Medical Workforce and Training

2019

1. Preamble

1.1. The health of a population relies upon care from a highly skilled, well-trained medical workforce and a strong comprehensive primary health care sector.

1.1. Over the past decade, the number of doctors in Australia has increased significantly, driven by a significant rise in the number of medical schools and medical graduates. The number of doctors in Australia (2015) sits just above the Organisation for Economic Co-operation and Development (OECD) average at 3.5 per 1000 population (compared to UK 2.8 per 1000 and USA 2.6 per 1000 population).[1] Record growth in medical graduate numbers[1] well above the OECD average has raised concerns about a potential medical workforce oversupply in the years ahead.

1.2. Notwithstanding this, distribution of the medical workforce remains an issue both geographically and by specialty. Australia continues to rely heavily on overseas trained doctors to fill workforce gaps, particularly in rural and remote areas. Some medical specialties are in undersupply, with others in over-supply, especially in metropolitan areas. This is exacerbated by a shortage of vocational training places, increased competition for entry into vocational training and exit block for employment of new fellows.

1.3. Delivering a medical workforce to meet future community requirements for health care requires the focus of medical workforce policy and planning to shift from increasing medical school places towards giving medical students and postgraduate doctors more opportunities to train in rural areas, targeted increases in postgraduate training capacity in the geographic areas and specialties where they are needed, and on improving the distribution of the medical workforce.

2. Capacity to train

2.1. The AMA calls on the Commonwealth and States and Territories to co-operate more closely in planning and coordinating the medical workforce. The creation of training positions needs to be informed by a national workforce plan that reflects other policy levers and health reforms. This requires a greater degree of cooperation between Colleges, State/Territory Government and the Commonwealth to ensure the training continuum is appropriately articulated and reflects national need.

2.2. The AMA believes a National Medical Workforce Strategy is critical to achieving policies that will deliver the future medical workforce that the community needs. Key areas for action include a focus on aligning specialist training with community need and health service requirements, providing more opportunities for specialist training in rural areas, supporting careers in undersupplied specialties and curtailing training in specialties already in/approaching oversupply.

2.3. This should be informed by consistent and evidence-based advice from a national medical workforce agency. The National Medical Training Advisory Network (NMTAN) currently fulfils this role and should continue to be resourced to report on medical workforce supply and demand, future workforce requirements, skilled immigration requirements and the number and distribution of training places.

2.4. Government funding must be provided to support capacity to train throughout the medical training pipeline, support for innovative training pathways in areas of need, and to leverage any latent capacity that exists within the private sector and non-hospital healthcare settings to

[1] Australia had the highest growth in medical graduate numbers in the OECD between 2000 and 2015 achieving 15.8 graduates per 100,000 population (OECD average 12.1 per 100,000 population in 2015).

create additional training places. Financing models must preserve the quality and safety of Australia's current training systems and reflect the dynamic nature of health service models, community health service requirements and workforce trends over time.

2.5. It is important that the Federal Government maintains control over the policy levers that influence the supply of doctors by regulating the number of Commonwealth supported and full-fee paying medical school places, and by regularly reviewing overseas trained doctor recruitment strategies and targets. Data does not support the creation of any further medical school places and the redistribution of places should be explored in line with community health service requirements.

2.6. Australian universities should continue to advise and inform all potential medical students, but particularly international medical students, about the opportunities and foreseeable limitations to completing medical training and ultimately practising medicine in Australia.

2.7. NMTAN modelling should be used to align specialty training numbers with future workforce and community needs. This includes identifying areas where non-accredited roles can be appropriately transformed into accredited training places, reviewing strategies aimed to increase training places and their uptake in specialties predicted to be in undersupply, and reducing training places in specialties already experiencing or approaching oversupply. Training places should be distributed to underserved areas, where possible.

2.8. Policies that prioritise employment of Australian trained doctors remain appropriate. Policies that encourage self-sufficiency in training doctors, acknowledge the contribution of overseas trained doctors and promote reciprocal international exchange will be most effective in achieving a balance between medical workforce supply and demand over time to meet community requirements[2].

2.9. As capacity to train is dynamic, data on the quality and effectiveness of medical training will be essential. The National Training Survey run by the Medical Board of Australia will provide a better understanding of the quality of medical training and how to improve it and will support the existing processes of accreditation of training providers and programs in Australia.[3]

3. Improved distribution

3.1. A well distributed workforce geographically and by speciality is essential to meet the long-term healthcare needs of communities, where undersupply impedes appropriate access and oversupply creates costly inefficiency. Medical workforce policy and planning must ensure there are enough doctors with the skills and commitment to provide care where it is needed most, particularly in underserved and rural and remote communities. This is an issue not only for general practice but across all medical disciplines.

3.2. Ensuring an appropriate balance between GP specialist and non-GP specialist workforce numbers is essential. Mechanisms must be in place to identify community requirements and service gaps, to direct the development of specialist training pathways, medical workforce and recruitment strategies.

3.3. Sub-specialisation in medicine must be appropriately balanced with support for generalist careers. Both metropolitan and non-metropolitan based training programs would benefit from an emphasis on generalist skills. The addition of sub-specialty skills or procedural expertise to generalist training may enhance the attractiveness and flexibility of vocational training and respond to changing community healthcare needs, especially those in rural and regional areas.[4]

3.4. Medical career decision-making should be informed by an understanding of future workforce requirements, available areas of practice, and community need. This requires availability of credible, contemporaneous workforce data and predictions, career counselling and management of career expectations and mentored supervision.

3.5. Training pathways that provide better integration between specialist training programs, allow for flexible entry and exit points, and commit to recognition of prior learning will support diversity, equal participation and a better distributed workforce.

3.6. There is an opportunity for greater collaboration between medical colleges, employers and federal and state/territory governments to increase training and employment opportunities to improve the distribution of the medical workforcein areas of unmet community need. A key consideration will be how to develop service networks, employment and training models to meet the healthcare needs of communities including the service requirements of hospitals without creating training stresses. This includes:

(a) prioritising funding for training places in underserved areas and undersupplied specialties, in accordance with college and professional standards of training and practice,

(b) implementing flexible models of supervision and enhancing professional support,

(c) implementing equitable working conditions across training programs,

(d) mapping community need to inform the number of accredited trainee positions (and where they should be reasonably located),

(e) based on the advice of the National Medical Training Advisory Network (NMTAN), working with the learned Colleges and jurisdictions to increase specialty training positions in areas of unmet community need and in specialties in undersupply, and to develop strategies for specialities in/approaching oversupply,

(f) balancing future workforce and skilled immigration requirements, and

(g) developing health system and information communications technology infrastructure to support training places and high-quality practice.

3.7. Evidence based policy initiatives that encourage improved distribution of the medical workforce are essential. Available evidence suggests attracting doctors to underserved geographic areas and specialties can be achieved by:

(a) setting targets for medical students and trainees with regional/rural backgrounds to enter medicine and training programs, and the redistribution of medical school places to regional centres; this could also be extended to specialties in undersupply,

(b) early and continuing exposure to regional/rural medicine and undersupplied specialties throughout training and increasing exposure to positive experiences in those areas,

(c) introducing contemporary supervision and work models to provide greater flexibility in employment and access to teaching and training; this includes employment arrangements that provide security of employment and portability of entitlements,

(d) integrated training and service delivery networks, providing a critical mass of doctors within a region to improve viability of practice, enhance collegiality, professional development and support,

(e) regional training networks, with opportunities to rotate into metropolitan teaching hospitals for advanced training as required, but removing unnecessary reliance on metropolitan and/or hospital-based teaching where appropriate alternatives exist,

(f) providing appropriate remuneration and broad incentives to attract and retain medical practitioners and their families, enhance viability of practice, and support teaching and training in underserved areas and specialties, [5] [6]

(g) consideration of the needs of doctors and their families including frequency of relocation, access to spousal employment opportunities, health and education, amount and ease of access to leave allowances and cover (such as locum) arrangements and social amenities, and

(h) proper medical infrastructure, access to community and professional resources, and stronger support for continuing medical education provide a rewarding professional and personal experience.

See also:

AMA Medical Workforce and Training Summit Report 2018

Capacity to train

AMA Position Statement Building Capacity for Clinical Supervision in the Medical Workforce 2017
AMA Position Statement International Medical Graduates 2015
AMA Position Statement Medical training in expanded settings - 2012. Revised 2015
AMA Position Statement Prevocational medical education and training - 2011. Revised 2017

Improving distribution

AMA Position Statement Rural Workforce Initiatives 2017
AMA Position Statement Employment of generalist medical practitioners 2017
AMA Position Statement Building a sustainable future for rural practice: the Rural Rescue Package 2017
AMA Position Statement Geographic Allocation of Medicare Provider Numbers - 2002. Revised 2014
AMA Position Statement Regional Training Networks - 2014
AMA Position Statement Fostering generalism in the medical workforce - 2012

[1] Organisation for Economic Cooperation and Development. Doctors overall numbers in Health at a glance 2017: OECD Indicators. Paris: OECD Publishing, 2017.
[2] World Health Organisation. WHO Global Code of Practice on the International Recruitment of Health Personnel. WHO, 2010.
[3] The Medical Board of Australia has previously announced that it will run a National Training Survey in order to better understand the quality of medical education in Australia. https://www.medicalboard.gov.au/registration/national-training-survey.aspx
[4] Strasser RP. Will Australia have a fit for purpose medical workforce in 2025? Med J Aust 2018; 208 (5): 198-199.
[5] Cheng T et al. What Factors Influence the Earnings of GPs and Medical Specialists in Australia? Evidence from the MABEL Survey. *Health Economics* 2012; 21 (11): 1300-1317.
[6] Yong J, Scott A, Gravelle H et al. Do rural incentives payments affect entries and exits of general practitioners? Abstract. Available online 24 August 2018.