccessibility of specialist medical training places has caused the unplanned and unintended growth of a now large cohort of doctors between PGY 3+, and specialist medical training variously known as unaccredited service registrars.

3.4. Unaccredited service registrars are PGY 3+ doctors who are not in an accredited training program but often perform the same work as specialty registrars to ensure service delivery. The unaccredited service registrar experience is characterised by intense competition for entry into college training programs and poor working conditions including excessive and unsafe hours, poor supervision, and job insecurity. An increasing number of these doctors are considering a career outside of medicine.[xi] The current bottleneck of unaccredited service registrars was projected in Health Workforce Australia's 2012 report '*Australia's Health Workforce 2025*.'[xii]

3.5. The AMA calls for an independent health workforce modelling and planning body to ensure there are efficiencies in coordinating and developing Australia's medical and health workforces. Health Workforce Australia provided this coordinating and reform role from 2010 before being abolished in 2014.[xiii] A similar body will also produce high quality data driven workforce forecasts informing and validating policy and planning and should be resourced and empowered to ensure accountability for implementation of workforce strategies developed.

3.6. The independent health workforce modelling and planning body should coordinate and consult with Australia's varied health stakeholders including state and territory health departments, colleges, and medical schools to ensure a well distributed and sustainable health workforce. Robust workforce data and analysis must drive medical workforce policy, planning and decision making. This includes advising the Commonwealth on the number of CSPs and full fee-paying medical school numbers and overseas trained doctor recruitments strategies and targets to optimise Australia's medical training outputs to meet community need.

4. Recommendations

4.1. The AMA advocates:

(a) That the Commonwealth funds an independent health workforce planning and analysis body that is resourced and empowered to ensure accountability for implementation of medical workforce strategies developed. It will provide evidence based, high-quality and contemporary data to inform health workforce planning and development.

(b) That medical school Commonwealth Supported Places (CSPs) are allocated and distributed according to workforce data and community needs.

(c) That CSPs are linked to university and medical school outcomes including the graduation of increased generalist and rural medical workforce.

(d) Any future alterations to medical school CSPs be paired with commensurate alteration and investment in downstream prevocational and specialist medical workforce reform designed to meet the geographic and specialty workforce needs of Australia.

See also:

[i] Australian Medical Workforce Advisory Committee. (2000). Medical Workforce Planning in Australia. *Australian Health Review*, 8-26.
[ii] Health Workforce Australia. (2012). *Health Workforce 2025 - Doctors, Nurses and Midwives Volume 1*.
[iii] Group of Eight Australia. (2022). *Essential Decisions for National Success: Securing the Future of Australia's Medical Workforce*. Retrieved from https://go8.edu.au/wp-content/uploads/2022/05/Essential-decisions-for-national-sucess_Securing-the-Future-of-Australias-Medical-Workforce.pdf
[iv] Department of Education. (2022, March). *More Opportunities for Regional Australia*. Retrieved from https://www.education.gov.au/job-ready/more-regional-opportunities#toc-regional-education-commissioner
[v] Department of Education. (2022, April). 20. *Commonwealth Supported Places (CSPs)*. Retrieved from Australian Government Department of Education: https://www.education.gov.au/higher-education-publications/higher-education-administrative-information-providers-october-2021/20-commonwealth-supported-places-csps
[vi] The ability for the commonwealth to allocate CSPs for medical courses is also outlined within the *Higher Education Support Act 2003* as a 'designated higher education course.'
[vii] Organisation for Economic Co-operation and Development. (2023). *Medical Graduates Indicator*. Retrieved from OECD: https://data.oecd.org/healthres/medical-graduates.htm
[viii] Medical Deans Australia and New Zealand. (2023). *Student Statistics*. Retrieved from MDANZ: https://medicaldeans.org.au/data/?md_year=2007&data_type=Graduates&country=AU&students=Domestic&preview=
[ix] Department of Health. (2021). *National Medical Workforce Strategy 2021-2031*. Commonwealth of Australia.
[x] Health Workforce Australia. (2014). *Australia's Future Health Workforce - Doctors*. HWA.
[xi] Medical Training Survey (2023). *Medical Training Survey 2022 Report for Prevocational and unaccredited trainees*. AHPRA/MBA.
[xii] Health Workforce Australia. (2012). *Health Workforce 2025 - Doctors, Nurses and Midwives Volume 1*.
[xiii] Jolly, R. (2014, June). *Bills Digest no. 77 Health Workforce Australia (Abolition) Bill 2014*. Retrieved from Parliament of Australia: https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1314a/14bd077