SUBMISSION TO PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY FROM THE POSTGRADUATE MEDICAL COUNCIL (PMC) OF NSW

The vision purpose and mission of the Postgraduate Medical Council (PMC) of NSW is attached at Appendix 1.

The PMC's response to the questions raised in the original Productivity Commission Study is set out below.

1. WORKFORCE PLANNING

The lack of accurate state and national workforce data in relation to both the current available workforce and the projected future workforce means that it is difficult to undertake any formal workforce planning.

Of particular importance to the PMC are a) the projected increase in student numbers, with the opening of three new medical schools (Wollongong, Western Sydney and Notre Dame) and b) the increase in the number of International Medical Graduates (IMGs) who are sitting and passing the Australian Medical Council (AMC) clinical examinations.

Medical workforce planning could be improved by a better understanding of the training and educational requirements of the workforce. In NSW the distribution of JMO Medical Officer Workforce is linked to the accreditation of facilities and terms and education and training of JMOs.

Increase in the number of Medical students

In the absence of formalised data the PMC has undertaken work with local Universities, the Australian Medical Council (AMC), the Postgraduate Medical Councils in other States and Territories and the Confederation of Postgraduate Medical Education Councils (CPMEC) to help inform its planning.

The lack of a national overview of the workforce entering the health system and the total number of positions available means that projections are likely to be a lot less predictable in the future. In NSW we are expecting to go from 500 students looking for internship in 2006 to 800+ students by 2011 with the commencement of the three new medical schools. As a consequence work is underway looking at ways in which this huge influx can be accommodated.

It is not clear whether other States and Territories will be able to employ the additional students graduating from new Universities in their own areas and/or if they are able to employ additional students on top. A national co-ordinated approach to this issue is therefore needed to ensure that all graduating students will be able to enter the medical workforce for internship and that there are sufficient training positions identified so that the current workforce shortages are addressed.

1.2 International Medical Graduates
The increase in the number of IMGs sitting and passing the AMC Clinical examinations is also having an impact on the system. IMGs undertaking their year of supervised training in NSW now represent approximately 20% of the junior medical officer (JMO) workforce as opposed to 7% in 1999. NSW has seen an increase of 285% in the number of IMGs since 1999, as there were 33 positions in 1999 and 94 positions in 2005.

This group of doctors can be particularly resource intensive for hospitals and in the future there may be a limit as to the number of these doctors that hospitals are able to employ (this issue is covered in more detail in the next section). Although there is some data available from the AMC as to the number of doctors who are currently in the examination process, it is unclear how many IMGs are resident in Australia who have yet to apply. With the recent changes in the migration policy allowing IMGs to gain residency following successful registration there may be a further increase in numbers and there is no available data on this.

Summary
There is an urgent need for accurate national and local data about:
1) The number of new medical students who will be graduating from the new medical schools
2) The number of available positions
3) The number of IMGs predicted to enter the medical workforce

and for a co-ordinated national approach to the employment of these doctors.

2. EDUCATION AND TRAINING
2.1 Generalist vs Specialist
For a long time the PMC has supported the concept of two years of generalist medical training for the first two years post attainment of a medical degree. In recent years the changing demographics of the workforce: older graduates, graduates with previous work experience (inside and outside the health system) has placed pressure on this model with increasing numbers of graduates seeking to specialise after the completion of internship.

This issue needs to be addressed. The value of generalist skills cannot be underestimated however it should be possible to move towards some form of specialisation while still achieving another generalist year to hone skills. Perhaps the first year of speciality training could straddle the second year of general training. The year could be hospital/community based and would have an emphasis on the broad generic skills that transcend speciality specifics but are important to the development of an ideal doctor. The special clinical skills would be obtained later though terms could be provided that fit with the doctors area of interest.

Work readiness
There is currently a great deal of variability in the ability of students and IMGs to perform basic procedures on day 1 of their internship/year of supervised training. This is sometimes a reflection of the competence of the individual, but can also be the result of the different curricula approaches of different Universities. There is also the potential for variability in the competence of unconditionally registered junior medical officers graduating in different states and territories.

To ensure that the risk of medical error is minimised there should be a nationally agreed set of basic procedures that all graduates must be trained in and able to perform prior to commencing internship. The development of a national Core Curriculum would assist in the delivery of this.

2.2 Core Curriculum

The PMC has been funded by the Medical Training and Review Panel (MTRP) to develop a national curriculum framework for junior doctors. A draft has been produced and is currently being amended to reflect the work undertaken in other States and Territories and by the "Curriculum for the Foundation Years in Postgraduate Education and Training" produced by the Academy of Medical Royal Colleges in the UK[1].

The Core Curriculum aims to set out the core knowledge, skills and attributes that need to be acquired by interns (PGY1s) and resident medical officers (PGY2s). It is likely that following its development discussions will take place with the Deans of the Universities as to expectations in relation to the skills levels required by graduating students.

To ensure that the curriculum delivers employees capable of undertaking the roles and responsibilities of their position the curriculum must be embedded into the health services system. It needs appropriate faculty development, infrastructure (educational resources), assessment of those participating in the training program and evaluation of the education and training program to ensure it continues to meet the needs of the health system.

The curriculum ultimately should be accelerated so skills can be acquired earlier and the performance of junior doctors in the system is enhanced. The initial NSW JMO curriculum has defined the prerequisites for internship and what needs to be achieved by the end of the two prevocational years.

2.3 Infrastructure for Education and Training

The current medical education and training system for junior doctors (and students) is heavily reliant on the goodwill of interested senior clinicians. These clinicians are generally unpaid and provide the training and education as an add-on to their existing roles and responsibilities. In an environment of workforce shortage the availability of these medical practitioners is reduced as their time is increasingly occupied with providing a health service to increasing unwell hospital based patients. This reduction in ability to provide work based training is exacerbated by what appears to be the same cohort of senior doctors providing education and training to the various levels of doctors in training including medical students.

In addition, there are limited resources available to support any formalised delivery of education and training. The additional JMOs and IMGs to be placed into the system will burden the system more and will undermine the current level of training provided and more importantly reduce the skills JMOs will achieve if significant work is not undertaken to support the education and training system.

Given the lack of resources and the heavy reliance on individuals there is not and could not be a cohesive approach to education and training and there the quality and standard of training is variable. Furthermore, with the influx of additional students, junior doctors and IMGs it is likely that the currently overstretched system will be completely overwhelmed and unable to cope. This will then in turn mean that training will suffer further.

[1] The Foundation Program Committee of the Academy of Medical Royal Colleges in co-operation with Modernising Medical Careers in the Departments of Health. Curriculum for the foundation years in postgraduate education and training. 2005 pp 95

A greater emphasis needs to be placed on the importance of education and training, not only for the junior medical office workforce but also for the system generally to ensure a high quality, well trained and safe medical workforce. This could be achieved by ensuring that individuals responsible for the delivery of education and training are a) paid for their education and training role b) have access to resources to assist them in the delivery of education and training and c) that part of their job description (and therefore appointment) reflects this role. An overarching education and training strategy also needs to be developed and implemented.

It may also be worth exploring a multi-disciplinary approach to the delivery of training and education. By pooling existing resources allocated for the training and education of nurses, allied health professionals and with the addition or resources for the medical workforce it may be possible to develop a more cost effective and efficient system with multi-disciplinary teams being trained together. By improving education and training not only will the workforce be of higher quality, more safe and better trained but it will also feel better supported and recruitment and retention rates may be improved.

Of particular interest is the funds being provided by universities for training and education of medical students in the hospital setting. The infrastructure provided by the university has not developed in a manner that consistently allows it be utilised by hospitals to assist with training other doctors. In some cases the funds from the university has shifted the emphasis of training from junior doctors to medical students. The clinical trainers of medical students are usually the same clinicians that train junior doctors. Additional resources for medical student training and trainer time constraints has meant the clinicians attempt to manage the workload by running the training and education of the these separate groups simultaneously. This is less effective because it does not meet the needs of the JMO group.

2.4 International Medical Graduates (IMGs)

The increasing number of IMGs in the hospital system and the lack of specific resources and infrastructure available to support this group is also a significant drain on hospital resources. A number of IMGs are not obtaining unconditional registration after a year of supervised training and are requiring additional terms in order to fulfil registration. In 2004, 17% of IMGs undertaking supervised training required additional terms to gain registration and the average number of terms required was 3.

Last year the PMC carried out a survey in relation to junior medical officer (JMO) performance and found that in the last 2 years 2.1% of local graduates (1 per PAC) under perform in comparison to 35% of AMC graduates (2-3 per PAC). It found that 54% of under performing local graduates had personal and professional issues whilst 39% had inadequate clinical knowledge, skills or judgement. In contrast 54% of AMC graduates had inadequate clinical knowledge, skills or judgement whilst 30% had inadequate communication.

Given that the IMGs are more likely to have performance issues and need additional support, dedicated resources for training are required to ensure that this group is more work ready before entering the health system. The PMC currently offers an optional pre-employment program but this is not compulsory and does not provide as much training as is required. Resources are also required for hospitals to provide dedicated intensive support and training for those doctors who are unable to reach the standards required for registration.

If the additional support and resources are not provided it may mean that in the future, given the increase in the workforce that hospitals will refuse to employ this group of doctors.

2.5 Training in the Private Sector

An increasing number of procedures carried out now take place outside the traditional public hospital setting i.e. in private rooms, the community and general practice. The current system of public hospital based training and education means that JMOs are not exposed to these procedures and are missing out on valuable training experiences.

The increase in the number of medical students and IMGs entering the workforce provides an excellent opportunity to expand and formalise the current training and education offered into these alternative settings. In order to do this however a number of issues would need to be addressed a) the indemnity cover b) resourcing to ensure that new facilities are accredited to receive junior medical officers and c) infrastructure support for education, training and supervision is identified.

There is also a desire in NSW to expand the training and educational experience of the junior medical officer by providing community based training terms. While it appears short term funding has been provided for GP terms by the Commonwealth, the long term sustainability is unclear as no one is quite sure who will fund these terms into the future. Yet significant structures will be developed to facilitate the accreditation of the terms and provision of the training and education to the JMOs involved in the terms.

2.6 Accreditation of Hospitals

The PMC currently accredits both the hospitals employing JMOs and the hospital terms that JMOs undertake against a set of Standards that it has developed. The Standards specifically address the education, training and supervision of JMOs and were developed to:

- Ensure JMOs have appropriate knowledge, experience and skills to provide quality patient care;
- Support a wide range of educational and training opportunities for JMOs to ensure they are competent and safe;
- Promote the welfare and interests of JMOs.

The Standards address a variety of areas including role definition, professional development, education program, education and information resources, assessment and feedback, service and training requirements, supervision and safe practice. A copy of the JMO Education and Supervision Standards can be found on the PMC website at www.pmcnsw.org.au.

Feedback from the PMC survey processes suggests hospitals feel burdened by the number of accreditation surveys they participate in currently (AMC, ACHS etc) and that although the PMC accreditation process is specialised in nature, repetition still occurs. If a co-ordinated approach to the accreditation of hospitals in relation to education and training was developed this would provide a significant improvement to hospitals and would cut down on a great deal of administration and save time.

3. WORKFORCE PARTICIPATION

The changing profile of the workforce is beginning to have a number of impacts on the available workforce and its distribution across the system.

As the junior workforce is older with more commitments both financial and personal, it is becoming more difficult to fill rural and regional rotations. There is also an increase in the flexibility that is being requested by the workforce because some individuals are seeking a better work/life balance whilst others have family and other commitments.

The PMC is currently undertaking a Flexible Working project funded by the Medical Training and Review Panel. This will be looking at models of flexible working, which could be implemented both locally and nationally.

In NSW we have also seen a significant increase in the number of doctors working as locums. Apart from the attractive remuneration that this provides, a number of doctors are choosing this option because it provides them with the work flexibility that they are seeking. The associated costs to the health system for the payment of locums is significant.

In order to address the current workforce shortages which are likely to continue for some time until the additional student numbers begin to impact on the system there are a number of options that could be explored.

3.1 Job re-design

The role of the JMO in the hospital system needs to be more clearly defined and their key responsibilities outlined. A lot of time is still spent on paperwork, which could be delegated to other member of staff thus freeing up the JMO to spend more time with patients.

3.2 Length of time to train

As the average age of a medical graduate is older, there is pressure to finish specialist training earlier. Consideration should therefore be given to switching to competence based rather than time based training.

The PMC's Core Curriculum project will look at whether it is possible to adapt and then adopt the proposals in the UK Curriculum document, which aims to provide credit in the second postgraduate year towards specialist training. This could then help to reduce total training time.

3.3 Modular Specialist Training

The development of a modular approach to specialist training would be extremely beneficial to the workforce as it would a) allow doctors to switch between specialist training a lot more easily and this in turn may assist in retention b) allow more flexibility to undertake training therefore meeting the needs of doctors with external commitments and c) assist in re-entry into the system of doctors who have left the workforce.

4. MIGRATION ISSUES

Given the increase in the number of locally trained doctors in the future, it is not clear what requirement there will be in the future for non-resident International Medical Graduates. This group are currently able to apply for residency once they gain medical registration.

Also, the issue of full fee paying students studying medicine at Australian Universities will need to be looked at as it is not clear what obligations or requirements there are for them to complete internship in Australia prior to returning to their home country. A number also currently apply for and obtain Australian residency.

5. REGIONAL, REMOTE AND INDIGENOUS ISSUES

As outlined earlier it is becoming more difficult to distribute the workforce to regional and remote areas given the change in its profile. There is a greater pressure to place junior medical officers in rural and remote areas as part of their training program, however this can be difficult to achieve. Junior medical officers need exposure to a general education and training. However there are significant shortages of doctors in rural areas, especially of clinicians with broad competencies and so the ability of these hospitals to provide the infrastructure, supervision, and training and education for junior doctors is restricted. Rural hospitals are more likely to have one year accreditation or an increased number of provisos with respect to JMO supervision, education and training.

Specific rural workforce training packages are one way of ensuring the doctors have the skills to undertake the work in a rural area however it should be noted that many junior doctors supporting rural communities are on secondments from metropolitan hospitals. Secondments provide a way of ensuring medical workforce to rural areas in situations where enough staff cannot be located to live more permanently in the area. In this case is maybe important to first define the skills required and assess those on secondment against the skills required.

Some options to encourage working and training in rural and remote areas may include:

a) the use of incentives - financial enhancements, changes to the Award to pay for additional travel to visit family/friends, more flexibility in training/work hours to visit family/friends, provision of housing and additional credits towards specialist training.
b) financial incentives and support for the trainers
c) Infrastructure to support education and training
d) removing barriers and/or changing perceptions that accessing specialist training is difficult if you work in rural and remote areas.
e) improved training networks to encourage rotation to rural and remote areas and ensure that those who want to undertake training in rural and remote areas can.
f) the establishment of more community/general practice terms in rural and remote areas to increase exposure to these areas.

The PMC is currently undertaking some project work in relation to options c) and d).

Appendix 1

PMC'S VISION
To take a leadership role in the professional development of the PGY1 and PGY2 medical workforce

PURPOSE
To support the sustainable delivery of quality patient care in NSW through managing and coordinating learning, hospital accreditation, distribution and the necessary support infrastructure including policy, process, people, training, advice and advocacy related to the PGY1 and PGY 2 medical workforce.

MISSION
It is the mission of the Postgraduate Medical Council to ensure that medical graduates meet agreed minimum standards of safety, clinical skill and professional confidence over the first two years of their postgraduate medical training.

Doctors who meet these standards are then capable of undertaking vocational training in clinical specialities.

To achieve its mission, the Postgraduate Medical Council has responsibility for:
- The accreditation of training sites and training posts
- The rational and equitable distribution of the Junior Medical Officer workforce throughout NSW and the ACT
- Junior Medical Officer education and training, overseen by a network of Directors of Clinical Training.

Note: The Postgraduate Medical Council of NSW will be converging with the Medical Training and Education Council to form the Institute of Medical Education and Training on 1 September 2005.