09/107

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Mr Elton Humphery
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Senate Standing Committee on Community Affairs
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Dear Mr Humphery

Re: Health Workforce Australia Bill 2009

I refer to your invitation to provide a submission concerning the above Bill that establishes Health Workforce Australia (HWA).

Before seeking to comment on the Bill, it is important to highlight that Australia has a world-renowned system of medical education and training. A robust and independent accreditation framework, overseen by the Australian Medical Council (AMC) underpins this system. The AMA is fundamentally opposed to any policy initiative(s) that might interfere with the independence of current accreditation arrangements.

The role of the AMC is consistent with policy principles set down by the World Federation for Medical Education (WFME)[1]. The WFME guidelines are very explicit on this topic, requiring that the accreditation of medical education (including the component of medical education that takes place during clinical training placements) should ensure that quality assessment is independent of government, the medical schools and the profession, and that the accrediting body (in this case the AMC) should be authorised to set standards in respect of medical education and training, including clinical training.

Australia's current compliance with WFME guidelines not only ensures that it has a well-trained medical workforce. From a practical point of view it also means that Australian medical qualifications and training is recognised in other countries. Similarly, international medical students studying in Australia will also have their Australia qualifications recognised when they leave to work overseas.

Within the current accreditation framework substantial diversity exists and is encouraged. For example, undergraduate medical degree courses are diverse in length, sequencing and entry requirements. This encourages medical schools to develop courses that meet student and community needs within a framework of social responsibility and academic excellence[2]. Diversity

[1] World Health Organisation/World Federation for Medical Education Guidelines for Accreditation of Basic Medical Education (Geneva/Copenhagen 2005).
[2] Submission – Higher Education at the Crossroads: A Review of Australian Higher Education. Committee Of Deans Of Australian Medical Schools. September 2002.

allows medical schools to build on their particular advantages and it is seen as one of the strengths of medical education and training in Australia.

It is essential for medical students to spend time in clinical settings in properly supervised roles to develop the clinical skills they need to practise safely and effectively as interns, and lay the foundations for lifelong learning and further prevocational and vocational training. Clinical placements provide essential clinical and professional learning opportunities to students by enabling them to gain experience in treating patients and to mix with peers.

Currently, the role of identifying appropriate clinical placements is in the hands of universities, postgraduate medical education councils, and medical colleges because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at undergraduate, prevocational and vocational levels respectively.

While the AMA welcomes the extra resources that the HWA will provide for clinical training as well as the enhanced capacity for health workforce research and planning that it may bring, the AMA is concerned that the HWA could potentially:

- Interfere with the standards of independently accredited undergraduate medical degree courses through the development and implementation of new funding guidelines that are not linked to current accreditation processes;
- Discourage diversity in undergraduate medical training through the imposition of an arbitrary one-size fits all approach;
- Extend its scope of activity over time into prevocational and vocational medical education and training by stealth; and
- Exclude the medical profession from having meaningful input into future HWA research and workforce planning activities.

Other health professions will be similarly affected by the activities of the HWA meaning that it could potentially lower the standards of health workforce education and training across the board. The AMA obviously does not support such an outcome and the consequent impact on patient care.

The establishment of HWA is an agreed outcome of the November 2008 Council of Australian Governments (COAG) meeting. Consistent with the November 2008 COAG Communiqué, the HWA is intended to have a number of functions including:

- Supporting health workforce research and planing;
- The provision of financial support for undergraduate clinical training;
- The provision of non-financial support for clinical training (eg matching students with clinical placements);
- Workforce redesign and reform; and
- The provision of advice to health ministers.

It is difficult to provide detailed comment on the Bill. It is basically technical in nature and in essence provides the legislative framework required to establish the HWA and form the basis for its ongoing operations.

The Bill does outline at section 5 various functions of the HWA. However, these are broad in nature and provide very little real insight into the activities of the HWA or its impact on health workforce education and training. Much of what the HWA will be able to do is yet to be revealed as a legislative instrument(s) will need to be put in place to support the operation of the Bill once it becomes law.

In examining the Bill, the AMA suggests that the Committee needs to look beyond its current content and consider how the Bill fits in with the Government's broader health workforce reform agenda and how it will operate in conjunction with the legislative instrument(s) that will be introduced at some point following the passage of the Bill.

The Bill does not provide a clear definition of clinical training and nor does it specify the types of courses considered eligible for funding by the HWA. Instead, these are largely left in the hands of the Minister for Health and Ageing who will have the power to:

- Determine via regulation what is considered eligible clinical training (Section 5, paragraph 3);
- Determine via regulation the kinds of students considered eligible for financial support in relation to clinical training (Section 5, paragraph 3(a));
- Determine via regulation the kinds of clinical training considered eligible for financial support (Section 5, paragraph 3(b)); and
- Determine via regulation the kinds of clinical training eligible for financial support by reference to specified courses or specified persons providing the course (Section 5 paragraphs 4(a) and 4(b)).

It is not hard to envisage that, with a budget under its administration in excess of $1.2b, the HWA will be able to significantly impact on the standards of medical education in Australia. There is an obvious potential for the HWA, through funding arrangements, to impose de facto standards for clinical training that are inconsistent with independently accredited arrangements.

HWA may adopt, for example, a standard funding formula to apply across medical schools – without regard for curriculum requirements or the sequencing of clinical training requirements. It could also seek to dictate:

- How many hours of clinical training are to be provided;
- The appropriate settings for clinical placements;
- How clinical placements are organised and allocated; and
- The timing of clinical placements.

Such a one-size fits all approach would clearly be inconsistent with current efforts to encourage diversity in medical education. Giving a practical example of how this might impact, the University of Wollongong's Graduate Medical School of Medicine (UOW) program makes significant use of community-based clinical experience and has a strong regional/rural focus – which is a good example of how a medical school responds to the health needs of the community and takes advantage of local resources.

The sequencing and structure of clinical placements in the UOW program will be quite different to many other medical schools and it would be a perverse policy outcome if future clinical training funding rules forced the UOW to modify its focus and curriculum.

Concerns that the HWA will play a very interventionist role have a strong basis. Material published by the National Health Workforce Taskforce (NHWT) in relation to the future role of the HWA states that "*HWA has both a policy, standards setting and implementation role*"[3].

The NHWT in its discussion paper, *Health Education and Training Clinical training - governance and organisation*, talks about the role of the HWA and the capacity of its funding and resource allocation mechanisms to influence the delivery of clinical training as follows:

> *Whilst the Agency's role in allocating funding to support clinical education is clear, its role in the management of the system is not. Models need to be considered that provide the Agency with the ability to influence the factors which determine the availability of placements in health services and to make more effective use of capacity across settings. Funding will be a key influence in this environment. Accordingly, the Agency's effectiveness is likely to be linked to its ability to allocate resources and its authority to make decisions regarding clinical placement issues*[4].

The HWA is also a creature of November 2008 COAG meeting, which reached agreement on National Partnership Agreements to drive reforms in a number of areas including health workforce. Schedule B of the National Partnership Agreement on Hospital and Health Workforce Reform (NPA) talks about the creation of the HWA at page 16 in the following terms:

> *Creating a National Health Workforce Agency to establish more effective, streamlined and integrated clinical training arrangements and to support workforce reform initiatives. Its responsibilities will include funding, planning and coordinating clinical training across all health disciplines; supporting health workforce research and planning; funding simulation training; and progressing new workforce models and reforms.*

The Commonwealth along with the states/territories clearly envisage that the HWA will be an agent of change with respect to health workforce education and training and a significant part of this focus is directed at reforms to clinical training. Indeed, the same NPA requires the parties to meet a number of key performance benchmarks including "*consistency in clinical placement hours and standardised models for clinical supervision*".

The work of the HWA will fit neatly with other reform measures being pursued by Government to give it much greater control over health workforce education and training. Through proposed national registration and accreditation arrangements for the health workforce, the Government will be able to influence accreditation standards for medical workforce training and potentially interfere with the role of the AMC. An unfettered role for the HWA will simply provide the Government

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[3] NHWT Presentation to the National Clinical Training Forum 27 March 2009. http://www.nhwt.gov.au/documents/Education%20and%20Training/National%20Health%20Workforce%20Taskforce%20Presentation%2027%20March%202009.pdf

[4] Health Education and Training Clinical training - governance and organisation. NHWT Discussion Paper February 2009

with another lever by which it can exert greater control. This agenda is totally at odds with world best practice in medical education and training.

As noted earlier, the Bill gives the Minister for Health Ageing broad powers to define what is considered to be eligible clinical training. For the same reasons as outlined above, this also has the potential to impose de facto standards for clinical training that are inconsistent with independently accredited arrangements.

The relevant provisions of the Bill also give the Minister power to expand the role of the HWA over time. While the Explanatory Memorandum to the Bill on pages 1 and 3 describes HWA responsibilities as relating to "pre-professional" entry clinical training, the Bill contains no such limitation. Looking at medical education and training, the Bill in its current form allows the Minister to make regulations covering not only clinical training during undergraduate medical education, but also prevocational and vocational training. This direction is flagged in the NPA on page 16 where, in relation to the HWA, it states that:

> *"Over time AHMAC will explore the expansion of the Agency's responsibilities in relation to clinical training in VET, post graduate and vocational training."*

If the Government does decide to expand the role of the HWA along the lines envisaged above, then its capacity to interfere with medical workforce training will be strengthened even further.

Indeed, it is unfortunate that the Explanatory Memorandum is deficient in that it does not explain adequately the full extent of the potential powers that could be given to the HWA by the Minister for Health and Ageing, or provide a more fulsome background to the introduction of the Bill. This type of information would no doubt be of assistance to the Parliament in helping it to understand the full ramifications of the Bill and the HWA.

The NHWT has issued two discussion papers during the last six months that, in relation to clinical training, have examined issues related to data collection as well as the governance of clinical training. The issues covered in these papers are highly relevant to the future work and activities of the HWA and in this regard the AMA has included as an attachment our earlier submissions to these discussion papers.

The broad thrust of the AMA's response to these discussion papers is that:

- the role of the HWA in the governance arrangements for clinical training must not undermine the role or independence of the Australian Medical Council (AMC), the postgraduate medical councils or the medical colleges,
- the existing roles of the AMC, the postgraduate medical councils, the medical colleges and the universities in clinical training should be maintained and supported, not taken over by, the HWA, and
- the HWA should focus on ensuring that funding arrangements adequately support universities to negotiate clinical placements at the local level.

Recommendations

Concerns that the HWA will be able interfere with accredited clinical training arrangements can be simply addressed through minor amendment(s)to the Bill as follows:

- The Bill could, for example, specifically require the HWA to link funding for clinical training to a course accredited by a recognised accrediting body such as the AMC.
- Any funding guidelines or related requirements that are imposed as conditions of funding should be developed in consultation with the relevant professional accrediting body such as the AMC.
- A provision should be inserted in the Bill that provides for the AMC, postgraduate medical education councils and medical colleges to have a direct governance role in the activities of the HWA in relation to prevocational and vocational medical training.

Stakeholder input

While the Bill in part 5 does provide for the establishment of advisory committees, there is no guarantee that the medical profession or the other health professions will have any meaningful input into the work of the HWA. The AMA believes that stakeholder input is essential to inform its activities in relation to all of its functions including the funding of clinical training, workforce planning and health workforce reforms.

In the absence of strong stakeholder input, the proposed governance structure means that there is a very real danger that the HWA will be dominated by the considerations of state/territory health departments that are focused on service delivery in public hospitals. Training is likely to become a "secondary" consideration while the need to better support general practice, which is funded by the Commonwealth, will not get the attention it deserves. This is a recipe for poor policy and is likely to lead to significant division between the HWA and the various health professions. Reform and change in the health sector will only succeed where the various health professions have buy-in and ownership.

It is worth noting that in 2006, the Australian Medical Workforce Advisory Committee (AMWAC) was abolished and its work handed over to the newly created NHWT. AMWAC previously brought together the medical profession and each of the jurisdictions to work on research and workforce planning. Over time it developed increasingly sophisticated approaches to data collection and workforce modelling/planning. It operated in a transparent way and enjoyed the support of all parts of the medical profession.

The work of AMWAC delivered real benefits. The Medical Training Review Panel (MTRP) was established by the Commonwealth to report on medical training opportunities in Australia. It provides an annual report to Parliament analysing the growth in medical training numbers, including vocational training. The MTRP has found that the majority of medical specialties are on track in implementing the AMWAC's recommendations to increase training numbers[5]. This demonstrates how working effectively with stakeholders delivers not only the right policies, but the required outcomes as well.

Since the NHWT took over the responsibility for AMWAC's work in 2006, the medical profession has largely been excluded from workforce planning activities. While AMWAC issued a series of reports each year, the NHWT has not issued a single medical or health workforce report of substance since its inception. Medical workforce planning has either disappeared from the radar or has simply been left in the hands of the various jurisdictions. Either way, an enormous information vacuum now exists and workplace planning appears to have lost all direction. There is now deep suspicion about the workforce agenda being pursued by the states and territories through the NHWT.

[5] Medical Training Review Panel. Eleventh Report, December 2007.

Recommendations

The HWA needs to be open and transparent in all areas of its activity. Stakeholder involvement will be fundamental to its success or otherwise. The AMA believes that the Bill could be improved by the inclusion of a specific function within the Bill as follows:

- To engage and consult effectively with stakeholders to ensure that the activities of the HWA are transparent and have strong input from the health professions.
- The HWA should be required to provide an annual report to the Parliament that details how it has consulted with stakeholders.

Thank you for the opportunity to provide comments on the Bill. The most pressing challenge facing the medical workforce at the present time is the need to ensure that the growing number of medical students and graduates will get adequate clinical training. The AMA welcomes the extra resources and investment in clinical training that the HWA will bring to face this challenge.

The AMA's major concerns with the Bill relate to the capacity of the HWA to interfere with independently accredited standards for medical education and to pursue health workforce reform and planning agendas without the proper input of the medical and other health professions. In this regard, the AMA would encourage the Senate to strongly consider the amendments that we have put forward as they will improve the operation of the HWA and ensure ongoing stakeholder support for its work.

Yours sincerely

Dr Rosanna Capolingua
President

Attachments: AMA Submission to the NHWT on clinical placements for medical students across Australia: capturing data and understanding demand and capacity.
AMA Submission to the NHWT on the governance and organisation of clinical training.

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Dr Lucy Firth
Project Manager
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Dear Dr Firth

Clinical placements for medical students across Australia: capturing data and understanding demand and capacity

Thank you for the opportunity to comment on the National Health and Workforce Taskforce's discussion paper on capturing data on clinical placements for medical students across Australia. The AMA has also appreciated the opportunity to participate in the recent roundtable discussions convened by the taskforce on this topic.

The AMA's comments do not deal with some of the more technical questions raised in the discussion paper such as the options for data management. These can be better addressed by the stakeholders who have direct involvement and expertise in these matters. The AMA's comments are also constrained by the lack of clear detail on the national health workforce agency announced by COAG in November 2008. In particular, there is scant detail available on the agency's precise role in collecting and modelling data for medical workforce projections.

General comment: the need for reliable data on clinical placements for medical students

It is clear that clinical training capacity must be lifted to match increased medical student numbers. Given that the number of first year medical school places will exceed 3,500 per annum by 2010 (which compares to 1,500 in 2000), much more work needs to be done to ensure that there are sufficient high quality clinical training places to support this increase.

Increased student numbers in nursing and allied health will also add to this pressure. In addition, a number of states are trialling of new classes of health professionals such as physician assistants. Clearly, lack of access to clinical training opportunities has the potential to become one of the most pressing health workforce issues over coming years.

Medical Deans of Australia and New Zealand highlighted in its report for the Medical Training Review Panel (MTRP) in 2008 that the current capacity of the health system to provide adequate numbers of clinical places for medical students will be stretched to the limit from as early as this year.[1]

[1] Medical Deans of Australia and New Zealand, National Clinical Training Review, *Report to the Medical Training Review Panel, Clinical Training Sub-Committee*, February 2008

Medical students, medical schools, hospitals, workforce planners, health departments and other stakeholders would benefit from more reliable data on clinical training and the better management of that data. As highlighted in the NHWT discussion paper, the collection of data on public hospital clinical placements is inefficient and fragmented, and it is difficult to obtain a reliable picture of available placements and the capacity of the health system to provide high quality clinical training at any given time. It is very important that accurate data on clinical placements for medical students is available to better support the provision of clinical training places and inform medical workforce planning.

General comment: role of the MTRP

The AMA believes that it is important for governments and stakeholders to have access to extensive and independent advice on medical workforce training issues across the undergraduate, prevocational and vocational training continuum. To this end, the AMA has sought a much broader role for the MTRP in relation to medical workforce training, including data collection.

In its submission to the Department of Health and Ageing's review of the MTRP last year, the AMA argued that the panel should collect, independently analyse and report on data across the full medical education continuum. This included the number of public hospital clinical placements for medical students on an annual basis. The AMA suggested that this data could then be used to determine if individual jurisdictions were meeting proposed training benchmarks set under the Australian Health Care Agreements.

If a central data collection system is established to cover clinical placements across the health professions, the AMA believes it is critical that the data collected on clinical placements for medical students is available to the MTRP. The NHWT would need to work with the MTRP regarding its data requirements and to ensure that it is provided in a way that allows the panel to perform its function effectively. The AMA would also expect that the data that is collected would be reliable, contemporary and readily available to stakeholders. In our experience, important data regarding training and the medical workforce and is often out of date, difficult to find or simply not made available.

General comment: a national approach to data collection on clinical placements

The AMA welcomes any improvements that increase the ease of allocating places for universities and improve the training outcomes for individual students. If feasible, the collection of data at the national level rather than the jurisdictional level appears to be sensible as it would ensure consistency of data and may help to identify under-utilised capacity as well as training bottlenecks.

The profession and other stakeholders must also agree on the type of data that is collected. Australia is renowned for its high standards of medical education and training, which have been developed by the profession. A strong clinical learning environment is fundamental to high quality medical education and improved data collection arrangements must effectively support current training and assessment practices.

The AMA would be concerned if initiatives in this area moved beyond data collection to the establishment of an agency that used the data collected to control or in any way micro-manage the allocation of individual clinical placements to universities, and/or the content and structure of clinical placements. The AMA would strongly oppose such an interventionist

role. These types of changes would undermine the professional learning environment and potentially impose changes on the structure of medical school programs and curricula. These changes would diminish Australia's high standards of medical education.

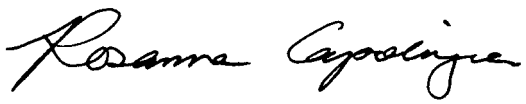
The planning for clinical placements is problematic because of lead times required, changing training requirements for students, variation in the length of placements, variations in curricula and the difficulties in coordinating arrangements. In this context, the establishment of an overarching clinical placement body is likely to prove to be a very costly exercise that will ultimately fail due to the significant hurdles involved. Clinical planning needs to be responsive and this is best done at the local level based on the best available data.

The AMA believes that there should be some clear guidelines for establishing an overarching national coordination body for collecting clinical placement data:

- it should be used in the best interests of students and meeting local needs – a directive approach to clinical placements would be counterproductive,
- data should be used to inform future workforce planning and support high-quality educational and training outcomes. Clinical placements for individual students must be consistent with their university's curriculum and should be arranged at the local level, and
- data should be readily available to relevant stakeholders, including professional bodies, students and the tertiary sector.

The AMA does support improved data collection and would reinforce the need for the NHWT (and its successor) to work closely with stakeholders as it attempts to move this concept further. In this regard, the AMA would welcome the opportunity to participate in any advisory group (s) established to further inform this work.

Yours sincerely



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13 February 2009

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National Health Workforce Taskforce
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Dear Madam/Sir

Re: Australian Medical Association submission to the National Health Workforce Taskforce discussion paper on the governance and organisation of clinical training

Thank you for the opportunity to provide feedback on this discussion paper. As the AMA does not engage directly in the planning, organisation or management of clinical training, our comments are restricted to the general issues raised in the discussion paper as they relate to medical education. The AMA's views on a national approach to data collection on clinical placements were outlined in our submission to the NHWT in February 2009.

Before providing any detailed comments, it is worthwhile highlighting that there is some confusion over the focus of the discussion paper, and indeed the scope of the NHWT's work, in so far as the discussion paper appears to cover both undergraduate clinical placements and provides commentary on areas such as specialist vocational training. This submission contains comments on the implications of the discussion paper across the medical education continuum.

It is essential for medical students to spend time in clinical settings in properly supervised roles to develop the clinical skills they need to practise safely and effectively as interns, and lay the foundations for lifelong learning and further prevocational and vocational training. Clinical placements provide essential clinical and professional learning opportunities to students by enabling them to gain experience in treating patients and to mix with peers.

Clinical placements are therefore fundamental to producing a well-rounded and highly skilled medical practitioner. This is currently recognised by the Australian Medical Council (AMC) in its standards for accrediting medical schools and college training courses. Clinical placements must meet the national standards prescribed by the AMC. This ensures that Australia's high standard of medical education is maintained and that the education and training experiences provided by universities and medical colleges across Australia meet nationally consistent, internationally recognised standards.

Further, in respect of undergraduate, prevocational and vocational education, the role of identifying appropriate clinical placements must remain in the hands of universities, postgraduate medical education councils, and medical colleges respectively because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at undergraduate and vocational levels.

The AMA recognises that Australia faces a huge challenge in finding sufficient clinical training places for medical students because of the current expansion of medical school places. Increased student numbers in nursing and allied health is also adding to this pressure. In addition, a number of jurisdictions are trialling new types of health professionals such as physician assistants, resulting in more competition across professional groups for clinical training opportunities within health services.

The AMA has consistently called for additional funding to support undergraduate clinical training and to that extent the AMA welcomed the extra funding for clinical training that was announced during the Council of Australian Governments (COAG) meeting in November 2008. The challenge now facing policy makers is to ensure that this funding goes to where it is most needed and not into new bureaucratic structures and processes.

Prevocational and vocational training

While the thrust of this discussion paper focuses on undergraduate training, there is significant concern that the principles are likely to apply to prevocational and specialist vocational training. If this is the intent of the NHWT then it should say so and provide a more detailed discussion paper that acknowledges the significant role of the postgraduate medical councils (PMCs) and the medical colleges in medical education. The medical profession requires clarity on how the PMCs and the medical colleges will interact with the new national health workforce agency and assurance that their existing roles will be maintained in full.

Prevocational training

The current postgraduate medical education infrastructure provides a bridge between the medical schools and medical colleges. The PMCs set the standards for prevocational medical education and training in Australia. They are strategically placed to understand and influence changes in the health workforce and are in a good position to enable change in the medical profession. The PMCs bring valuable experience to postgraduate medical education through their work in the national accreditation of prevocational education, clinical teaching and curriculum development.

The AMC is investigating the feasibility of establishing a process for reviewing and accrediting the PMCs. The AMA supports the AMC assuming the external accreditation role because it would:

- improve the continuity of medical education and training by increasing the AMC's links with the middle stage of medical education and complement its roles of accrediting basic medical education and vocational/specialist training,
- assist with the introduction of the Australian Curriculum Framework and the Prevocational Medical Education Framework, which if implemented properly, will improve education and training outcomes for PGY 1 and PGY 2 doctors,
- heighten recognition at the national level of the importance of prevocational training, and
- provide increased transparency of accreditation practices.

The likelihood of the AMC taking on the external accreditation of the PMCs would be thrown into doubt under the principles and arrangements outlined in the discussion paper. The PMCs' pre-eminent role as the bodies responsible for the first two postgraduate years and non-vocational trainees must be preserved and supported with adequate levels of resources by state and territory governments. This will ensure that PGY 1 and PGY 2 placements are of

high quality, that equivalent and consistent training experiences are provided in hospital and other health settings across Australia, and that they provide the nationally consistent, essential precursor training experience required for further study at the vocational level.

Vocational training

The specialist medical colleges set standards and conduct training for specialist vocational training in a cost-effective manner focusing on safety and quality. Much of the work of the colleges is delivered by committed individuals who are passionate about increasing safety and quality within their discipline. These people give their time freely or at a far lower cost than would be available to other bodies. The colleges are also engaged in partnerships in education for their trainees, particularly with universities accredited by the college to provide components of training or professional development.

None of the proposed models refer to or integrate any involvement of the medical colleges who have for many decades successfully supported or provided specialist medical training and have been responsible for setting the highest standards for this training, including approving appropriate vocational training placements. This role must remain in the hands of the medical colleges to ensure that clinical placements at the vocational training level are of high quality, that they provide equivalent and consistent training experiences in hospital and other health settings across Australia, and that they properly complement the course requirements at the vocational training level.

The role and operation of the national health workforce agency must not interfere with the role of medical colleges in:

- accreditation and standard setting,
- determining specialist qualifications held by medical practitioners,
- approving and in many cases managing professional development programs for the medical profession, and
- assessment of overseas-trained specialists who are applying for recognition to practice in Australia.

Role of a national health workforce agency in clinical education and training

The discussion paper suggests that the new national health workforce agency could take the form of a central workforce planning agency that would be tasked with linking the health and education sectors; overseeing the development of a multi-disciplinary and competency-based training framework for health professionals; managing clinical placements; and managing funding arrangements for clinical training. Under this model many facets of medical education and training would be effectively controlled by a government agency.

This model would not improve the governance and organisation of clinical training in Australia. A nationally consistent structure for maintaining the high standards of education and training for the medical profession already exists under the auspices of the AMC. The AMC is the independent national standards body that accredits medical education and training and maintains standards to protect patient safety. Within this framework, the AMC has in place standards that underpin undergraduate clinical training as well as processes to encourage medical schools to work with each other collaboratively so that available resources for clinical training are utilised effectively.

The role of the AMC is consistent with policy principles set down by the World Federation for Medical Education (WFME).[1] The WFME guidelines are very explicit on this topic, requiring that the accreditation of medical education (including the component of medical education that takes place during clinical training placements) should ensure that quality assessment is independent of government, the medical schools and the profession, and that the accrediting body (in this case the AMC) should be authorised to set standards in respect of medical education and training, including clinical training.

Patient safety and public confidence in the system will be supported by sound assessment and recognition processes. Training placements must also offer a satisfactory range and scope of training. Training numbers are just one element: appropriate standards are essential.

A continued and important role for the AMC has not been acknowledged in the discussion paper and none of the proposed models suggest a role for the AMC as it functions currently.

The proposed model presented in the discussion paper could undermine the independence of the AMC and establish a framework where the current standards for medical education and training could be eroded and manipulated. This would undermine Australia's hard won reputation for excellence in medical workforce training and risk international recognition of students who undertake medical education and training in Australia.

Further, any governance model that compromises the effective and independent role of the AMC will not be supported by the medical profession on the basis that quality of patient care could be compromised. The role of accrediting medical education and training, at university, prevocational and college level, must be fully delegated to a body with medical professional expertise and the support and confidence of the profession, such as the AMC.

The accreditation body must remain independent from any outside influence, including from influence or interference in its decisions by all levels of government or any government established body such as the new national health workforce agency, in undertaking the following activities:

- setting of standards,
- ongoing accreditation of individual education and training courses, and
- assessment processes for international medical graduates.

Notwithstanding the need for the AMC arrangements to remain independent, it is important to highlight the fact that the existing AMC council and standing committee arrangements are highly accountable and transparent, including through the following processes:

- the Commonwealth and the jurisdictions (Australian Health Ministers' Advisory Council) are represented on the council and its major standing committee (currently by a representative of the Commonwealth Chief Medical Officer and the Chair of the Health Workforce Principal Committee),
- health consumers are also represented on the council, its standing committees and accreditation assessment teams,

[1] World Health Organisation/World Federation for Medical Education *Guidelines for Accreditation of Basic Medical Education* (Geneva/Copenhagen 2005).

- medical boards are represented on the council, standing committees and (periodically) on accreditation assessment teams,
- medical students and trainees are members of accreditation standing committees and accreditation assessment teams,
- medical schools and specialist accreditation reports are made public and are available through the AMC website,
- recognition of medical specialties reports are made available to the Commonwealth Minister of Health and are also made public when the Minister has decided on the outcome,
- there are comprehensive appeals mechanisms for all of the AMC assessment activities,
- all assessment criteria and examination specifications, including statistics on pass rates, are published on the AMC website and are available in hard copy from the AMC,
- the AMC has produced comprehensive reference publications that detail the content and assessment criteria for all AMC examinations, together with detailed commentaries on clinical best practice in the Australian context, and
- a number of the AMC's processes are subject to external validation and/or compliance with international standards, such as the approval of the medical school accreditation process by the US Federal Department of Education and compliance with WFME guidelines.

Current arrangements which allow individual jurisdictions to have some input into the work of the AMC through the arrangements outlined above are appropriate in helping ensure that local workforce issues are drawn to the attention of the AMC. However, it would not be appropriate for either the Australian Health Ministers' Conference itself or the new national health workforce agency to seek to influence unilaterally the national standards set by the AMC for medical education and training across the country.

There is also a high risk that the national health workforce agency would result in extra layers of administration and bureaucracy that would soak up valuable resources and have little understanding of local needs. It is hard to imagine, for example, how a national health workforce agency would be able to assess the resources available at the local level or leverage local relationships to expand clinical training opportunities for medical students into the private sector and into community settings.

Apart from the important role of collecting data on clinical training capacity for informing future workforce planning, a national health workforce agency should focus on ensuring that adequate funding is available to support universities in their efforts to place students in high-quality undergraduate clinical placements. Universities and local health service providers are best placed to understand local needs and already work effectively together with other local stakeholders.

The national health workforce agency could assist in improving the overall coordination of undergraduate clinical placements by encouraging more cooperation at the regional or statewide level. The AMA believes that there would be some merit in establishing consultative mechanisms that provide a forum for universities, health departments and other stakeholders to work together to develop plans that support a strategic approach to the effective provision and resourcing of undergraduate clinical placements.

Critically, it should not be the role of the national health workforce agency to control or in any way micro-manage the allocation of individual clinical placements, and/or the content and structure of clinical placements. This role must appropriately remain in the hands of the universities who are the best position to ensure that clinical placements complement their courses at the undergraduate level.

The AMA would strongly oppose such an interventionist role. These types of changes would undermine the professional learning environment and potentially impose changes on the structure of medical school programs and curricula. These changes would diminish Australia's high standards of medical education.

The most appropriate model for delivering sustainable clinical training and ensuring that the needs of students are met is where education providers coordinate arrangements for clinical training with health providers at the local level. Medical schools are best placed to ensure that:

- students are exposed to a range of models of care and to an appropriate range of clinical disciplines,
- the length of clinical placements meet local requirements and are consistent with the medical school's curriculum, and
- sufficient clinical teaching and learning resources, including appropriate supervision, are arranged for clinical placements.

This approach is consistent with the AMC's standards for accrediting medical schools, which encourages medical schools to work collaboratively with other schools, clinical placement sites and state and territory health departments to provide a high-quality clinical experience for their students.[2]

Multi-disciplinary and competency-based training

The AMA suggests a cautious approach to implementing multi-disciplinary health education and training as described in the discussion paper. Multi-disciplinary training is effective for medical students when the standard of teaching and training is at the level that will be required for the future medical practitioner's scope of practice. In reality, multi-disciplinary training is likely to be applicable to medical students at a very basic level only, as medical training quickly becomes more intense, detailed and extensive than the other health disciplines.

The AMA supports medical students being able to gain experience working in teams with other health professionals, as well as developing a good understanding of their roles, but it does not want to see changes that could undermine the high standards of medical training in Australia.

Similarly, competency-based training and assessment has limitations in its application to medical education. Medical education needs to be approached as a continuum and should not be fragmented. Learning continues throughout the career of a medical practitioner, building

[2] Australian Medical Council, *Assessment and Accreditation of Medical Schools: Standards and Procedures 2009*.

on the solid foundation of knowledge gained firstly from the undergraduate, then prevocational and vocational years.

There is much that is learned and developed through non-competency measures. In particular, effective clinical judgement can only be developed progressively using a number of different competencies and significant clinical exposure.

Competency-based training is often seen as a model to shorten training. In fact, training may be shorter or longer depending on the capability of the trainee.

The AMA would be concerned by any moves to fragment medicine through the development of curricula that simply serve to meet a set of minimum standards for the various stages of medical education. Developing such minimum standards only serves to reduce the quality of our medical graduates.

Undergraduate medical education based on a list of competencies required for internship presents the serious risk of overlooking the important elements of medical education. While a well-defined curriculum is important, if it is too narrow and shortsighted in its design, it is likely to promote the achievement of a number of competencies at the sacrifice of a deeper understanding of the methodology and underpinning knowledge.

In one of the proposed models, a central agency would decide the adequacy and length of competency-based training. The AMA does not see this as an appropriate role for a national health workforce agency.

The AMC is working with stakeholders to improve medical workforce training and is actively looking at the extent to which multi-disciplinary and/or competency-based training are appropriate and relevant in medical training. The AMC should be left to continue this work as the body responsible for accrediting medical education and training in Australia.

Relationship between the provision of medical services and clinical training

The potential conflict between workforce/service provision and quality education/training is a significant issue that has not been covered at all in the discussion paper but requires consideration and careful handling. Doctors in training make a significant contribution to the provision of medical services in the health sector and to the teaching and supervising of more junior members of the team, as well medical students. As a result, there are significant advantages for service providers in having secure training numbers and length of contracts for trainees. Shortening or lengthening training time is a challenge for hospital and community health planning.

Training in medicine cannot be separated from the provision of medical services, both in terms of the contribution that doctors in training make to the provision of medical services, and the contribution that fully qualified doctors make to the training of medical students and trainees while they provide medical care and supervision. Any proposed restructuring must continue to recognise and integrate both these aspects at an educational and resource level.

Medical profession input into the national health workforce agency

The AMA understands that the broader governance and structure of the national health workforce agency has not been decided. While it is not a topic of the discussion paper, the AMA would reinforce that it must include appropriate mechanisms that provide for strong professional input into its activities.

Workforce planning

Previous workforce planning agencies such as the Australian Medical Workforce Advisory Committee (AMWAC) were able to capture professional input effectively and there was broad stakeholder support for the work of agencies such as AMWAC. The health professions are now largely excluded from workforce planning processes and very little now appears to be happening in this area. There is a lack of accountability in current workforce planning activities and deep suspicion about the workforce agenda being pursued by various jurisdictions.

Enhancing community-based training

There is a significant opportunity for further community-based training for undergraduate, prevocational and specialist vocational medical training and for other health professionals; however, investment in community infrastructure for this training will be required. The AMA would welcome early consideration of this issue by the new national health workforce agency.

Recommendations

In summary, the AMA believes that:

- future governance arrangements for clinical training must not undermine the role or independence of the AMC, PMCs or the medical colleges,
- the existing roles of the AMC, universities, PMCs and medical colleges in clinical training should be maintained and supported, not taken over by, the national health workforce agency,
- the future role of the national health workforce agency should focus on ensuring that funding arrangements adequately support universities to negotiate clinical placements at the local level,
- the role of the national health workforce agency should not involve micro-managing the allocation of individual clinical placements, which should continue to be done by universities in respect of undergraduate training because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at the undergraduate level,
- in respect of prevocational and vocational medical education, the role of identifying appropriate clinical placements must remain in the hands of PMCs and medical colleges respectively, because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at the prevocational and vocational levels,
- the national health workforce agency could assist in improving the overall coordination of undergraduate clinical placements by fostering cooperation at the regional or statewide level between educational institutions and health care providers,

- competency-based training and assessment has limitations in its application to medical education, as much needs to be learned and developed through non-competency measures,
- the potential conflict between workforce/service provision and quality education/training is a significant issue that requires consideration and careful handling, and
- the national health workforce agency must include appropriate mechanisms that provide for strong input from the medical profession into its activities.

The AMA looks forward to participating in the upcoming forums that will discuss the matters raised in the discussion paper.

Yours faithfully

Dr Rosanna Capolingua
President

30 March 2009