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Dear Mr Hallinan

Assessing the distribution of medical school places in Australia

The AMA welcomed the opportunity to present its views on the distribution of medical school places at the recent meeting of the National Medical Training Advisory Network. Given the importance of the structure of medical training to Australia's future medical workforce, we have also prepared the attached formal response to the Department's *Summary facts and discussion paper*.

The AMA believes that the redistribution of medical school places, of itself, will not do anything to address workforce shortages. The Government needs to take a longer-term view and recognise that unless additional postgraduate training places in rural areas and undersupplied specialties are made available, addressing workforce shortages in these areas will remain an elusive goal.

If the Government does intend, as a result of this review, to consider redistributing medical school places, the following criteria should be applied:

- overall student numbers are not increased,
- the redistribution is an evidenced-based process that takes into account infrastructure requirements, selection criteria, and there are assurances on the availability of quality supervision and appropriate resources for teaching, and
- it is linked to efforts to improve the downstream availability of postgraduate training places.

Thank you for the opportunity to raise these issues with you.

Yours sincerely

Dr Michael Gannon
President

Dr John Zorbas
Chair, AMA Council of Doctors in Training

Current trends

1. What are the current trends in medical education and training, across all stages of medical training, and the implication of these trends for the training of doctors?

Australia has seen dramatic growth in medical student numbers, with around 3,700 domestic and international students now graduating each year. This compares to 1,426 graduates in 2002. In terms of postgraduate medical education, there are sufficient intern places nationally to provide all domestic medical graduates with an intern place, although circumstances in each state and territory vary, so graduates may not be able to get access to an intern place in the jurisdiction they trained in. Around 200 medical graduates (internationals) who could contribute to the Australian medical workforce cannot get an intern position.

Of great concern to the AMA is the growing 'bulge' of prevocational doctors, which reflects a shortage of first-year vocational training places. The former Health Workforce Australia (HWA) predicted a shortage of 569 places by 2018, and noted the need for prevocational trainees to acquire various experiences and qualifications to be competitive in college selection processes.

We are also seeing the emergence of the phenomenon of 'exit block', where recently graduated Fellows stay in training positions that would otherwise be filled by specialist trainees because of the lack of consultant jobs.

There is strong support for more generalist training, although the approach to this is relatively fragmented and there is little evidence that the trend towards sub-specialisation has changed. In the last few years, we have seen specialist workforce numbers increase rapidly in comparison to general practice to the extent that (other) specialists now make up bigger proportion of the medical workforce than GPs. It is important that more modelling is undertaken on the future demand for generalism.

The introduction of postgraduate medical schools in recent years means that the age at which some doctors become fully qualified is increasing. These doctors will be more likely to have established home and social networks that are not easy to leave and could be less able to work in underserviced areas of the country, potentially undermining attempts to address workforce issues.

2. How effectively does the current distribution of medical schools with CSPs address workforce need, particularly in regional, rural and remote areas?

The AMA's observation is that the creation of new medical schools over the past ten years has not always been linked to proper workforce planning. For example the establishment of Curtin Medical School in metropolitan Perth was allowed to proceed despite opposition from the profession and specific DoH, HWA and NMTAN recommendations against it.

The distribution of medical schools and places is only one factor in addressing workforce need in regional, rural and remote areas. The availability of prevocational and vocational training places is also critical, along with the prospects of long-term employment in these areas. Other factors such as remuneration, accommodation, access to education for family members, professional development and various forms of leave are also critical.

There is some evidence to suggest that graduates of medical schools that have rurally oriented selection and clinical training (such as James Cook University) are more likely to work in rural areas after graduation, but this effect diminishes over time – potentially a result of the lack of postgraduate training places in rural areas.

Evidence also suggests that students from rural backgrounds and/or those who train in a rural area (12 months) are more likely to practise in a rural area. This suggests that Rural Clinical Schools, enrolment targets for students with a rural background, and requirements for students to spend extended periods in rural clinical settings are effective policy measures that should be built on.

With regard to bonded medical places, there is no evidence to show that they have had any impact on rural workforce shortages so far, with only a limited number of BMP graduates completing their return-of-service obligations to date.

3. How would expansion, reduction or redistribution of medical schools/medical places, to target regional/rural/remote health care needs, impact on the number of doctors practising in these locations?

The AMA believes that Australia has sufficient numbers of medical graduates and medical school places should aim at the current levels until reliable modelling indicates otherwise. Any measures that are designed to redistribute medical school places must be evidence-based, as opposed to addressing political pressure or designed to achieve short term political gain.

Redistributing places on its own will do little to address medical workforce shortages if the downstream postgraduate medical training places are not available. Ensuring the availability of these places is critical.

4. What key factors should be considered to achieve a sustainable, well distributed medical workforce that provides access to quality medical services in all remoteness areas, and which factors are most relevant to future allocation of medical Commonwealth supported places/schools?

There are a range of factors supported by the literature and feedback from our members including:

- selection of students with a rural background,
- training in a rural clinical setting,
- access to supervision,
- quality infrastructure,
- post-graduate training places,
- adequate clinical experience,
- various workforce incentives,
- access to professional development,
- leave, and
- family employment and educational opportunities.

The AMA has developed a number of policy positions for improving the sustainability and distribution of the medical workforce. These include:

- lifting the targeted intake of medical students from a rural background from 25 per cent of all new enrolments to one-third of all new enrolments,
- lifting the proportion of medical students required to undertake at least one year of clinical training in a rural area from 25 per cent to one-third,
- establishing a Community Residency Program for prevocational doctors to provide three-month GP rotations in rural areas, which we believe would be far more effective than the current proposal to fund 240 three-month rotations for interns,
- expanding the Specialist Training Program to 1,400 places per annum (from 1,000 in 2018), with a strong emphasis on rural placements, and
- establishing regional training networks, that will enable graduates to complete most of their training in rural areas. We note that the Government is proposing something similar with its rural training hubs model, though we have not seen much in the way of details of this proposal.

5. What role can/should full fee paying places (international and/or domestic) play in addressing medical workforce need?

The AMA believes strongly that full-fee paying places will not address medical workforce need as students with high debt will be likely to enter higher paying medical specialities in metropolitan areas rather than choosing specialties and locations where shortages exist.

In relation to international medical students, while there is some evidence that around two-thirds intend staying in Australia, we have not seen hard evidence that this intention translates to reality.

Clinical training

6. Is clinical training for medical students geographically well distributed, or are changes needed?

Establishing Rural Clinical Schools and requiring at least 25 per cent of medical students to complete at least 12 months clinical training in a rural area are positive measures, with the AMA proposing that the latter should be lifted to one-third.

There is no evidence to suggest that the current requirement for at least 50 per cent of students to complete a rural training experience of at least four consecutive weeks during their degree course is having any effect. The AMA believes it would be appropriate to direct the resources needed to underpin this requirement to boosting Rural Clinical Schools, higher enrolment targets for students with a rural background and boosting the number of students completing at least 12 months clinical experience in a rural area.

7. What are the key factors to providing, and improving, high quality clinical training experiences, in particular in remote and very remote Australia?

For medical students in these areas, the key factors are:

- supervision,
- mentoring,
- infrastructure,
- exposure to a variety of clinical experiences,
- quality and safe accommodation, and
- rotations/placements should be at least 12 months in duration.

8. What is the availability, including constraints, on clinical supervision, and/or pressures on clinical supervisors (across the stages of medical training, from medical school through to postgraduate training and/or across different remoteness areas)?

There appears to be the capacity to provide more clinical supervision, but this is hampered by:

- funding pressure on public hospitals, where it is increasingly difficult to balance service delivery and training,
- lack of recognition of the role of supervisors – both financially and professionally,
- limited support for supervision in expanded settings,
- available infrastructure, particularly in rural areas,
- limited recognition of the role doctors in training can play in this area, and
- workforce pressures, particularly in rural areas.

<u>Rural training during the medical school years</u>

9. What is the best available evidence on medical school programs, extent of their rural focus, and influence on doctors ultimately working in areas/locations of workforce need?

To our knowledge, no large country has developed a package of policy initiatives that have been shown to completely address problems in maldistribution of the medical workforce; however, the available evidence indicates that early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas. (See also our responses to questions six to nine.)

10. In some rural locations multiple universities are providing rural training for their medical students. Are these arrangements effective and/or how are universities working together (and with health services)?

The AMA is not in a position to comment on these arrangements in any detail, but it appears that collaborative arrangements are generally in place.

11. What are your views on running a full medical program in one specific geographic location, compared with more dispersed models of delivery, for achieving a sustainable well distributed medical workforce across all remoteness areas?

Australian Medical Council standards effectively dictate that medical students should graduate with the broad skills required for entry into the internship year. This requires access to relevant clinical experiences and we are not aware of any medical school currently delivering all of these in one geographic area. Again, it is important to emphasise that medical school is only one part of the training pipeline. Attempts to adjust the distribution of medical school places will not have the desired long-term impact in the absence of a strategy to increase postgraduate training places in rural areas.