

## NATIONAL MEDICAL TRAINING ADVISORY NETWORK – CONSULTATION

### SUBMITTING YOUR FEEDBACK

Please review the discussion paper (available as a pdf on the HWA website [www.hwaconnect.net.au/nmtan](http://www.hwaconnect.net.au/nmtan)) and provide your feedback in accordance with one of the preferred options below:

#### **Option 1:**

Complete your feedback using this form and email it to [nmtan@hwa.gov.au](mailto:nmtan@hwa.gov.au)

#### **Option 2:**

Hard copy – send a printed copy of your completed form to:

Health Workforce Australia  
National Medical Training Advisory Network consultation  
GPO Box 2098  
ADELAIDE  
SA 5001

### **Feedback form**

#### **Instructions**

Please provide responses using the template provided. The questions are designed to help you to focus your response and help HWA when analysing submissions. You do not need to answer every question.

## Section 1: Cover page

### Your details

Organisation or individual providing feedback: Australian Medical Association

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### Response from an organisation

Role or involvement in medical training: Professional body representing doctors at all levels of the health system as well as medical students

National or jurisdictional response: National response informed by the experience of jurisdictional representatives

### Confidentiality

Health Workforce Australia (HWA) would like to give you the following options about publishing your name (organisation or individual) on our website as a participant in this consultation:

- ☒ Yes, I give permission for the organisation or my name to be published on the HWA website as a participant in this consultation.
- ☐ I do not give permission for the organisation or my name to be published on the HWA website as a participant in this consultation.

### General Comment

The AMA does not participate directly in the planning, organisation or management of clinical training. This submission provides an independent perspective informed by a diverse membership. The experiences of students, trainees, consultants, experienced medical educators and senior hospital administrators have all been captured in the comments below.

The education and training of the next generation of doctors is a huge challenge for all medical stakeholders. The significant increase in the number of medical students and their impending progression through prevocational and vocational training will create training bottlenecks if the status quo persists. It is clear that more supervisors and educators will be needed to train these new doctors. Education and training must be a core function of both public and private health services if the future health workforce requirements of the Australian community are going to be met.

In this context, the AMA welcomes the planning for a National Medical Training Advisory Network (NMTAN). The Association's supports the NMTAN in developing effective strategies to address the urgent issues in medical training and workforce planning. Advice and co-ordination must be matched with funding models that expand teaching and training capacity and stakeholder co-operation.

Aligning medical workforce to community needs must be done through positive interventions, as restrictive or coercive interventions have been unsuccessful in the past. The AMA hopes that that NMTAN is able to realise its objectives using this approach.

## Section 2: What are the key elements of a coordinated medical training system?

### Consultation questions

#### Principle 1

**Training of the medical workforce should be matched to the community's requirements for health services, including where those services are required geographically and in what specialty.**

#### 1. **What is working well (and why) in the current training system and should be continued?**

The community's requirements for health services should be the overriding driver of medical workforce provision and development. The AMA strongly supports this goal.

The current training system has evolved gradually to produce structures that are largely effective in training the medical workforce. Many of these structures have developed organically in response to various drivers within the healthcare system. The development of the forerunner to the Specialist Training Program (STP) in 1997, its expansion in 2006 and consolidation into STP in 2010 shows natural progression of a successful program. Its mandate to create training places in settings other than traditional public teaching hospitals has enhanced medical training and strengthened the medical workforce<sup>1</sup>.

A number of entities work exceptionally well within the current training system and should be continued. These include the Prevocational General Practice Placement Program (PGPPP), Australian General Practice Training (AGPT) Program and internship accreditation through the post-graduate medical councils or their equivalent in each state and territory.

A pivotal element of medical training are the specialist medical colleges. These ensure the continuing high standards of the Australian medical

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<sup>1</sup> AMA Position Statement on Medical Training in Expanded Settings <https://ama.com.au/position-statement/medical-training-expanded-settings-2012>

workforce. Their transparency and independence ensures the world-class quality of medical training in Australia<sup>2</sup>. Rigorous and flexible standards support training in a diversity of settings, helping to expand training opportunities throughout the country and abroad. The independence of the standards, and the colleges that maintain them, is integral to the continuing success of the system.

The Australian Medical Council (AMC) has shepherded the training system through a period of intense change and continues to have the confidence and support of the profession. The AMC ensures that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community<sup>3</sup>. With moves to introduce national standards for intern training, the AMC will soon accredit a majority of the medical training continuum<sup>4</sup>. This will inevitably strengthen prevocational medical education. The AMA Training and Education Survey 2012 shows that real progress can be made to streamline training by improving the relationship between different levels of training<sup>5</sup>.

While there are looming issues and inefficiencies between different levels of training, the findings of successive Medical Training Review Panel reports demonstrates tangible responses by the medical training system to challenges such as the significant expansion of internships and vocational training capacity<sup>6</sup>.

Capacity can be built at all levels through innovation and targeted funding, which currently happens in some circumstances. The AMA has previously submitted that specific funding should be made available through HWA to support access to and/or the development of innovative programs such as the More Learning for Interns in Emergency (MoLIE) program<sup>7</sup>.

The AMA believes the medical training system requires support and high-level advice through an NMTAN to better co-ordinate stages of training and to ensure that the human capital invested in the system is put to its best use in the service of the community.

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<sup>2</sup> Australian Medical Council: Assessing specialist medical education and training  
<http://www.amc.org.au/index.php/ar/sme>

<sup>3</sup> Australian Medical Council: Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council 2010  
<http://www.amc.org.au/images/Accreditation/standards-for-specialist-medical-training-2010.pdf>

<sup>4</sup> Australian Medical Council: Communiqué on proposed National Intern Training Standards and Framework  
<http://www.amc.org.au/images/Accreditation/Communique-Intern-Training-10Apr13-F.pdf>

<sup>5</sup> AMA Junior Doctor Training, Education and Supervision Survey 2012 <https://ama.com.au/2012-ama-junior-doctor-training-education-and-supervision-survey>

<sup>6</sup> Department of Health and Ageing. Medical Training Review Panel: Fifteenth Report.  
<http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-mtrp-15>

<sup>7</sup> AMA Submission to the HWA Clinical Supervisor Support Program 2010. <https://ama.com.au/ama-submission-health-workforce-australia-clinical-supervisor-support-program>

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2. **How can we balance the need for better national coordination of medical training with existing state, regional and local training coordination efforts?**

The AMA believes that healthcare delivery must firstly be viewed at the level of the individual practitioner and their patients. Medical care is primarily a service and promoting high quality service starts on the micro level.

Strategies at higher levels that do not align with the agreed requirements of the local area are likely to have long-term impacts on practitioner retention and satisfaction as well as the overall care of the community in that area. Therefore, notwithstanding the work done as part of Health Workforce 2025 (HW2025), there must be the continued development of standardised tools and expertise at local and regional levels to underpin the planning of service requirements. These tools should “feed up” a granular picture of the future medical workforce requirements that can be used to align the training efforts at a state level and national level.

HWA must take the lead here through their advice to the Standing Council on Health (SCoH). While the national data developed through HW2025 provides useful national data, the absence of granularity means that there is little evidence for jurisdictions, as the funders of hospital based training, to change their practices appropriately.

The AMA is convinced that the training of the medical workforce must acknowledge the relationship between primary care and sub-specialist care. Developing both sectors of medical specialisation is integral to delivering care consistent with community expectations<sup>8</sup>.

The AMA consistently calls for an end to the cost shifting between Commonwealth funded primary care and state run hospital care systems. The cost shifting impedes co-ordination of medical training. It entrenches a mentality that more trainees are a cost rather than an investment in the future of a balanced health system. This is evident when state health services place caps on their intern and prevocational employment numbers that align with future hospital based staffing requirements only<sup>9</sup>.

Cost shifting is endemic in the Australian health system and has become more evident due to budget containment strategies in many states and territories. This prioritises short-term cost savings in public hospitals at the expense of future investment in training. The issue about cost shifting is that the service or

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<sup>8</sup> AMA Position Statement on Fostering Generalism in the Medical Workforce 2012.  
<https://ama.com.au/position-statement/fostering-generalism-medical-workforce-2012>

<sup>9</sup> The Sunday Mail 28/10/2012: Queensland Health leaves trainee doctors out of work.  
<http://www.dailytelegraph.com.au/news/queensland-health-leaves-trainee-doctors-out-of-work/story-e6freuy9-1226504514577>

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function is not delivered. This will not be corrected until jurisdictions commit to training as an integral pillar of their health systems.

The AMA believes that a COAG agreement is urgently needed to ensure that each jurisdiction funds training positions appropriately and in a coordinated fashion to meet the health workforce requirements of the entire country. Moreover, COAG agreement will give subsequent advice and decisions weight, ensuring the continuing development of coherent policy in medical training.

This is a critical first step in achieving a training pipeline that is matched to future demand for health services.

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3. **How can incentives in the system achieve a better alignment of training and workforce need?**

As an overriding principle, training, whether delivered in a structured fashion or opportunistically, must be recognised for the value it brings to the care of patients. Training takes significant inputs from trainer and trainee alike. The AMA firmly believes that better and sustainable systems of incentives are required to ensure that high quality training can be given the appropriate time and priority within the health system<sup>10</sup>.

Foremost among these is a structure of funding that efficiently prices episodes of training and allows them to be funded appropriately. This allows a facility to support a culture of training without being subject to financial disadvantage.

Within a funding model that places an effective price on training there can then be normative pricing to support training activities in those areas where community demand dictates or where it is disproportionately harder to undertake training. This pathway could be used to both support and incentivise clinicians to become supervisors especially in regional and rural areas.

Areas of projected specialty shortage are most often found in the 'cognitive' generalist specialties. Experience suggests that the loss of a generalist workforce is linked to fragmentation of care and increasing health care costs<sup>11</sup>.

Alignment of training and workforce need also requires change to the

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<sup>10</sup> AMA Proposal: Proposal to Increase the PIP Teaching Incentive. <https://ama.com.au/ama-proposal-proposal-increase-pip-teaching-incentive>

<sup>11</sup> The Weekend Australian 22/09/2012: Time to revive the doc-of-all-trades  
<http://www.theaustralian.com.au/news/health-science/time-to-revive-the-doc-of-all-trades/story-e6frg8y6-1226478830458>

perceptions of potential trainees. Perceptions of specialty choice are formed prior to medical school by over 30% of future practitioners<sup>12</sup>. This requires education about available areas of practice within the medical profession to be brought forward to allow career choice to develop in an informed manner. That more than one-third who rank surgery as their first preference when entering medical school subsequently change their preference by the completion of internship suggests that career decisions are flexible and therefore can be molded by effective information campaigns<sup>12</sup>.

Improving the image of certain specialty areas would be a potential course of action. The potential workforce attracted to medicine is, by nature, altruistic but also competitive. Non-procedural specialties are subtly promoted as 'fall back' options. This creates a hierarchy of prestige associated with certain careers in medicine that has very little to do with actual career satisfaction.

The results of the MABEL study<sup>13</sup> show that overcoming some of the lack of interest in particular specialty areas and geographic regions can be achieved by improving the financial incentives for the practitioner<sup>14</sup>. These incentives should be combined with targeted marketing campaigns for specialties as a way to facilitate the expansion of training in these specialties and geographic areas. These incentives cannot operate in a vacuum and in underserved regions should be matched with support for allied health and nursing staffing as well as infrastructure incentives.

Incentives must always reinforce high quality medical training and not promote substitution with lower quality, cheaper alternatives. Such incentives should be treated with caution, even those developed with sound logic. In complex systems such as medicine they can have unintended consequences.

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#### 4. **What training barriers limit the distribution of the workforce both geographically and across specialties?**

A significant amount of research has been conducted into the determinants of trainee career choices and maldistribution. As an overriding principle, interventions to combat relevant barriers should be evidence based.

The AMA strongly supports diversity of entry into medical school<sup>15</sup>. Entry to medical school and the formative years of medical training have a significant impact on long-term career decisions. For this reason, mechanisms to attract

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<sup>12</sup> Medical Schools Outcomes Database Outcomes Newsletter March 2012

<http://www.medicaldeans.org.au/wp-content/uploads/MSOD-Newsletter-6.pdf>

<sup>13</sup> <https://mabel.org.au>

<sup>14</sup> Cheng TC, Scott A, Jeon SH, Kalb GRJ, Joyce C, Humphreys J. What Factors Influence the Earnings of GPs and Medical Specialists in Australia? Evidence from the MABEL Survey. *Health Economics*, 21 (11): 1300-1317.

<sup>15</sup> Becoming a doctor - a guide for prospective medical students <https://ama.com.au/node/4130>



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trainees to certain disciplines should be applied in the early stages of the medical training pathway. Targeted medical school recruitment of rural-origin students is a good example, and has been shown to be effective<sup>16</sup>.

Workforce distribution programs should utilise positive incentives. Bonding should be avoided as it is associated with negative stigma, and implicitly suggests that rural practice is an unattractive career option.<sup>17</sup> Small incentives early in training are more likely to develop goodwill and alter future prospects than larger incentives later in training.

The use of integrated regional training networks is another critical element in addressing workforce distribution. Retention in regional areas during prevocational and into vocational training is essential to long term regional and rural workforce.

Improvements in specialty distribution are most likely to be impacted by early education of future practitioners of specialties with predicted shortage. Student and early career decision-making needs to be supported by an understanding of the potential workforce requirements so that individuals make informed decisions about community's need for particular specialties.

The AMA supports cohesive models of care that provide clear care pathways. Models of shared care, such as diabetes cycles of care, rely on clear delegations that feed back to a coordinating practitioner. This model supports the training of medical specialists in community settings through increasing access to the community burden of disease. This delegated model can also support indirect supervision of a registrar by a hospital-based specialist through the general practitioner who manages the patient's care in the community.

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5. **What training measures could be applied to achieve a better distribution of the workforce - both geographically and across specialties?**

Training, especially as a student and prevocational doctor, facilitates exposure to a variety of specialties influencing the final decision of specialty choice. The structure of medical school and prevocational training heavily favours hospital based disciplines to the detriment of others. Restructuring early experiences to align with the burden of disease would better achieve an appropriate distribution for the workforce.

Similarly, increased exposure during early prevocational training by specialties with workforce shortages by mechanisms such as the offering of elective terms may improve the uptake of these specialties. It should also be noted that in

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<sup>16</sup> Easterbrook M, Godwin M, Wilson R, Hodgetts G, Brown G, Pong R, Najgebauer E. Rural background and clinical rural rotations during medical training: effect on practice location. CMAJ 1999;160:1159-63

<sup>17</sup> AMA Submission to the Australian Government Review of Health Workforce Programs 2012  
<https://ama.com.au/ama-submission-review-australian-government-health-workforce-programs>



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many of the specialties with workforce shortages prevocational doctors cannot provide service delivery and as such these rotations are viewed as providing less return to jurisdictions.

The rural clinical schools (RCS) program, with a greater emphasis on primary care, generalism and community medicine, is an example of alignment between community need and training<sup>18</sup>. The principles of the RCS program do not need to be limited only to rural and regional areas. For instance, community clinical schools might provide students with a similar experience to those who participate in longitudinal rural immersion programs.

Extension of these models into prevocational and vocational training would also be appropriate. Current exposure to general practice and community care is seen as a detour from hospital based training. Community exposure through PGPPP is a starting point to balancing positive experience in community medicine with hospital medicine.

The AMA has developed a comprehensive position statement regarding rural and regional workforce recruitment and retention that is included as an appendix. This provides further detail on the mix of initiatives and incentives that are likely to realise a medical workforce that is more equitably distributed.

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#### Principle 2

**Matching supply and demand for medical training should recognise the changing dynamics of the healthcare system over time, including advances in service models and workforce development trends.**

1. **What is the best way to incorporate changing workforce trends and dynamics in the healthcare system into training planning?**

The HW2025 report was an important first step in the process of aligning medical training to community demand. The AMA strongly supports yearly updates to the input data for the HW2025 modeling including ongoing re-assessment of the assumptions upon which the model is based.

Demand modeling in HW2025 has continued to be based on the quantum of doctors providing services. The relevant formulae will need to evolve with time, reflecting trends in disease and new models of care. Increased emphasis on preventative healthcare and chronic disease management is also required.

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<sup>18</sup> Sturmberg JP, Reid S, Khadra MH. A Longitudinal, Patient-Centred, Integrated Curriculum: Facilitating Community-Based Education in a Rural Clinical School. *Education for Health*, Vol. 15, No. 3, 2002, 294 – 304

Mapping of workforce trends is currently an ad hoc process based on sub-optimal data. For instance, there are no accurate figures in relation to the number of prevocational trainees and unaccredited registrars. These data inadequacies must be addressed as a matter of priority.

In the first instance, annual workforce surveys administered by the Australian Health Practitioner Regulation Agency should be optimised. Looking forward, however, developing evidence through an annual National Training Survey (NTS) would allow for the modification of training planning as well as assessment of training interventions. This could be achieved by capturing both quantitative and qualitative data. An NTS would ideally incorporate a view of the entire training workforce allowing for the assessment of workforce distribution interventions. Data linkages with the Medical Schools Outcomes Database (MSOD) could also be explored.

The NTS might be based on a similar initiative in the United Kingdom, as managed by the General Medical Council (GMC)<sup>19</sup>. The AMA is currently in discussions with the AMC about how an NTS might be developed for Australia, and would be keen to discuss this further with HWA, particularly with respect to quantitative components.

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## 2. **How can flexibility in training the medical workforce be retained to ensure the workforce can adapt to future health system changes?**

Current training models are relatively inflexible with trainees being essentially stuck in 'training silos'. Decisions made early in training are difficult to deviate from because of sunk costs and lack of recognition of prior learning (RPL) to allow career change. This incentivises retention in careers that no longer align with clinician's desire for practice or potentially community demand and results in deliberate under employment and potentially shorter clinical careers.

RPL is fundamental to achieving efficient training and only one-quarter of current trainees believe that their college has granted appropriate credit for relevant prior training and experience and furthermore believe that this negatively impacts their career progression<sup>20</sup>. Achieving a balance between vocational training flexibility and maintaining high quality training is essential.

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<sup>19</sup> GMC National Training Survey: Background [http://www.gmc-uk.org/education/survey\\_background.asp](http://www.gmc-uk.org/education/survey_background.asp)

<sup>20</sup> AMA Junior Doctor Training, Education and Supervision Survey 2012 <https://ama.com.au/2012-ama-junior-doctor-training-education-and-supervision-survey>

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The development of higher order thinking skills, rather than solely clinical competence, is common to all medical training and structures that recognise the cognitive development of trainees would generally increase the flexibility of RPL systems.

Assuming appropriate college representation, optimisation of RPL processes should be an initial area of discussion of the NMTAN.

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### Principle 3

**Medical training should be provided in the most cost effective and efficient way that preserves the high quality and safety of Australia's current training system and the sustainability of the health service delivery system.**

#### 1. **How can effectiveness and efficiency of medical training in Australia be measured?**

Practitioners are the greatest resource in medicine and training is an investment in this resource. While training, doctors provide invaluable service that supports the highest level of care that patients experience through the public hospital system and in general practice.

Effectively training cohorts of medical students and doctors cannot be achieved without determining their subjective understanding of the experience they are receiving. This further builds the argument for an NTS, as discussed earlier, which would provide aggregate data on the experiences of trainees and enhance understanding of the objective data regarding training numbers and outputs.

Ensuring that there is a mechanism for input into the development of appropriate funding models in Teaching, Training and Research through the Independent Hospital Pricing Authority is an important lever to both set and measure efficiency. The AMA has worked with stakeholders and peak bodies to develop an objectives and principles document regarding funding models for medical teaching, training and research<sup>21</sup>. Using and influencing the effective price for training to create a normative context for less attractive specialty or geographic training settings would allow for the efficient use of training funding.

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<sup>21</sup> Funding models for teaching, training and research – objectives and principles  
[https://ama.com.au/system/files/funding\\_models\\_for\\_teaching\\_training\\_and\\_research\\_-\\_objectives\\_and\\_principles\\_statement\\_18\\_october\\_2012\\_0.pdf](https://ama.com.au/system/files/funding_models_for_teaching_training_and_research_-_objectives_and_principles_statement_18_october_2012_0.pdf)

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2. **How can the cost effectiveness and efficiency of medical training be improved without impacting on the high quality and safety of Australia's current education and healthcare services?**

Cost effectiveness and efficiency are inconsequential if the medical workforce is not trained to meet the future needs of the community. Aligning firstly the training pipeline to community demand and then assessing potential efficiency gains is most prudent.

The AMA supports moves by colleges to continually improve their processes when it comes to ensuring efficiency of medical training. One specific area where more work is required is the current bottleneck of un-accredited registrar positions. These positions are detrimental to the efficiency of medical training as they often supplant accredited training time by requiring that trainees be at a higher standard of competence before entering training<sup>22</sup>.

The entry bottleneck to certain specialties suggests a mismatch of integration and recognition of prevocational experience and vocational training. Junior doctors often reach a level of competency in prevocational training but are not deemed fit to meet the entry requirements of vocational training. The requirement for extraneous activities and experience, albeit reinforced by the highly competitive nature of entry to some vocational training programs, detracts from the cost-effectiveness and efficiency of medical training.

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3. **Assuming all college and accreditation requirements are met, should there be a maximum period of subsidised postgraduate training for medical trainees?**

The governance and costs of medical training are set by the respective professional and regulatory bodies along the training continuum. Limits exist at multiple levels to ensure that training does not extend beyond an agreed length; this includes the Medical Board of Australia for internship training<sup>23</sup> and colleges for fellowship training<sup>24</sup>. The greatest cost borne in the system is that of time; time by trainees as they strive to progress and time by supervisors to support this progression. Support for both parties will impact on the ability of trainees to progress.

The AMA recognises that the colleges should collect the data regarding specialty completion time and it should be reported by MTRP to provide an

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<sup>22</sup> AMA Junior Doctor Training, Education and Supervision Survey 2012 <https://ama.com.au/2012-ama-junior-doctor-training-education-and-supervision-survey>

<sup>23</sup> Medical Board of Australia: Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.  
<http://www.medicalboard.gov.au/Registration/Types/Provisional-Registration.aspx>

<sup>24</sup> Department of Health and Ageing. Medical Training Review Panel: Fifteenth Report.  
<http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-mtrp-15>

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understanding of potential barriers to training completion.

Recognising that not all medical professionals attain or desire to attain Fellowship of a relevant college is important. Working with colleges to determine if alternative endpoints to Fellowship exist would allow self-identification by trainees who would otherwise use maximum training time for ultimately limited or no reward.

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#### Principle 4

**Training requirements should be informed by relevant and up-to-date information about future service needs.**

##### 1. **How well does the current health system determine medical training requirements?**

The AMA considers that current training requirements are shaped mainly by the needs of hospitals and general practices to manage increasing acute care demands. This distorts training requirements away from prevention and other desirable qualities such as care integration between primary and tertiary facilities. The current training system therefore perpetuates a worldview based on treatment of disease rather than promotion of good health.

In expanding medical training there has been specific examples of training being linked to service requirements and not long-term community needs. This is apparent in the anaesthetic and intensive care workforces, which require large numbers of registrars but fewer consultants. These examples of 'registrar provided services' in public hospitals lead to imbalances with training numbers set to provide services at this level rather than to create an appropriately sized consultant workforce. In many circumstances this leads to underemployment of those who have recently achieved Fellowship. Specific cases, such as these, need to be recognised and training pathways managed appropriately.

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##### 2. **How well does the current higher education system determine medical training requirements?**

At an undergraduate level, AMA supports equity of access to medical education for domestic students. Any push to allow domestic full fee places in medical schools that also offer Commonwealth supported places (CSP) is irresponsible and destabilises planning for the medical workforce. There is already concern regarding the increase in medical school places and the translation of this investment into proper workforce planning. The AMA believes that domestic full-fee paying places in medicine at public universities should not be allowed.

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While there are underlying financial drivers to recruit international full fee paying students to study in Australia, the investment these students make in the health care setting is valuable and they should be treated with respect. This does not absolve governments of the responsibility for increasing the funding for medical education. International student numbers should be controlled through agreements between jurisdictions and universities to allow for appropriate workforce planning. Similar arrangements could be considered for private universities enrolling full-fee domestic students.

With these arrangements, governments could assert control over medical school intakes by the provision of capped numbers of Commonwealth supported (domestic) enrolments and an agreed quantum of full-fee (domestic and international) students.

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### 3. **What feedback mechanisms exist for reviewing these system requirements?**

There are current feedback mechanisms that the AMA strongly supports. The Medical Training Review Panel (MTRP) has been one of the strongest bodies for reviewing system requirements within medical training. Its position to advise on changes to Medicare Provider Number legislation and as a peak forum for training data collection should be continued as it has been invaluable to workforce planning and training development.

That said, MTRP's activity in recent years has dropped off and its capacity to address systemic issues in medical education and training is seriously limited. It is not sufficiently resourced to deal with the major capacity problems affecting the system. The Panel is appropriately constituted, but it is currently failing to realise its function as a key policy advisory committee. The NMTAN may be able to fill this void.

The emerging role of HWA to collect data and feedback on training requirements has been demonstrated in the development of HW2025. This role needs to be continued to support the development of training plans and give appropriate advice to government and the profession.

The specific role of the MSOD in determining the effectiveness of medical school programs is essential to the success of future workforce and education initiatives and should be integrated into formal feedback mechanisms.

The Australian Institute of Health and Welfare and the Medicine in Australia: Balancing Employment and Life (MABEL) project have niche roles to inform system requirements.

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It should be acknowledged that there is only rudimentary modeling for assessing community demand. Modeling that incorporates community need must be improved and used as a feedback mechanism for understanding system requirements.

Optimised annual workforce surveys, consolidation and review of data sources and an NTS, as discussed previously, would also serve to provide quantitative feedback on the supply of doctors and their progression along the training pathway.

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4. **How can the data and information that shapes medical training policy decisions be improved?**

Workforce and training planning is a dynamic process built on a myriad of inputs and assumptions. The development of a robust model for the future workforce and its training requirements through HW2025 must be matched by ongoing iterative development of the model in response to system inputs. The profession must be engaged to regularly challenge the assumptions upon which the model is based. This will allow for the development of training plans with appropriate and achievable targets. The NTS is one method by which this might be achieved and the data from this should be corroborated by improved reporting from jurisdictions.

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5. **In a health system that is increasingly planned at a local level, how can local intelligence and data sets be balanced with national information?**

As addressed earlier, aligning local data sets through the use of standardised tools that “feed up” a granular picture of the future medical workforce requirements can balance whole-of-population information. The experience of local areas in innovating to develop solutions to workforce and training problems also needs to be highlighted, encouraged and shared. This data should be mapped to quantitative information provided by annual workforce and training surveys.

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**Principle 5**

**Training places for Australian trained medical graduates should be prioritised over immigration of overseas trained doctors to fill workforce gaps in responding to short and long-term workforce need.**

1. **How can immigration be better managed to respond to short-term demand issues, while retaining a focus on domestic training to fill workforce gaps?**

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Australia currently utilises large numbers of international medical graduates (IMGs) to fill workforce gaps, particularly in rural and remote areas. As increasing numbers of local medical graduates progress through training and attain Fellowship, the requirement to recruit IMGs to these positions should decrease. The AMA supports this approach and has communicated with the former Minister for Immigration and Citizenship, Chris Bowen MP on the topic. The letter is attached as an appendix to this submission.

The responsibility, however, for enacting policies on international medical graduates (IMGs) still sits with jurisdictions and local hospital boards which should ensure that the recruitment of suitably trained domestic medical practitioners is prioritised over the recruitment of doctors practicing overseas. The use of integrated training networks that connect hospitals in a region has been an effective strategy at reducing the need to recruit from overseas to fill vacancies based on maldistribution and temporary deficiencies in staffing.

This approach is consistent with Australia's strategic objective of being self-sufficient in health workforce. As a developed nation, it has a responsibility to minimise its contribution to international 'brain drain'.

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2. **How can local employment actions be linked to a state and national strategy, to replace immigration of doctors with Australian trained medical graduates?**

The relationship between immigration and local employment actions is reciprocal and is detailed above. Local employment actions are regularly driven by costs which are short term and transferrable, in the case of locums, even if they undermine long-term sustainability and retention of workforce. The ability to 'fill the gap' needs to be superseded by strategies that utilise regional training networks and remote supervision to provide both flexibility in training and deliver workforce to where it is needed. HWA's work to determine the costs and benefits of immigration can be used to present a case for change to local employment actions based on better evidence than simply short-term costs.

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3. **How do we get the balance right between domestic training and skilled migration to meet current and future health service requirements?**

Australia is viewed internationally as a desirable place for medical training and practice for many reasons. The quality of training is often enhanced by the inclusion of trainees from other systems and by allowing for the sharing of Australian medical graduates to other parts of the world. This sharing of knowledge, experience and perspective is enhanced when IMGs are supported throughout their time in Australia. Their contribution to the health system and to the training of other doctors is vastly increased by structured,

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comprehensive support<sup>25</sup>. The dynamic equilibrium that currently exists is a product of long-term workforce shortage and favours skilled migration. Shifting that equilibrium to slowly favour domestic training and reciprocal international exchange is the most efficient course of action to ensure ongoing service requirements are met.

To do this requires the sharing of data between jurisdictions and organisations. The difficulty in quantifying the number of doctors at certain levels of training is evidence of the uncertainty in the training system.

The use of common nomenclature and a data capture tool throughout hospitals, primary care organisations, training bodies and the Department of Immigration to correctly identify and map the medical workforce would be a significant step forward in aligning domestic training and skilled migration.

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4. **Accepting many communities are reliant on employment of overseas trained doctors, how can the potential adverse impact on service provision be avoided as policies are adjusted?**

The premise of this statement suggests that many communities do not appreciate those doctors who currently provide a significant service that would otherwise be unavailable. Many communities are incredibly appreciative and attached to 'their' doctor. This practitioner often carries great respect and adulation for the service they provide. The AMA does not support replacing established overseas trained doctors providing essential services with local graduates. The implication of this statement, that these doctors provide a substandard service is unjustifiable. Instead the AMA believes that policies should concentrate on reducing the 'pull' the factor that attracts overseas doctors in the first place and increasingly use graduates of Australian medical schools to fill these positions.

In many localities, supporting an IMG with a locally trained doctor to provide cover, reduce fatigue and promote safe practice is ideal. This can over time provide a phased transition between practitioners and not leave communities languishing with the replacement of one doctor with another. The bond between practitioner and community must be supported for a new generation of locally trained doctors through stable incentives and coordinated support from larger regional and metropolitan centres.

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<sup>25</sup> Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors.  
[http://www.aph.gov.au/Parliamentary\\_Business/Committees/House\\_of\\_Representatives\\_Committees?url=haa/overseasdoctors/report.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm)

## Section 3: What are the key functions of the NMTAN?

### Consultation questions

#### Function 1

The NMTAN should provide a mechanism to link governments, professions, employers, colleges and universities.

1. **Is this the right mix of members or should others be considered?**

Linking those stakeholders who have an appreciable impact on medical training in Australia through the NMTAN is the right approach. The proposed representatives to NMTAN are comprehensive but ultimately membership of the body should be flexible to reflect the dynamics of the sector.

Given that MTRP is similar in size and composition, the successes and failures of this committee should be considered when determining the form that MTRP will take.

Inevitably NMTAN will have a large number of members. Strategies that utilise the members appropriately whilst avoiding the inefficiencies of overly large committees need to be developed in parallel with considering membership.

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2. **What are the benefits and drawbacks of having the National Medical Training Advisory Network of this size?**

The NMTAN needs to be appropriately constituted to make recommendations and decisions regarding medical training. To be adequately informed the NMTAN needs to comprise a large pool of stakeholder representatives. Admittedly, having such a significant number of representatives is likely to limit the flexibility and efficiency of this body.

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3. **How should the National Medical Training Advisory Network be managed and operationalised to maximise impact?**

Support for the NMTAN is essential to its ongoing impact. It has been demonstrated by other peak medical consultative forums that without strong secretariat support, a clear, prioritised and achievable work program and regular reporting on progress that impact wanes dramatically. Setting aside time, resources and personnel for considered evaluation of activity is also desirable.

The structure of NMTAN is central to its ability to provide relevant advice. As previously discussed, comprehensive stakeholder engagement is essential however a large group is likely to become unwieldy and bureaucratic which is

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not in the interests of pursuing timely policy advice and decisions. These limitations might be mitigated by the use of subcommittees and a management committee.

A 'subcommittee' structure, based around areas of expertise may provide a useful means for maximizing effectiveness of a large membership. Each subcommittee could then nominate several members for the executive committee that would provide a sign off for policy. There are two organisations, the AMC and MTRP, which have similar membership to that envisaged by NMTAN. Much can be learnt from their structures and their policy output.

The full committee of NMTAN would be convened to give final sign-off for particular pieces of work that spanned large sections of medical training or represented significant policy change. Initial meetings of NMTAN would likely involve the full committee as priorities were established.

Healthcare is politically sensitive and therefore the work of NMTAN should be transparent with training plans published with clear targets for training intakes that can be monitored and reported against annually through a separate body such as the Medical Training Review Panel.

As discussed previously, the AMA believes that to be effective this body must have the ability to do more than provide advice and that significant NMTAN decisions are elevated to the level of ScOH and COAG to achieve coherent and coherent jurisdictional policy in medical training.

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4. **In a system that is becoming increasingly regionally devolved, how can a national approach add value?**

Regional approaches must be integrated into and aligned with national policy. As an example, no single region can know whether workforce self-sufficiency is being achieved and hence using consistent tools across regions that allows regional understanding of national plans will add significant value through the NMTAN.

In addition, specialty training programs are increasingly nationalised and many applicants apply for positions in other jurisdictions. Interstate rotations are also required in several disciplines. Each year, more and more medical graduates apply for internships in other jurisdictions, further complicating regional workforce planning.

The same issues are evident when examining the disconnect between the public and private sectors as well as the hospital and primary care sectors. Each of these groups needs to be represented within the NMTAN to allow coordination of medical training in a cohesive fashion.

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Whilst the regional devolvement is important NMTAN can add significant value by providing co-ordination to this process both through policy recommendations and data collection.

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## Function 2

**The NMTAN should develop medical training plans informed by analysis of information and quality data sources to identify future workforce supply**

### 1. **What would be the best approach to accessing and collating such data?**

The AMA strongly supports the development of five year medical training plans. The data sub-committee of the Medical Training Review Panel has developed excellent knowledge regarding the available data sources and their expertise should be utilised.

Workforce requirements are driven by community demands. NMTAN should not be in charge of modeling future demand. Expert advice from NMTAN should support the development and revision of demand models, with cross referencing against data derived from health services and peak bodies,. Explicit consideration should be given to moving away from demand models that focus on practitioners as a primary determinant of system demand.

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### 2. **How can service planning information, and therefore workforce requirements, be best accessed to inform national considerations of medical training?**

The AMA recognises that including jurisdictions in NMTAN will give greater exposure to their service planning rituals. The use of a COAG agreement to commit jurisdictions to funding training should also include publication of jurisdictional service planning information. There should be a process by which this workforce planning is fed up to NMTAN. The use of consistent tools to assess demand and the requirements for service should allow for harmonization of data from regional and national levels. Local service innovation can drive revision of workforce requirements in consultation with relevant bodies.

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### 3. **Where are the anticipated data gaps that need to be filled and how can they be filled?**

HWA's development of a national clearinghouse for health workforce data is a first step towards determining the data gaps that potentially exist.

Most obvious of the current gaps that have been identified is whether the current workforce is adequate for community demand. The assumption from HW2025 was that workforce supply and service demand were currently in

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balance, which is not consistent with anecdotal reports. That assumption will have significant downstream effects on future workforce projections and must be rectified through thorough analysis of qualitative data. The AMA supports this as a priority goal of HWA and NMTAN, which can be derived through consultation with the profession. Current evidence also suggests that measures of the impact of changes in productivity and service models are inadequate.

On the supply side, there are large data holes in relation to prevocational trainees, unaccredited registrars and career medical officers. These must be urgently addressed in order to develop accurate training plans and workforce projections.

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4. **Where key data sets are unavailable, what approach should be adopted to get the necessary information?**

Deciding on which data sets are unavailable first requires the determination of which data sets are available, reliable and contemporary. The synergistic insights from the collation of data are unknown at this time and may well remove the need for the development of new data sets but rather prioritise meta-analysis, literature and data review as achievable short term approaches. Comments have also been made above about the annual workforce surveys might be optimised, and an NTS introduced to capture accurate trainee data.

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### Function 3

#### The NMTAN's rolling five-year medical training plans should consider employment demand

1. **How well do the potential elements identified in the training plans meet national, regional, enterprise or sectoral needs?**

The suggested elements appear appropriate.

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2. **How could the training plans recognise the changing dynamics of the health system including reform and innovation?**

Variance against the training plan would be a key insight into the dynamics of the health system. With no current high-level training plan variances are not analysed and there are few mechanisms by which to redress problems. Regular reporting against training plans would provide this mechanism.

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At a health system level reform is often driven by service delivery with benefits or consequences to training an unintended by-product. An early priority of NMTAN would be to utilise a sentinel site (see the Menzies School of Health policy review of sentinel sites for the Indigenous Chronic Disease Package<sup>26</sup>) approach for evaluation of reforms and current innovation. Building this in to the training plans allows for ongoing qualitative research rather than retrospective analysis. This builds a richer picture of why certain outcomes occurred and what innovation was required to achieve better outcomes.

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3. **What additional issues should the plans consider to meet national, regional, enterprise or sectoral needs in the short, medium and long term?**

The AMA believes that training plans should recognise the value of training, trainees and the positive culture and workplace changes that having trainees promotes. Changing the approach of health services to training would be a significant achievement.

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4. **What areas should be outside the scope of National Medical Training Advisory Network advice?**

The NMTAN should provide advice regarding the quantum of training that is required and mechanisms by which that training is incorporated into service delivery.

There is no place for NMTAN to supplant the role of the colleges and post-graduate medical councils or their equivalent in setting training standards or administering accreditation for their trainees.

Keeping those functions at arms length protects the system and importantly reduces the opportunity for 'scope creep' over time. The basic medical education system, with its diversity of entry points and degree lengths, is appropriately accredited against global outcome requirements by the AMC and should also remain outside the scope of NMTAN advice.

As an extension of training requirements and professional standards, continuing professional development is an area that is not currently within the scope of NMTAN advice and should remain as such.

Finally, the pricing of training should also be out of scope of NMTAN. However,

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<sup>26</sup> Department of Health and Ageing: Indigenous Chronic Disease Package Monitoring and Evaluation Framework <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ICDP-monitoring-and-evaluation-framework>



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NMTAN should be intimately involved in the development of models to price training with IHPA.

### **Final comment**

The AMA is an independent peak body representing the medical profession at all stages of their medical training and continuing practice. While the proposal for a National Medical Training Advisory Network is a positive development the implementation of such a body will require meaningful engagement with the medical profession. The AMA is supportive of NMTAN as a concept and recognises the need for a consistent policy function to advise government regarding long-term medical workforce and high quality training requirements.

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