



Australian Medical Association

AMA

Medical Workforce & Training Summit, 3 March 2018

Australian Medical Association
**Medical Workforce &
Training Summit Report**



3 March 2018, AMA Victoria, 293 Royal Parade, Parkville



Introduction

The AMA Medical Workforce and Training Summit was held at AMA Victoria in Melbourne on 3 March 2018.

More than 80 key stakeholders took part in the Summit to discuss key medical workforce challenges and how to better meet community need. This included a lack of training places for medical graduates, the maldistribution of the medical workforce, under- and over-supply in some specialty areas, and the long-standing imbalance between generalist training and sub-specialisation.

The Summit brought together representatives of doctors in training, rural health groups, medical schools, prevocational and specialist training bodies, private healthcare organisations, medical registration and accreditation agencies, State AMAs, and Commonwealth, State, and Territory Health Departments.

The Summit Program and a list of organisations who attended the Summit is provided at Appendices 1 and 2 respectively.

Key outcomes

The principal outcomes from the Summit were:

- Strong agreement that current workforce data does not support the establishment of any new medical school places, and for the Commonwealth to ensure that medical student numbers continue to be regulated to match community need.
- Strong support for greater collaboration between Commonwealth and State/Territory Governments in planning workforce, training, and future care delivery models to meet community need.
- Broad support for the development of alternative hospital employment models to better align service delivery and workforce requirements with training requirements and community need.
- Strong support for establishing a general set of competencies for all doctors in training that will allow the medical workforce to respond to community requirements, and facilitate generalist careers across disciplines.
- Support to explore the provision of longer-term employment contracts to create security of employment for all trainees, and, in particular, for trainees in rural and regional areas as an incentive to live, work, and train in those areas.
- Strong agreement that workforce planning must continue to be informed by national systematic collection, analysis, interpretation, and reporting of medical workforce supply data.
- Strong support for the Council of Australian Governments (COAG) to take greater responsibility to align government policy and medical workforce planning with the long-term health needs of communities, and for this to form part of the next National Health Reform Agreement.
- Strong support for reforming governance arrangements for training providers that place greater accountability on them to be training a 'fit for purpose' medical workforce.



And specifically, in relation to developing a rural medical workforce:

- Broad support to build on existing regional training infrastructure to create networked training models that support trainees to live, work, and train in rural and regional areas.
- Support for College selection into training processes that give additional weighting to rural origin and exposure, supported by dedicated training pathways in rural and regional areas.
- Strong support for the development of a clear national rural generalist pathway, beginning in prevocational training, underpinned by a national set of competencies and informed by community need.

The Summit

The Summit was opened by Federal AMA President, Dr Michael Gannon. Dr Tony Bartone, Federal AMA Vice President, provided an overview of the background to the Summit, noting the Summit had been convened to discuss how to ensure we are training a sustainable 'fit for purpose' medical workforce aligned with community need.

In Panel Session One, Mr Phil Truskett, Chair, Council of Presidents of Medical Colleges, discussed access to training places, innovative practices to expand training places, rural workforce and training issues, and whether the way we train needs to change. Professor Brendan Murphy, Chair, National Medical Training Advisory Network, explored issues of medical workforce under- and over-supply, distribution, our reliance on international medical graduates (IMGs), trends in requirements for entry into vocational training, and options to reconfigure the service workforce in hospitals to better meet training needs. Dr Alex Markwell, Co-Director, Emergency Medicine Training, Royal Brisbane Women's Hospital, discussed data on supply and demand as it related to Emergency Medicine, her experiences as a supervisor, the importance of flexible work and training arrangements, and options for alternative models of emergency medicine practice.

The ensuing discussion highlighted three immediate challenges facing medical workforce planning in Australia:

- An immediate need to provide training places for increasing numbers of medical graduates.
- An imperative to reorient current medical workforce planning, training, and hospital service delivery models to meet future health and community care needs.
- Consideration of how to rebalance our historical reliance on IMGs to meet service delivery needs using a locally trained medical workforce.

In Panel Session Two, Dr John Zorbas, Chair, AMA Council of Doctors in Training, facilitated a discussion that explored medical workforce distribution, College approaches to workforce issues, the development of an integrated national rural generalist training pathway, and the potential to leverage off regional training hub infrastructure to support training in rural and regional centres.

Some of the key issues discussed during this session were how to:

- Balance the requirement to train doctors to meet community needs with the service needs of hospitals.
- Provide certainty and security of employment for prevocational and vocational trainees.
- Enhance rural training opportunities for vocational trainees.



Key themes emerging from Panel Session Two discussion were:

- The challenge for Australia is to ensure there are sufficient numbers of doctors and other health professionals who have the skills and commitment to provide care where it is needed, most particularly in undersupplied specialties and in underserved remote, rural, and regional areas.¹
- The focus needs to shift away from increasing medical school places towards delivering postgraduate training places in the areas and specialties where they are needed, and giving medical graduates more opportunities to live, work, and train in rural and regional areas.
- A key consideration is the mix of generalists and specialists geographically, between specialties and within specialties.¹
- Thought needs to be given to how training pathways can evolve to meet the healthcare needs of communities, such as mental health or aged care, rather than the service workforce needs of hospitals.
- Health systems with a strong comprehensive primary health care sector are the most efficient and effective, both in terms of overall costs and generally healthier populations.¹
- A 'fit for purpose' workforce is one that produces medical graduates with the competencies and enthusiasm to provide the right care in the right place at the right time.
- Current workforce supply arrangements involve many stakeholders and components that are not well connected to one another.¹
- A whole of government approach is required to review health service models, training pathways, and employment arrangements to better align medical workforce and training with community requirements.
- Sustainable financing is a critical issue and will be for a long time, recognising workforce is a key driver of financing.
- Colleges need to focus on how to train doctors with the skills and commitment to provide care where it is needed most, particularly in underserved rural and regional communities.
- There should be a greater emphasis on rurally based training programs with educational curricula that develop generalist skills.
- Employment arrangements need to ensure year by year continuity of employment for trainees, beginning in the prevocational training years.
- There was unequivocal support for an integrated national rural generalist training pathway that extends across medical disciplines.
- Training programs need to incorporate flexible supervision and training models. This is important for all trainees, but is particularly important to support doctors who live, work, and

¹ Strasser RP. Will Australia have a fit-for-purpose medical workforce in 2025? *Med J Aust* 2018; 208 (5): 198-199.



train outside of metropolitan areas. The development of functional links between regional training hubs, networks, and existing training infrastructure is integral to this.

In the afternoon, Summit attendees considered a number of topics at individual tables, and identified key ideas and strategies to address the following areas:

1. Medical school places.
2. Training targets.
3. Promoting generalism.
4. Rural training terms.
5. International medical graduates.
6. A National Rural Generalist Pathway.
7. Addressing undersupplied specialties.
8. Incentives for rural training.
9. Commonwealth and State/Territory collaboration.

The final session utilised polling technology that enabled all Summit attendees to indicate preferred strategies to address each area. The end result was a list of preferred strategies to address key challenges in medical workforce and training, including distribution of the workforce both between and within specialties, and geographically. The results of this polling are provided at Appendix 3.

Summary

1. Medical school places

There was a general consensus among Summit attendees that current workforce data did not support the establishment of any new medical school places. In the audience polling undertaken, there was significant support to impose a moratorium on funding any new medical school places. This result was even more pronounced when analysed on a first-choice basis.

Summit attendees also indicated strong support for the Government to introduce legislation to regulate the establishment of any additional full fee paying medical schools and places, and for every medical graduate to be guaranteed an internship at the end of training.

Attendees agreed the establishment of any new medical school places would divert training resources away from where they were most needed i.e. more prevocational and vocational training places, and would push more graduates into a training pipeline already overwhelmed by existing medical graduate numbers.

There was support for every medical graduate to be guaranteed an internship at the end of training. This is in keeping with a view that:

- The intern year is, in reality, the final year of basic medical education.
- Governments should take a proactive role in ensuring the provision of intern positions for all graduates.
- We should reduce our reliance on IMGs and harness the benefits of a larger locally trained medical workforce.



2. Setting training targets

Summit attendees discussed the current situation of under- and over-supply in some medical specialties, and the difficulties experienced by some graduating fellows in finding employment at the end of training. There was general support for developing a 'fit for purpose' workforce with the right skills to provide the right care in the right place at the right time.

Audience polling indicated broad support for a whole of government approach to planning future care delivery models to meet expected community need, and for governments to collaborate on workforce planning, training, and coordination to meet that need. Strong support for this result was further reflected in first choice analysis.

Summit attendees agreed that alternative hospital employment models were needed to better align service, workforce, and training requirements, and to address imbalances in specialty training numbers.

There was also support to explore opportunities to shift to competency-based instead of speciality-based job descriptions to better align training requirements with community need.

3. Promoting generalism

Whether we are training the right mix of generalists and specialists across and within disciplines was a key consideration for Summit attendees. Attendees agreed the trend towards centralised, sub-specialised care is not always in the best interests of the patient or cost effective for the health system. There was broad support for the development of generalist skills throughout training and across all disciplines to create a more adaptable medical workforce, and to support generalist career paths in specialist training.

Polling indicated significant support for the recognition of a general set of competencies for all doctors as the most preferred strategy for action to promote a generalist career. This was reinforced on a first choice basis.

There was also strong support for the development of strategies to break the nexus between hospital workforce needs and specialty training numbers. Attendees acknowledged this would require a review of service delivery and employment models, prevocational and vocational training program content, and current methodology for allocating and accrediting training posts.

Summit attendees also indicated support for mandating and resourcing general practice experience for prevocational doctors early in their training.

4. Rural training terms

Summit attendees were asked to consider existing strategies and future opportunities for Colleges to establish and promote training pathways in rural areas.

There was broad support to build on the existing regional training hub infrastructure to create networked rotational training models characterised by:

- A clear enunciation of the expectations of rotated rural/regional training.
- Longer-term employment contracts for trainees recruited to rural areas.



- Mentored supervision.
- Accreditation of training posts.
- Rotation into metropolitan centres for advanced training.
- Incentivised selection for trainees with rural background and/or experience.

Attendees noted successful rotational training models already in place in the field of anaesthesia in Tasmania and surgery in Victoria.

Consideration was also given to whether alternate models of supervision could provide greater flexibility in establishing training pathways in underserved areas/areas of need while continuing to meet training program and accreditation standards.

In considering other models, Summit attendees noted the success of the Canadian Resident Matching Service model, where residency training, post medical school, consists of two to five years of postgraduate medical education and clinical service. Under this model, as long as the resident meets requirements, employment is guaranteed for the entire training program, with no need to re-apply each year.²

Summit attendees indicated a clear preference for College selection into training processes to give additional weighting to rural origin and exposure, with access to dedicated training pathways as a key strategy to encourage doctors to live, work, and train in rural, regional and remote areas. An overwhelming 41 per cent of Summit attendees polled indicated this as their first choice.

Audience polling revealed strong support for the provision of longer-term registrar contracts to provide certainty of employment for all trainees, but particularly for trainees in rural and regional areas, as a strategy to encourage trainees to train in those areas. This was followed by support for the development of alternate models of clinical supervision to support trainees to live, work, and train in rural and regional centres.

There was also support for greater collaboration between Commonwealth, State, and Territory Governments to better align service, workforce and training requirements, and allocation of training places with community need. This emerged as a consistent theme throughout the Summit, and is consistent with a push towards workforce planning based on the premise of social accountability, rather than the service workforce needs of hospitals.

5. International medical graduates (IMGs)

Summit attendees recognised the substantial contribution that IMGs make to the medical workforce and delivery of health care in Australia, particularly in providing patients with access to care in under-served communities, including rural and remote areas of the country. Attendees agreed it was important that appropriate, clearly defined, and transparent standards are in place to oversee the assessment, recruitment, and training of IMGs, and that every effort should be made to support IMGs to enhance their contribution to the medical workforce.

² Canadian Resident Matching Service. <https://www.carms.ca/en/> (accessed April 2018).



At the same time, there was a view that, given the increase in medical graduate numbers, medical workforce planning should aim to reduce any unnecessary reliance on IMGs while maximising the use of a locally trained medical workforce to meet community need.

Audience polling revealed Summit attendees were evenly divided about what actions were required to balance IMG intake and domestic training numbers with the end goal of developing a sustainable medical workforce.

When analysed by first choice, ensuring that IMGs who work in rural and regional areas are appropriately credentialled to meet the care needs of the community was identified as the first priority for action.

6. A National Rural Generalist Pathway

The Summit acknowledged that health systems with a strong comprehensive primary health care sector are the most efficient and effective, both in terms of overall costs and generally healthier populations. There was strong support from Summit attendees to develop a dedicated and integrated national rural generalist pathway (NRGP), starting from medical school and extending across prevocational and vocational training.

In particular, Summit attendees discussed the lack of exposure to rural generalist training in prevocational training following the abolition of the Prevocational General Practice Placements Program (PGPPP), and subsequent lack of exposure to a future career as a rural generalist.

There was some support for a NRGPs to span across disciplines, with all doctors developing competencies across a broad scope of practice to allow them to respond to changing community needs.

Audience polling indicated strong support for a NRGPs that was underpinned by a clear framework and supported by a national set of competencies. There was broad support for the development of a dedicated prevocational rural generalist pathway in collaboration with the Colleges.

There was strong agreement from Summit attendees that a NRGPs should be informed by the needs of rural communities and that the resulting pathway, standards, and competencies should be developed to meet those needs.

Once again, this is consistent with a general emphasis throughout the Summit on training a 'fit for purpose' medical workforce with the skills to meet community need, such as maternity services or cancer care, rather than the service workforce needs of hospitals.

7. Addressing undersupplied specialties

Summit attendees considered what strategies were needed to encourage doctors to work in undersupplied specialties. Attendees discussed the strong societal contract that all of government, health services, and Colleges had to train and employ doctors to meet community needs. Attendees affirmed the importance of a NRGPs as part of a suite of strategies to improve access to care and services for underserved rural, regional, and remote communities.



The importance of managing the career expectations of trainees early on in their career paths was also discussed, as was providing safe, respectful, and flexible training opportunities, pathways, and work environments in all specialties.

Audience polling revealed strong support for ongoing access to meaningful data to guide workforce planning and service development, including workforce supply, areas of need, disease prevalence and the impact of changing models of care as the first priority for action from policy makers. This result was even more pronounced when analysed on a first-choice basis.

The following strategies were supported by Summit attendees to address undersupply in specialities/areas:

- The provision of early career counselling across the medical training continuum.
- Managing career expectations and promoting training opportunities in undersupplied specialties/areas.
- Longer-term employment contracts to create security of employment.
- The development of contemporary work models e.g. regional training hubs, tele-health, training in expanded settings.
- Support for a NRGPs to promote a career as a rural generalist.

8. Incentives for rural training

Summit attendees considered how to create a strong rural training pathway and noted there was significant medical student 'buy in' to train in rural areas, with internships in regional areas oversubscribed.³

Audience polling indicated clear support for the development of a NRGPs, beginning in internship and extending over a 2-5-year period on the basis that training requirements are met. Further analysis revealed 36 per cent of attendees voted for this as their first choice.

Summit attendees strongly supported Colleges having selection into training processes that gave greater weight to selecting trainees into their programs from a rural background or with rural experience. This is another common theme emerging from the Summit, and is supported by evidence that shows doctors who come from a rural background and/or spend time training in a rural area are more likely to take up long-term practice in a rural location.

There was also broad support from Summit attendees polled to leverage off the regional training hub model to create rural training pathways in prevocational and vocational training. The importance of identifying regional and rural champions in the success of this model was also highlighted.

9. Commonwealth and State/Territory collaboration

Summit attendees unanimously agreed that a whole of government approach was required to improve workforce planning, training, and coordination.

Audience polling revealed strong support for COAG to take responsibility for better aligning medical workforce and training requirements with community need, and that this should be placed on the next

³ Australian Medical Students' Association verbal communication. 3 March 2018.



COAG agenda. There was strong support to leverage the next National Health Reform Agreement to fund additional prevocational and vocational training places.

Reforming governance arrangements for training providers to increase their accountability to train a 'fit for purpose' medical workforce without reducing standards was also strongly supported by audience polling.

Other challenges and issues

Other issues raised as important to consider were:

- The need to review the efficiency of current clinical practice with a view to trying to predict the next paradigm change in medicine and technology, which could influence workforce and training requirements, service delivery, and community care needs.
- The wellbeing of doctors and medical students is paramount to a sustainable, 'fit for purpose' workforce. This will be a significant driver of workforce planning, training, and service delivery moving forward, and the consequences of any changes in workforce planning, training, or service delivery must be considered in this context.
- Providing access to flexible work practices and training pathways will be central to building a sustainable medical workforce.

Next steps

The AMA Medical Workforce and Training Summit 2018 generated constructive debate and resulted in a range of ideas and strategies to tackle key medical workforce and training challenges, many of which had broad support. Many of these already feature prominently in AMA policy with the Summit reinforcing the need for the AMA to continue to pursue these proposals. However, many new ideas emerged from the Summit and the AMA will take those into account when developing new policy and in its planned review of the AMA Position Statement on Medical Workforce and Training.

The AMA would like to thank all Summit attendees for providing their expertise and insight into the key issues impacting on medical workforce and training and community access to services, and the actions we might take to address these issues.

Further comments on the Summit and this Report are welcome and can be directed to:

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Australian Medical Association
E: whough@ama.com.au



Appendix

Appendix 1: Summit Program

Appendix 2: Summit Attendance

Appendix 3: Summit Polling Results



Appendix 1: Summit Program

<p>9:30 – 10:00am</p>	<p>Registration & Morning Tea</p>
<p>10:00 – 10:10am <i>(10 minutes)</i></p>	<p>Welcome to AMA Victoria Dr Lorraine Baker President AMA Victoria</p> <p>Welcome to Summit Dr Michael Gannon President Australian Medical Association</p> <p>Overview by Summit facilitator Dr John Zorbas Chair AMA Council of Doctors in Training</p>
<p>Panel Session One – Setting the scene. Chair: Dr Tony Bartone</p>	
<p>10:10 – 11:25am</p>	<p><u>Speakers:</u></p> <p><i>College perspective:</i> Mr Philip Truskett Chair-elect Council of Presidents of Medical Colleges</p> <p><i>Medical workforce perspective:</i> Professor Brendan Murphy Chair, National Medical Training Advisory Network</p> <p><i>Training perspective:</i> Dr Alex Markwell Emergency Physician, Co-Director Emergency Medicine Training Royal Brisbane Women’s Hospital</p>

**Panel Session Two – Building a sustainable medical workforce. Chair: Dr John Zorbas**11:25am –
1:15pm**Speakers:***Integrated training pathways:*

Dr John Keenan
Senior Medical Adviser, Office of the Chief Medical Officer
Department of Health, Western Australia

Training hubs and workforce distribution:

Mr Dave Hallinan
Health Workforce Division
Department of Health

Professor Robyn Langham
School of Rural Health
Monash University

Expanded settings:

Dr Daniel Heredia
Deputy Chief Executive Officer & Director of Medical Services
Hollywood Private Hospital, Ramsay Health care

College perspectives

Dr Simon Judkins
President
Australasian College of Emergency Medicine

Professor Ruth Stewart

President
Australian College of Rural and Remote Medicine

1.15 –**Lunch 30 mins****1:45pm****Session Three – Break-out sessions**1:45 –
3:30pm

Smaller Group discussions, with each having specific questions to answer. Report back to group on findings.

Session four – Where to from here?3:30 –
4:00pm

Led by: Dr Tony Bartone, Vice President, Australian Medical Association
Identification of priorities for the way ahead.

4:00 –
4:45pm

Post-Summit Networking: Catch up with colleagues post-summit to continue the discussion and discuss other areas of interest.



Appendix 2: Summit Attendance

AMA Australian Capital Territory
AMA Council of Doctors in Training
AMA Council of General Practice
AMA Council of Private Specialist Practice
AMA Council of Public Hospital Doctors
AMA Council of Rural Doctors
AMA Federal Secretariat
AMA Federal President
AMA Federal Vice-President
AMA New South Wales
AMA Northern Territory
AMA Queensland
AMA South Australia
AMA Tasmania
AMA Victoria
AMA Western Australia
Austin Health
Australasian College for Emergency Medicine
Australasian College of Dermatologists
Australasian College of Emergency Medicine
Australasian College of Sport & Exercise Physicians
Australasian College of Sport and Exercise
Australian Capital Territory Health
Australian College of Rural and Remote Medicine
Australian Indigenous Doctors' Association
Australian Medical Council
Australian Medical Students' Association
Australian Salaried Medical Officers' Federation
Australian Society of Anaesthetists
Australian and New Zealand Association of Neurologists
Australian and New Zealand College of Anaesthetists
Australasian Junior Medical Officer Committee
Commonwealth Department of Health
Council of Presidents of Medical Colleges
Country Health South Australia Local Health Network
General Practice Registrars Australia
Medical Board of Australia
Medical Deans Australia and New Zealand
Monash University
Royal Australasian College of Surgeons
Royal Australasian College of Medical Administrators
Royal Australasian College of Physicians
Royal Australian College of General Practitioners
Royal Australian College of Medical Administrators
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Brisbane Women's Hospital
South Australia Health
South Australian Medical Education and Training
Western Australia Health



Appendix 3: Summit Polling Results

Each table was asked to identify key strategies to pursue within the relevant topic heading. In some cases, this elicited a response that fell outside of the related topic. The graphs below show Summit polling results ranked by preference as compared to results ranked by first choice.

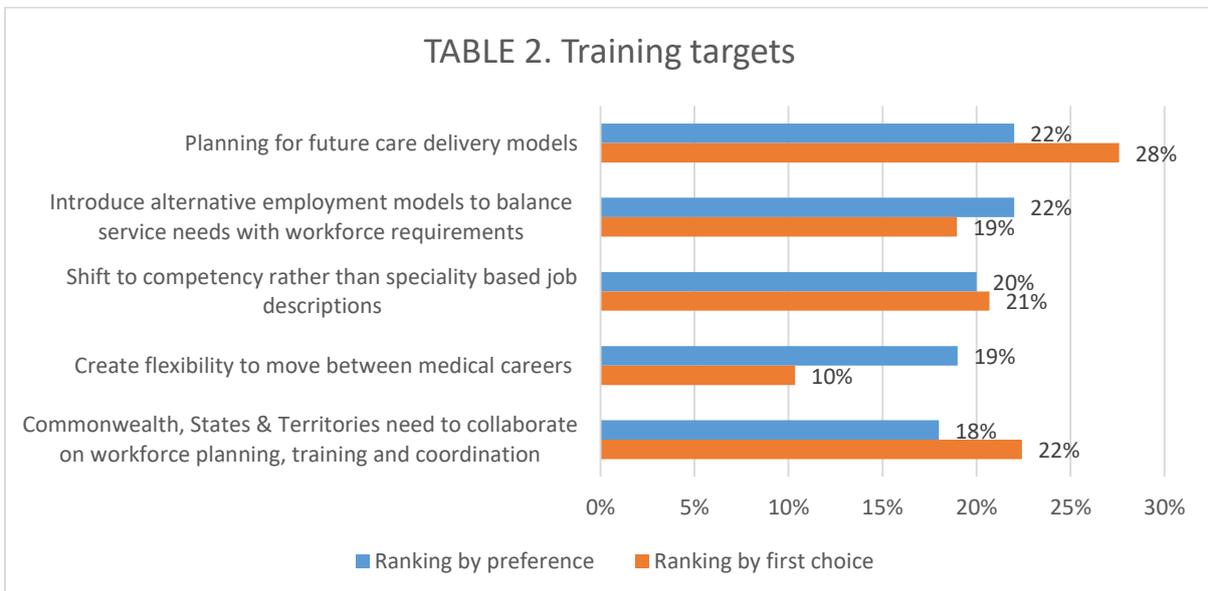
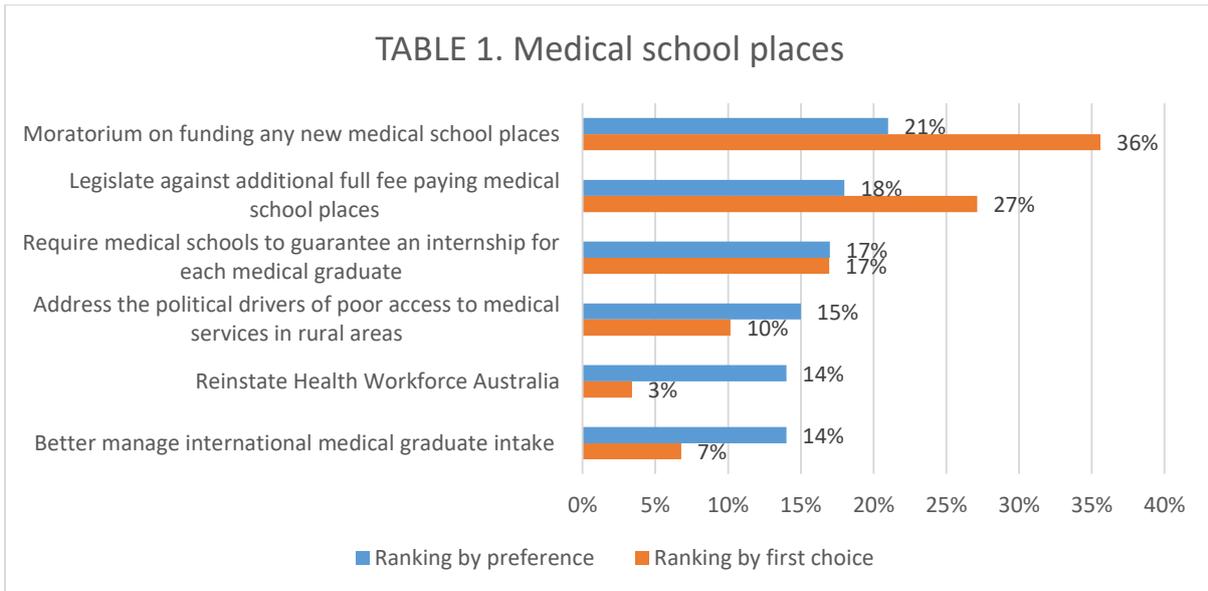




TABLE 3. Promoting generalism



TABLE 4. Promoting rural training terms

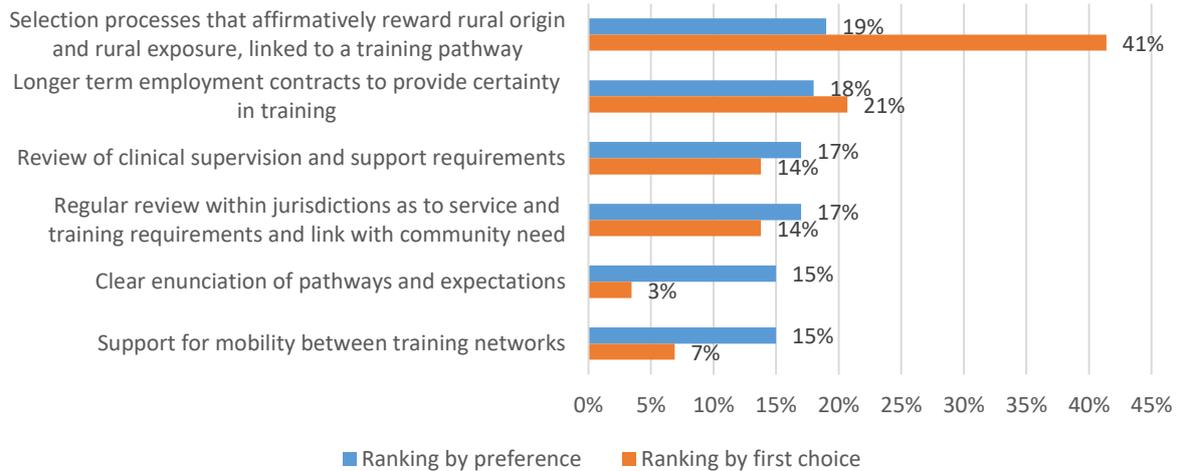




TABLE 5. International medical graduates

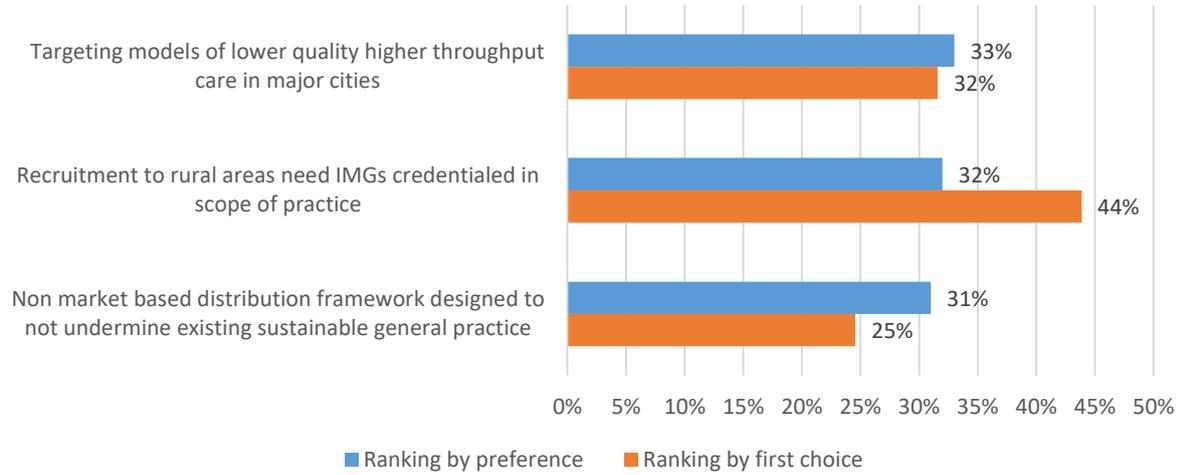


TABLE 6. A National Rural Generalist Pathway

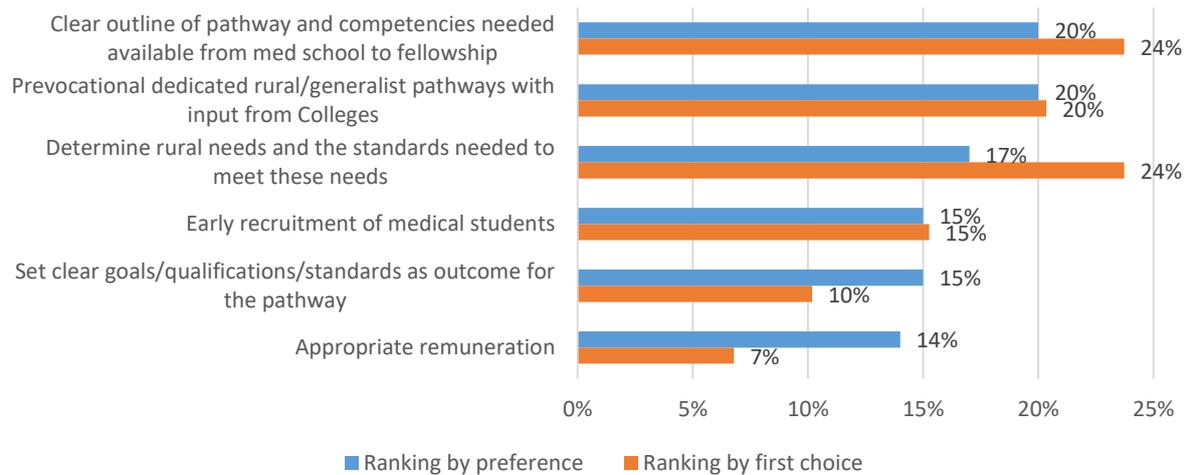




TABLE 7. Addressing undersupplied specialties

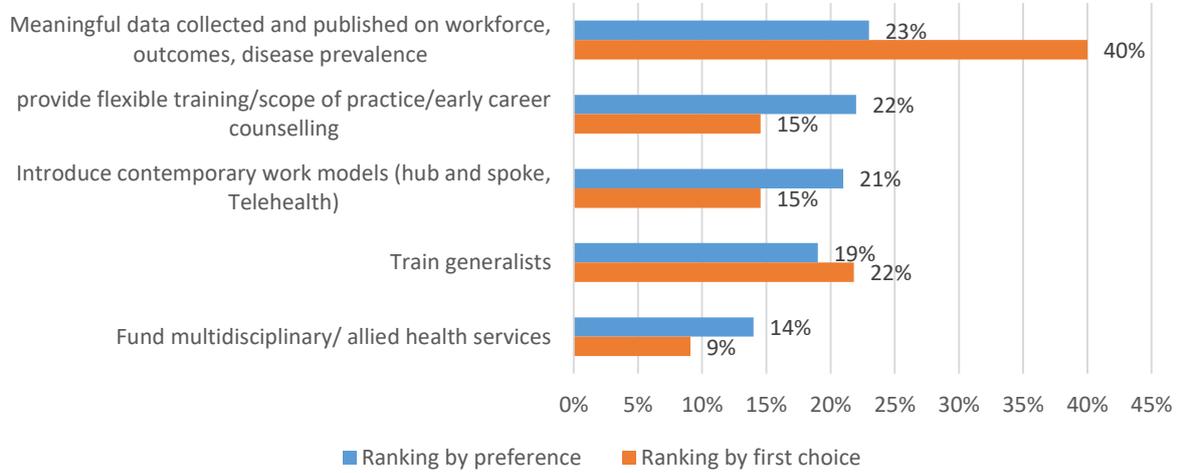


TABLE 8. Rural training pathways

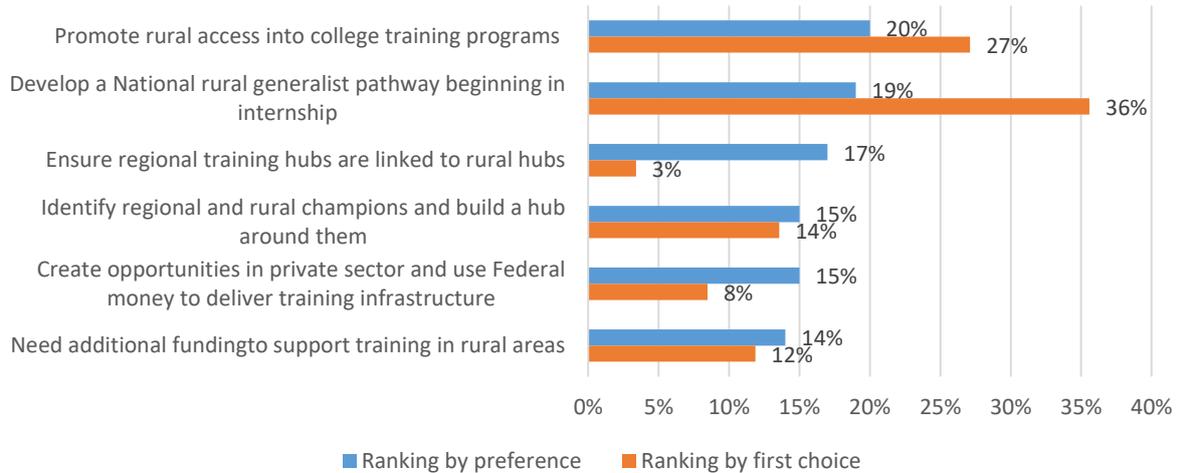




TABLE 9. Commonwealth and State/Territory collaboration

