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Health Workforce Study
Productivity Commission
PO Box 80
BELCONNEN ACT 2616

Dear Commissioners

THE HEALTH WORKFORCE - PRODUCTIVITY COMMISSION ISSUES PAPER

The Royal Australasian College of Medical Administrators (RACMA) appreciates the opportunity to comment on the Health Workforce Issues paper.

RACMA welcomes this paper and the Commission's review. The quality of training of the Australian health workforce has been excellent and the workforce is generally highly skilled. There are, however, significant, well-documented problems with workforce availability and distribution. These problems necessitate a critical and objective review of past and current practices.

In this brief submission, we offer comment on our College's training program and workforce concerns in our own medical specialty. As many of our members are involved in managing health services and therefore dealing with the effects of growing health workforce challenges, we also offer some observations on other health workforce issues, especially in relation to junior and specialist medical staff.

About RACMA's training program and workforce

The mission of the Royal Australasian College of Medical Administrators (RACMA) is to improve the practice of management by medical graduates by providing training, education, research, development and support.

The main roles of the College are to:

- Set educational standards, accredit educational programs and conduct examinations that lead to the awarding of Fellowship of the College;
- Organise a continuing education program for Fellows and Members;
- Nurture, guide and encourage Candidates, Members and Fellows; and
- Assist clinicians and other health personnel who are increasingly being required to manage their clinical departments and health programs and provide a clinical service.

Fellowship of the College (FRACMA) is available only to registered medical practitioners and is a recognised specialty qualification, awarded after a training program which, like other medical specialist College programs, is accredited by the Australian Medical Council, and involves:

- A minimum of three years approved clinical experience
- A minimum of three years approved management experience
- Academic requirements generally complied with by the completion of:
  - an approved Masters degree course (such as a Masters in Business Administration or Masters in Health Administration)
  - two compulsory residential workshops for Candidates run by the College
  - a Case Study dealing with management action, presented in writing and verbally
  - a formal final oral examination dealing with all aspects of the College curriculum
- Participation in the mentorship program for new Fellows.

The majority of medical administrators serve in senior management and clinical leadership positions within public teaching, metropolitan and major rural hospitals. However, College Fellows are widely dispersed across the health system including government departments, defence forces, private hospital and insurers and the pharmaceutical industry.

The College believes there is an important role for specialist medical managers to serve health services and the community in a number of ways, but notably the increasingly challenging areas of clinical governance, medical workforce planning, the management of relationships with employed and contracted medical practitioners as well as more generally in operational management.

Therefore, we are pleased that medical administrators have traditionally, and still do, hold a significant number of senior management positions in the public health services in each state of Australia.

The College has not advocated that any individual professional or other group should exclusively hold any particular senior position but we believe that there should be a balance of skills, qualifications and experience in the most senior levels of management of health services.

Although many hospital-based positions for Director of Medical Services or similar titles are appropriately classified as requiring FRACMA qualifications or equivalent, to some extent our members compete with other medical, nursing, allied health and non-clinical management staff for other positions. Generally this is accepted as a situation of complementary skills and experience and their valuable role in health service management is recognised. RACMA has responded to changes in many large hospitals and health services toward clinician management structures by offering them support through management training programs and a new category of College Membership.

RACMA is contacted frequently by hospitals that are seeking assistance in the recruitment of medical managers. Our impression is that it is becoming increasingly difficult for these hospitals to recruit well-trained people into senior medical management positions, and that this has been a long-standing problem that appears to be worsening.

Although shortages of various categories of clinical staff are more widely noted, RACMA was recently approached by an area health service in New South Wales, seeking support for an 'Area of Need' categorisation in order to facilitate appointment of an overseas applicant to a medical manager position. Despite extensive advertising and a prestigious position, no local candidate was identified.

The reasons for this emerging workforce shortage partly relate to the general factors that have negatively impacted on medical workforce distribution to rural areas, but are also understood to reflect a relative reduction in the number of positions traditionally used for training medical administrators, such as junior medical administrative positions in teaching hospitals and deputy medical superintendent positions in metropolitan hospitals, as well as increased opportunities to move into the private sector and other areas of the health system. The attractiveness of the role has also been variously adversely and positively impacted upon by the effects of different jurisdictions' organisation structures and restructuring.

The College is concerned that unless there is appropriate recognition of the specialty of Medical Administration, as evidenced by the availability of reasonably stable senior positions to aspire to, with appropriate remuneration and related conditions comparable to other medical specialties, we will have increasing difficulty in both attracting and retaining the bright and committed young trainees that we believe ought to be part of health service leadership teams that address undoubtedly ever-increasing challenges in the future. We believe it is important that state health services recognise the value of specialist medical managers who have been trained and are qualified for that role, so that we can offer high calibre RACMA Fellows in the future, practising their medical specialty as clinical leaders and health service managers.

Nationally, RACMA candidate numbers have fallen from 107 in 2000 to 101 in 2004, and the number of active RACMA fellows has fallen by almost 10%, from 277 in 2000 to 250 in 2004.

The current Candidates work in the following settings:

Training setting of current Candidates	**Number**	**Percentage**
Public Hospitals	32	36%
Government Health Departments	23	26%
Australian Defence Forces	13	14%
Private Enterprise (Health Insurance, Pharmaceutical Industry, etc.)	12	13%
Other (Breast Screen, Medical Practitioners Board, etc.)	7	8%
Private Hospitals	3	3%

RACMA, with financial assistance from the Australian Government Department of Health and Ageing, is about to commission a study to ascertain trends in and factors affecting recruitment and retention of medical managers in Australian hospitals, with the expectation that it will then inform the development of an evidence-based workforce strategy. By the time of the scheduled consultation on the Productivity Commission's Draft Report at the end of 2005, there may be relevant issues learnt from this project.

Other Health, especially Medical, Workforce

The ability of our society to provide health care services is inevitably linked to the availability of skilled health care workers, across the full range of caring professions. For all the reasons identified in the Issues Paper, there is good reason to recognise

workforce shortages already exist in some areas and to be concerned about our ability to cope with the likelihood of worsening shortages in the future.

Not only due to the broad issue of geographic maldistribution, which particularly affect outer metropolitan, rural and remote areas, many hospitals and community based services are experiencing significant difficulty with recruitment and retention of a range of medical, nursing and allied health disciplines, such as podiatry and pharmacy. To some extent this reflects a global phenomenon, as noted in the Issues Paper.

Within medicine there has been growing reliance on overseas trained doctors, many of whom are providing high quality services but in the global marketplace, and with increasing concern about the impact of losses of skilled workers from developing countries, it is unlikely that net migration will be sufficient to meet demand into the future.

In some areas we are probably already at the stage where there needs to be recognition that a 'no doctor' solution is sometimes better than a `bad doctor' solution, or a doctor forced to act outside their appropriate scope of practice. This will mean that some current services will need to be rationalised and some, mostly rural, medical services may need to close and/or be converted to nurse practitioner or other health worker models.

RACMA believes that it is appropriate that there be, in the community interest, regulation (and some self-regulation) of the health care professions. We also accept that there will be some changing of roles and scope of practice within and between professional groups but believe that such changes need to be conservatively managed to ensure the high standards of the Australian health care system are maintained.

Consistent with principle 7 of The National Health Workforce Strategic Framework, it will be necessary to work collaboratively with relevant stakeholders when seeking to implement realignment of existing workforce roles or the creation of new roles envisaged in principle 5.

There have also been changes in the workforce, as noted in the Issues Paper, some of which reflect broad changes in the community views about work and lifestyle choices. One impact of this has been the growing reliance of many hospitals on locum medical officers for routine service provision, at not only a cost premium with at times variable performance, but also variable familiarity with and loyalty to individual facilities.

At page 22 of the Issues Paper there is discussion about fragmented roles and responsibilities, including the place of professional colleges.

RACMA believes that Colleges should continue to set the standards and assess the competency of individuals to practice within specific disciplines, but recognises that there will need to be complementary sources of input to training programs, which generally involve some training programs, materials or sessions provided directly by the College; some provided by specialised external educational bodies (such as RACMA's requirement for appropriate university Masters' degree qualifications) and much training being "on the job" albeit with College members as tutors and supervisors.

Accordingly, RACMA recognises the points made at page 29 of the Issues Paper regarding conflicting incentives between aspects of education and health services delivery, and the need for effective coordination between education providers and those responsible for funding post-graduate training, which for medical training largely occurs within the

context of employment in mixed service/training positions within public hospitals. We suggest examples such as the NSW Medical Training and Education Council, now merging with the Postgraduate Medical Council, as an example of efforts to provide that coordination.

The number of trainee positions in public and private hospitals for the different medical training programs varies considerably, but for many Colleges it is strongly influenced by the availability of funding by state health departments for what are largely service positions.

RACMA believes that there may be opportunities to increase the flexibility of approaches to training medical specialists. In our view, the current site-specific or position-specific apprenticeship model may not be sufficiently flexible and adaptable to the challenges of the health care system in the future. Some elements of training may be able to be provided in a more flexible, individually-responsive manner, without compromising the quality of training or the competence of trainees. Our comments in relation to models of training apply to the training of medical specialists generally.

In the future, RACMA considers that a range of factors will both enable and necessitate the development of more flexible approaches to training medical specialists:

- The move of considerable amounts of clinical practice into new settings, in the private and/or ambulatory sectors;
- New technology and changes in clinical practice, reducing hospital lengths of stay;
- The imperative to expose trainees to rural practice;
- The recognised need for trainees to become competent in a wider range of areas, some non-clinical (e.g. communication, teamwork, safety and quality);
- Greater understanding of the relationship between clinical volume and quality of patient outcomes, enabling the development of more reliable training standards;
- Organisational "networking' of hospitals and health services, and collaborations between the public and private sectors; and
- The increasing availability of health care performance information, enabling more rigorous objective assessment of trainee competence.

High quality mentoring and individual support will always be necessary throughout a specialist's training (both basic and advanced), but training programs could (and arguably should) also provide for flexible combinations of training experiences in different practice settings (for example, rural, ambulatory, private sector) and using different educational techniques (for example, computer-aided learning and simulation techniques). We consider that the following principles should apply:

- Principles for accreditation of specialist training
  - RACMA strongly supports the highest level of transparency in relation to all aspects of specialist accreditation programs.
  - Standards for accreditation of hospitals and posts should be unambiguous, freely available and understandable by all parties: hospitals, trainees and the relevant specialist college. There should be a clearly demonstrable link between each standard and its expected contribution to the quality or experience of training.
  - Rather than specifying minimum organisational inputs, standards should, where possible, identify the specific quantity and quality of experience to be gained by the trainee, the expected competencies to be achieved and the manner in which their competency will be assessed.

- Accreditation inspection processes should be rigorous, valid and reliable. RACMA supports the inclusion of participants independent of the relevant College.
- Hospitals, trainees and the relevant College all have a legitimate interest in accredited training posts. The accreditation process should be supported by an agreement detailing the obligations of each party, and the processes available to each party if any other party materially fails to fulfil their obligations.

Training program accreditation requirements

- RACMA believes that competency can be achieved in many ways and that training programs in most medical specialties could enable higher degrees of flexibility to accommodate different learning styles, opportunities and preferences.
- We understand that the intensity and volume of clinical experience required to complete specialist training has, in the past, generated a focus on individual positions or organisations. Clearly, clinical and training experience depends to a large extent on local organisational or clinical factors, and a sufficient volume of suitable clinical experience must be accessible by each trainee.

At page 39 of the Issues Paper, the possibility of allocating funding for aspects of workforce training through some form of competitive tendering, to encourage the entry of new providers and allow bodies other than the medical colleges to undertake vocational training of doctors, is canvassed.

Counter to that view, it should be noted that probably all of the medical colleges, and certainly this one, rely substantially on the volunteered services of its members to develop, provide and examine their training programs and continuing education programs, seeking to put something back into their profession and for the good of the community, in keeping with the "social duty" mentioned in Box 8 on page 40. Portions of the colleges' activities are provided and managed by staff, who are generally paid from members' subscription fees. Moves to alternative providers of specialist training risk alienation of those who must be involved with imparting their knowledge and supervising trainees if not carefully and collaboratively considered.

We trust this information is of assistance and interest to the Commission in reviewing matters related to the Australian Health Workforce. Should any matter require clarification or the provision of further information, please do not hesitate the College Registrar, Mr Bob Bishop.

We look forward to reviewing the Draft Report later in the year.

Yours sincerely

Dr Philip Montgomery
President