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AMA feedback on Discussion Paper – redistribution pool of medical places

The AMA welcomes the opportunity to provide feedback on the above discussion paper.

While the AMA agrees with the redistribution of Commonwealth Supported Places (CSPs) to support medical school training in rural areas we remain opposed to the one off decision to allow medical schools to increase their intake of full fee paying places in order to offset any net loss of CSP places. There is good evidence to show that, due to the significant debts that they accrue, full fee-paying students will not practice in rural areas or in those specialties that are currently in short supply. The increase in places also runs contrary to Department of Health modelling showing a predicted oversupply of 7000 doctors by 2030.

It is also important to highlight that this redistribution will not be enough to address workforce shortages and maldistribution without continuing emphasis on increasing capacity in the prevocational and vocational medical training pipeline. Notably, there is significant investment needed from State/Territory and Commonwealth Governments to improve both the training environment for prevocational doctors, and the resourcing and opportunities for prevocational and vocational training in regional and rural areas.

Despite having one of the highest numbers of medical graduates in the OECD[1],workforce shortages persist in rural and regional areas. With evidence showing that rural background and rural training exposure are strongly associated with rural practice, the creation of a rural training pipeline that provides early exposure to rural medicine and continues through to vocational training will make a significant contribution to improving the distribution of the medical workforce in Australia.

As such, the redistribution of medical school places should ensure that:

- Overall student numbers are not increased;
- The redistribution is evidence-based and considers infrastructure requirements, selection criteria, and assures the availability of quality supervision and teaching resources; and
- It is linked to improvements in the downstream availability of postgraduate training places and employment in regional, rural and remote areas.

[1] Organisation for Economic Cooperation and Development. Doctors overall numbers in Health at a glance 2017: OECD Indicators. Paris: OECD Publishing, 2017.

These issues were raised in our response[2] to the Departments *Summary facts and discussion paper* in 2017 and are still valid at present.

AMA responses to specific questions in Discussion Paper

AMA view on the options for managing the distribution pool

Of the three options presented by the Department of Education to redistribute medical CSPs, Option 1 most closely aligns with the AMA's standards for medical training arrangements, as listed above.

Option 1 suggests that redistribution of the 28-remaining medical CSPs – after the allocation of CSPs to CSU – occur via a competitive bidding process based on the Assessment Framework and agreed policy parameters. All elements of the Assessment Framework must be addressed by proposals seeking the additional CSPs.

The Framework seems to provide comprehensive guidance for new or expanding rural medical programs that, by all appearances, would benefit the long-term sustainability of the medical workforce in underserviced areas. However, the AMA is concerned that the Framework only applies to Option 1, not Options 2 or 3, as we understand it.

The AMA is pleased to see that the first two elements of the Assessment Framework safeguard against increases in the number of domestic or international full fee paying (FFP) medical students. Record growth in medical graduate numbers has raised concerns about a potential medical workforce oversupply in the future[3]. Combined with ongoing shortages in internship places nationally[4], the regulation of medical student places is critical for successful medical workforce planning.

Likewise, elements 4, 6, 8 and 11 work in concert to improve the medical training pipeline and maldistribution of medical practitioners in areas of identified workforce need. By ensuring that existing medical CSP are redistributed to areas of need AND by creating opportunities for internship and specialist training in these areas, retention of doctors after graduation and beyond is far more likely[5].

This type of training pathway could be achieved using the AMA's Regional Training Networks[6] model. Regional training networks (RTNs) are designed to enhance generalist and specialist training opportunities, and support prevocational and vocational trainees to live and work, in regional, rural and remote areas. That is, RTNs can support end-to-end medical training in rural areas, from medical school to vocational training. Importantly, the infrastructure to support RTNs already exists, but as mentioned previously, governance and funding from State/Territory and Commonwealth Governments to support medical colleges and health services to implement RTNs is still required.

The AMA is aware that the Government's Rural Health Multidisciplinary Training Program (RHMTP) was designed to serve this same purpose – to improve the recruitment and retention of rural and remote health professionals – using regional training hubs. In the AMA's submission to the evaluation of the RHMTP, it was acknowledged that the RHMTP is an important program and must be retained, but could

[2] AMA submission on assessing the distribution of medical school places in Australia 2017.
[3] AMA Position Statement Medical Workforce and Training – 2019.
[4] National Internship Crisis – Australian Medical Student Association (sighted 24 October 2019).
[5] AMA Position Statement Rural Workforce Initiatives – 2017.
[6] AMA Position Statement Regional Training Networks – 2014.

be improved by redirecting funding from the regional training hubs to the AMA recommended RTNs. This is because overall, the hubs are only one of the necessary components required to develop a structured pathway for retaining students interested in pursuing a rural career.

While many medical students have positive training experiences in rural areas, progression through prevocational and vocational training often requires a return to metropolitan centres. This is especially relevant for specialist training, as rural hospitals do not have the specialist medical workforce on hand to provide supervision and training[7]. RTNs would ensure that resources are available to support senior staff roles and private specialist practice to create sustainable models of supervision, education and training in rural areas. This would support trainees to remain in rural practice, rather than return to major cities out of necessity.

The Framework also puts in place assurances that medical students will receive high-quality training in rural medical programs though elements 3, 9 and 10. The AMA is satisfied that medical training is adequate when Australian Medical Council accreditation standards are met, and when there is transparency of each new/expanded medical program. In addition, the Framework outlines that retention strategies be employed to support the academic workforce and clinical supervision staff that are essential for the training of medical students, junior doctors and specialists down the pipeline.

The AMA has outlined challenges facing the current rural medical workforce, and solutions to improve recruitment and retention of doctors in rural areas in the Position Statements – Rural Workforce Initiatives 2017 and Medical Workforce and Training 2019. This includes appropriate remuneration, especially given the reduction in clinical load for supervising doctors, and support for their families. The AMA welcomes the opportunity to contribute to the development of appropriate support structures for the doctors recruited for any expanded medical programs in rural areas. Further, the AMA's Medical Workforce and Training Summit in 2018 canvassed many of these issues. The Report from the Summit outlined several key outcomes to address workforce maldistribution, including support for:

- Greater collaboration between Commonwealth and State/Territory Governments in planning workforce, training and future care models to meet community need;
- The development of alternative hospital employment models to better align with service deliver and workforce requirements with training requirement and community need;
- Building on existing regional training infrastructure to create networked training models that support trainees to live, work and train in rural areas.

These, and further recommendations can be found in the AMA Medical Workforce and Training Summit Report.

It is imperative that any strategy adopted by the Government in this Discussion Paper – and more broadly for future rural medical school programs – aligns with the goals of the National Medical Workforce Strategy. The Strategy has a focus on addressing workforce maldistribution and the supply of specialists in areas of need.

The Framework should be equally relevant to Options 2 & 3

[7] Dr Gannon – The World Today – Murray Darling Medical School Proposal 2017

While Options 2 and 3 have a rural focus, for administrative simplicity the Framework is not applied to these. We disagree with this approach as many of the criteria outlined in the Framework would make them more effective, particularly with respect to the creation of a rural training pipeline and the need to guard against further increases in medical student numbers – which current workforce modelling by the Department of Health does not support.

The AMA recommends that similar guidelines are in place for Options 2 and 3 if the Department decides that they are the preferred strategy. This will ensure the same degree of support is available for prevocational and vocational trainees – such as training opportunities in rural hospitals – as well as recruited teaching and supervising doctors as outlined by the Framework.

Further, the AMA believes that the Department of Education should move forward with the 2018/19 Budget decision to make recommendations on setting controls on full fee paying places for medical schools. By allowing unrestricted domestic and international FFP places, over time, the AMA is concerned it will undermine the Commonwealth's ability to match medical workforce requirements to community need. It also poses a threat to the quality of medical school training due to overcrowded training environments diluting clinical experience and overwhelming supervisory capacity.

Increased medical student numbers will exacerbate the ongoing shortages of training places post medical school. For example, by 2030, there is a predicted shortfall of 1000 specialty training places, creating a bottleneck in prevocational training[8]. The AMA is troubled that this Discussion Paper has not taken some newer medical schools, like Macquarie University, into consideration when making projections on medical commencements/graduates, as FFP medical graduates will enter the already overburdened training pipeline and likely worsen current training position shortages. Tighter regulation of medical student places outside of the Framework is essential for improving these barriers in completing medical and specialist training.

The AMA requests that universities have very clear and transparent guidelines in place to inform FFP students about the likelihood of them being able to obtain an internship position following graduation to gain general registration in Australia. Many students report that they are not aware of these barriers until after commencing their degree.

AMA view on the policy parameters for the 2021 redistribution process

Overall, the AMA agrees with the policy parameters outlined by the Discussion Paper.

The AMA supports the policy to maximise opportunities for medical students with a rural background to practice in rural and regional areas when qualified. Previously, the AMA has called for an increase in the proportion of medical students from a rural background from 25 per cent to one third of all new enrolments. In addition, the AMA has recommended at least one third of medical students undertake a minimum of one year of clinical training in a rural area, as medical graduate retention in rural areas is more likely when they have long-term training in a rural setting.

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

[8] Clark R 2019. A student's eye view of the training crisis. *MJA InSight.*

- establishing a Community Residency Program for prevocational doctors to provide three-month GP rotations in rural areas to replace the previously successful PGPPP program;
- 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 (discussed previously).

Again, a concern lies in that the policy parameters only appear to apply to Option 1, not Options 2 and 3. If options 2 or 3 are selected as the strategy for CSP redistribution, the AMA would recommend universities offering rural programs to adopt features of the policy parameters for their existing programs, such as increasing the intake of medical students with a rural background.

Please direct any queries relating to this submission to kfarrell@ama.com.au.

Yours sincerely,

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President