National Health and Hospitals Reform Commission

Submission Cover Sheet

Please complete and submit this cover sheet with your submission to:

By email: talkhealth@nhhrc.org.au
By mail to: PO Box 685 Woden ACT 2606

A. Details of the person or organisation that prepared this submission

Date of submission: 10 June 2008

Who prepared this submission?
☐ Individual ✓ Organisation

For individuals:

Name of individual:_____
Street address: _____
Mailing address (if different from above): _____
Phone (daytime): _____
Fax: _____
Email: _____

For organisations:

Type of organisation. (Please tick all that apply)
☐ Consumer group
☐ Government agency
☐ Private company
✓ Professional body
☐ Other non government organization
☐ Other (Please specify) _____

Geographic focus of organisation. (Please tick all that apply)
✓ Nationwide
☐ Statewide (Please specify State/Territory) _____
☐ Metropolitan
☐ Rural / regional
☐ Remote

Please specify the particular sector focus of your organisation (if applicable).
_____

Purpose/s of organisation. (Please tick all that apply)
✓ Research
✓ Education
☐ Service provision
✓ Advocacy
☐ Other (Please specify) _____

Name of representative: **Dr Jagdishwar Singh**
Position within organisation: **General Manager**
Name of organisation: **Confederation of Postgraduate Medical Education Councils**
Street address: **Level 9, 27 Victoria Parade, FITZROY, VIC 3065**
Mailing address (if different from above): **P.O. Box 2900, St Vincent's Hospital, FITZROY, VIC 3065**
Phone (daytime): **03 94191217**
Fax: **03 9419 1261**
Email: jsingh@cpmec.org.au

Please note that in making a submission you agree that it may be made public.

B. Response to draft principles

✓ This submission specifically comments on the draft principles developed by the Commission to shape Australia's future health system. (Please tick if this applies)

C. Response to key themes

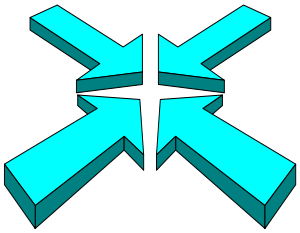
This submission specifically responds to the following key themes taken from the Commission's Terms of Reference. (Please tick all that apply)

☐ A greater focus on prevention to the health system
☐ Improving frontline care to promote healthy lifestyles and prevent and intervene early in chronic illness
☐ Improving Indigenous health outcomes
☐ Integrating and coordinating care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health
☐ Improving the provision of health services in rural areas
☐ Integrating acute services and aged care services, and improve the transition between hospital and aged care
☐ Reducing inefficiencies generated by cost-shifting, blame-shifting and buck-passing
✓ Providing a well qualified and sustainable health workforce
☐ Maintaining the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care
☐ Maximising a productive relationship between public and private sectors
☐ Providing a more seamless experience across public and private services
☐ Providing advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks
☐ Addressing the escalating costs of new health technologies
☐ Increasing access to services
☐ Addressing the growing burden of chronic disease
☐ Providing for an ageing population
☐ Managing the escalating costs of new health technologies
☐ Addressing overlap and duplication including in regulation between the Commonwealth and states

☐ Other (Please specify)_____

_____

Confederation of Postgraduate Medical Education Councils



Submission to the National Health and Hospitals Reform Commission

10 June 2008

Executive Summary

The Confederation of Postgraduate Medical Education Councils (CPMEC) is an association of State Postgraduate Medical Councils (PMCs) and the Education Committee of the Medical Council of New Zealand. PMCs develop, support and implement the education of prevocational doctors and provide education and support to International Medical Graduates (IMGs) and Career Medical Officers (CMOs). Education and training for health professionals is central to Principle 7 in *Beyond the Blame Game*, *Providing for Future Generations*, Barriers to education and training are recognized in Challenge 12, *Ensuring Enough, Well-trained Health Professionals and Promoting Research.*

Pre-vocational training provides the foundation for specialist and general practice training. PMCs have considerable expertise in pre-vocational training, which has been used to develop the Australian Curriculum Framework for Junior Doctors (ACFJD).

The quality of our health system depends on well trained health care workers. CPMEC suggests that the education, training and support of all health workforce trainees and practitioners can be incorporated within a conceptual framework, 'A *Skilled and Valued Workforce'* with commitment to:

- ensuring an adequate supply of health professionals for all sites, particularly rural, regional and outer metropolitan areas, through coordinated workforce planning,
- high quality, appropriately resourced training for health professionals,
- effective career planning and career development support,
- effective professional regulation and maintenance of professional standards,
- ensuring the welfare, health and well-being of health professionals

CPMEC would like to draw attention to the following pre-vocational medical training issues:

1. The continuum of medical training

Medical training is a continuum from medical school to continuing professional development. Training takes place within a complex, fragmented health system. Many groups and individuals are responsible for each phase (see Appendix). Prevocational training is a period of workplace-based learning, during which trainees master the generic knowledge, skills, attitudes and behaviours needed for safe practice.

Uncoordinated funding streams have led to poor integration between phases of training and affected the content of training, exacerbating workforce shortages and mal-distribution. For example few trainees are exposed to general practice during postgraduate years 1 and 2, when most make career decisions.

Recommendation 1 **There should be explicit funding and accountability for all stages of training to end the 'blame game,' prevent cost shifting and protect the training continuum, including explicit funding for health service based training for: educational supervision and support, teaching facilities, clinical skills laboratories and professional development programs. This should include adequate funding of PMCs, and clearly identified costs of teaching for medical schools.**

Accreditation of training posts and providers is a key accountability measure. PMCs currently accredit all PGY1 posts but many PGY2 positions are not accredited. PMCs are not accredited.

Recommendation 2. **All pre-vocational training positions should be accredited and PMCs should be accredited by the Australian Medical Council.**

CPMEC strongly supports robust, relevant performance indicators to ensure accountability for education and training and promote collaboration between all stakeholders.

Recommendation 3. **NHHRC should develop performance indicators that ensure that all groups involved in education and training are accountable.**

2. Increasing Training Capacity

The expansion of medical school places over the last 5 years will have limited impact on the medical workforce crisis without targeted expansion of postgraduate training posts. The increased number of medical graduates creates opportunities to address some of the deficiencies of pre-vocational training.

Recommendation 4. **Expansion of pre-vocational training posts should be targeted to:**

- **areas of workforce shortage in rural, regional and outer metropolitan Australia,**
- **disciplines with workforce shortages,**
- **provide exposure to ambulatory medicine and the private hospital system,**

- **achieve ACFJD learning objectives and provide protected training time,**
- **manage the risk of unsafe workload and unsafe working hours.**
- **provide research funding to adapt or develop new methods of training and assessment.**

This will not occur without a significant improvement in coordination between levels of government, continued funding for the development and implementation of the ACFJD and increased support for clinical supervisors and Medical Education Officers (MEOs).

Recommendation 5. **Ongoing development and implementation of the ACFJD should be funded.**

3. Integration and coordination of medical training and workforce planning

Medical workforce planning is fragmented and suffers from a lack of accurate workforce data. An integrated medical workforce planning system based on accurate data and robust demand modelling is urgently required. At the pre-vocational level this will require much better consultation between Federal and State governments, workforce agencies (MTRP, NHWT), CPMEC and PMCs. Performance indicators should incorporate meaningful, measurable workforce planning objectives.

Recommendation 6. **Performance indicators should be linked to workforce planning objectives.**

4. The relevance of training

Most postgraduate medical training is focussed on acute healthcare problems in public hospitals but most patient care occurs in the community and is focussed on chronic, health problems. The majority of elective surgery takes place in private hospitals, which provide very little training. Training in community based and private settings should be significantly expanded. See ***Recommendation 4***.

5. Recognition of clinical teachers

Australian medical education is critically dependent on clinical teachers, who are under increasing pressure because of higher workloads and public hospital financial pressures.

Recommendation 7. **Clinical teachers should be recognised and rewarded by: realistic remuneration; inclusion of teaching in contracts and performance appraisals; access to professional development training; academic titles and administrative support; and clearly defined career pathways.**

6. Simulation based clinical training

Simulation is an important adjunct to (but not substitute for) clinical supervision and training, providing opportunities to develop clinical skills in a safe environment. Only a minority of pre-vocational and vocational trainees currently have access to clinical skills laboratories.

Recommendation 8. **Australia should develop a coordinated network of clinical skills laboratories in clinical sites for use by trainees in all clinical disciplines.**

7. International Medical Graduates and Career Medical Officers

Australia will be heavily dependent on IMGs for at least a decade. The Australian public must be assured that they are appropriately assessed and educated. IMG assessment and training is poorly coordinated and significantly under resourced. CPMEC strongly supports the new registration pathways for IMGs but has major concerns about funding and the level of preparation,

Recommendation 9. **Resources for IMGs should be significantly expanded to provide a well supported recruitment pathway, appropriate cognitive and clinical assessment at the time of recruitment, and educational resources to remedy any deficiencies identified.**

Despite their important service role, CMOs' educational programs are limited and poorly coordinated.

Recommendation 10. **CMOs should be provided with structured education programs.**

8. Protecting and promoting the welfare of health professionals to ensure high quality care

Doctors and other health professionals suffer stress related health problems and burnout. There is a growing body of research on the links between stress, fatigue and medical errors.

Recommendation 11. **NHHRC's performance indicators should include measures to improve and maintain the health and welfare of health professionals.**

1. Introduction: The Confederation of Postgraduate Medical Education Councils

The Confederation of Postgraduate Medical Education Councils (CPMEC) is an association of Postgraduate Medical Councils (PMCs) of each State or Territory in Australia and the equivalent agency in New Zealand.

In Australia, CPMEC comprises the following organisations:

- NSW Institute of Medical Education and Training (IMET)
- Postgraduate Medical Council of Queensland (PMCQ)
- Postgraduate Medical Council of South Australia (PMCSA)
- Postgraduate Medical Council of Victoria (PMCV)
- Postgraduate Medical Council of Western Australia (PMCWA)
- Postgraduate Medical Institute of Tasmania (PMIT)
- Postgraduate Medical Council of Northern Territory (PMCNT)

The Education Committee of the Medical Council of New Zealand recently became a full Executive member of the CPMEC.

PMCs are responsible for developing, supporting and implementing the education and training of junior doctors during their prevocational years (usually postgraduate years 1 and 2). PMCs also have a role in provision of general support for this group of junior doctors and in provision of education and general support for International Medical Graduates (IMGs) working in junior medical positions in Australian hospitals. In some states[1] PMCs also have responsibility for the training and support of Career Medical Officers (CMOs), doctors who choose not to undertake vocational training but continue to work in the public health system, particularly in emergency departments, mental health services, and community health services.

Pre-vocational training is an important component of the Australian medical training system which provides the foundation for specialist and general practice training. Satisfactory completion of the first year of pre-vocational training, the intern year, is the basis for full registration by State medical boards. Over the last decade PMCs have accumulated a broad range of skills, expertise and experience in pre-vocational workplace based training. This has led to the development of a national curriculum framework, the Australian Curriculum Framework for Junior Doctors (ACFJD), which is currently being implemented by PMCs, and individual healthcare providers throughout Australia. The ACFJD has also been adopted as a blueprint for prevocational training in New Zealand. CPMEC has set up a broad stakeholder-based National Steering Group to coordinate these various implementation initiatives.

2. "Beyond the Blame Game" - Principles and Challenges

In calling for submissions, the NHHRC described fifteen principles to shape Australia's health system. In its initial report, *Beyond the Blame Game*, twelve health and healthcare challenges 'where the need for improvement is well understood and extensively documented,'

[1] In NSW, the NSW Institute of Medical Education and Training has an interest in the delivery of specialist (vocational) training through formal training networks that are supported with funding from NSW Health.

have been identified. The principles and challenges are broad ranging and reflect a long-term, integrated view of health, which has often been lacking in previous discussions of healthcare reform.

CPMEC and its constituent PMCs are primarily concerned with the training, development and support of junior doctors during their prevocational training. Provision of education and training for health professionals is clearly central to Principle 7, *Providing for Future Generations*, and the difficulties of providing education and training in the Australian healthcare system are recognized in Challenge 12, *Ensuring Enough, Well-trained Health Professionals and Promoting Research.* Education and training, and support of health professionals are also relevant to several other principles and challenges enumerated in the report.

The quality of our health system – no matter the setting (community, public, private), or complexity (public health, clinical care from primary through to tertiary services) - depends largely on the high quality training, professional standards and dedication of health care workers. Even the most sophisticated technology will not allow modern health care facilities to operate without skilled professionals.

However, there are longstanding health workforce shortages and misdistribution throughout Australia, particularly in rural, regional and outer metropolitan areas. These problems have caused widespread community concern and have become one of the dominant issues on the health agenda in recent years, as evidenced by the Productivity Commission Review of the Health Workforce in Australia and COAG's subsequent active intervention in health workforce policy.

We submit that the need for a skilled and engaged health workforce warrants its elevation to a key design principle in its own right. This would be consistent with best practice frameworks seeking to promote service excellence where workforce focus is given explicit recognition as a key factor in meeting current and future service delivery challenges[2]. CPMEC suggests that the education, training and support requirements of all health workforce trainees and practitioners can be incorporated within a broad conceptual framework, 'A *Skilled and Engaged Workforce'*. Alternatively, adoption of this framework could be emphasised within the existing principle, *Providing for Future Generations,* and would include long term commitment to:

- ensuring an adequate supply of health professionals for all sites, particularly rural, regional and outer metropolitan areas, through coordinated workforce planning
- high quality, appropriately resourced training for health professionals
- effective career planning and career development support
- effective professional regulation and maintenance of professional standards
- ensuring the welfare, health and well-being of health professionals

3. Australian Prevocational Medical Training: Major Issues

1 The continuum of medical training

Medical training is a continuum that begins with entry into medical school (Phase 1 'basic medical education"); transition into supervised clinical practice following graduation (Phase 2 "prevocational"); entry into general practice, specialist training or other medical training (Phase 3 "vocational training"); and continuing professional development (Phase 4 "life-long learning").

This training takes place within a complex and fragmented health system where many groups and individuals have responsibilities for each phase (See table in the Appendix).

[2] See for example the 2008 Health Care Criteria for Performance Excellence, Malcolm Baldrige Quality Program, accessed from http://www.quality.nist.gov/HealthCare_Criteria.htm, 25 May 2008.

Whilst the boundary between these phases is not always sharply defined, each phase of training makes a unique and important contribution to the professional development of an independent medical practitioner. Prevocational training is an essential period of workplace-based learning which allows graduating medical students to master a range of generic knowledge, skills, attitudes and behaviours needed for full registration and safe practice. These competencies are an essential prerequisite for all vocational training programs.

CPMEC notes the emergence of competency based training models for the health professions. It is important to recognize that medical training demands much more than a series of procedural competencies that can be learned as checklist; it encompass broad expertise in complex areas such as clinical management, communication and professionalism which are practised in context and must be learned in context. For example, competency in Emergency Medicine is much more than being able to master individual competencies such as managing an airway or setting a fracture. Emergency Medicine practitioners must be trained to competently triage, diagnose, investigate and treat a group of undifferentiated, acute presentations simultaneously. CPMEC believes that it is essential that this broader view of competency underlies discussions of task substitution in health system reform.

Prevocational trainees make a significant contribution to the operation of Australian hospitals, particularly PGY2 trainees, who provide a large proportion of out of hours and weekend cover. The service provided by pre-vocational trainees is increasingly being delivered in the context of an interdisciplinary team. It is important that this context is recognised in the training curriculum. The prevocational doctor's central role within that team should be recognized, defined, and valued. In this context, any attempt to streamline the duration of postgraduate medical training should not be at the expense of diluting this phase of medical education and training.

Two groups of doctors do not follow the traditional path through the medical education and training continuum; International Medical Graduates (IMGs), doctors trained in other countries who work in the Australian healthcare system, and Career Medical Officers (CMOs), a group of Australian graduates who choose not enrol in vocational training through a college program. Both these groups play a vital role in service provision particularly in emergency departments, mental health services, and community health services, but both currently have poor access to training and professional development programs.

The fragmentation of Australian medical training limits the quality of education and training provided to our trainees. For example:

- CPMEC has recently developed a national curriculum framework, for the two pre-vocational years, the ACFJD. The framework contains many learning objectives which are repeated in College curricula. National implementation of the ACFJD would allow recognition of prior learning by Colleges and help to streamline medical training.
- University based medical schools do not have the capacity or clinical workforce to oversee postgraduate teaching but they have a great deal to offer in areas such as curriculum development and assessment, medical ethics, medico-legal issues, health administration and other topics that are less familiar to clinical supervisors.
- There is limited coordination of teaching programs for pre-vocational trainees, IMGs and CMOs.
- There is little collaboration between colleges on teaching programs in significant areas of common ground such as training in professional skills (teaching, research, ethics, health administration, clinical sciences).
- Inter-professional learning is being adopted at some universities but is not well developed in postgraduate training. Obvious areas for collaboration between health professionals include clinical skills training in simulation centres, team training and leadership and management training.

The traditional separation of funding streams has discouraged integration between phases of training (Commonwealth funded basic medical training, State funded pre-vocational and hospital based vocational training, Commonwealth funded general practice training) with resultant inefficient use of scarce clinical teaching resources and loss of economies of scale.

Poor coordination of these funding streams has also had a deleterious effect on the content of training, which has almost certainly exacerbated workforce shortages and mal-distribution. For example: only a small minority of trainees are exposed to general practice during pre-vocational training, the period when most graduates make career decisions; most specialists spend most of their working life in ambulatory settings, to which they receive very little exposure during their vocational training.

CPMEC recommends that in order to protect the training continuum, there should be explicit national funding and accountability for all stages and sites of medical training. If there is no change to the funding and organisation of medical training, there will be a continuing tendency for organisations involved in the different stages of training to shift costs and/or responsibility for training to others and to operate according to sectional interests which may not align to the interests of the community as a whole: the 'blame game' will continue.

It is recommended that current mechanisms of government funding for medical training be reviewed with the aim of achieving the following outcomes at a national level:

- Explicit funding for health service based postgraduate training to cover the costs of: educational supervision (mostly clinician time); education support (administrative support and medical education officers); payment of directors of postgraduate training programs; teaching facilities including lecture theatres, tutorial rooms, clinical skills laboratories and libraries; internet access and on-line learning resources; and generic professional development programs such as Teaching on the Run and the CPMEC Professional Development of Registrars program. This funding should include adequate resourcing of PMCs

- Clearly identified funding for university medical schools to cover the costs of teaching (academic staff, clinical teachers, teaching facilities, laboratories, clinical skills laboratories, libraries, student accommodation and facilities). Australian medical schools are poorly funded in comparison with medical schools in other developed countries. A recent New Zealand review of the cost of medical education has resulted in a 50% increase from pre-existing levels which were similar to current Australian funding.

Recommendation 1. **There should be explicit funding and accountability for all stages of training to end the 'blame game,' prevent cost shifting and protect the training continuum, including:**

- **Explicit funding for health service based training for: educational supervision and support, teaching facilities, clinical skills laboratories and professional development programs. This should include adequate funding of PMCs**
- **Clearly identified funding for medical schools which covers the costs of teaching**

A key accountability measure is accreditation of training posts. PMCs currently accredit all Australian PGY1 posts. However, PGY2 positions are not accredited in all states. CPMEC strongly recommends that all pre-vocational training positions should be accredited. A pre-vocational national medical education and training accreditation framework, which is integrated with undergraduate and vocational accreditation processes, is currently under development. CPMEC also strongly supports the MedEd 2007 conference recommendation that PMCs should be accredited by the Australian Medical Council so that the same accreditation body oversees the key education providers at undergraduate, pre-vocational and vocational levels.

***Recommendation 2*. All pre-vocational training positions should be accredited and PMCs should be accredited by the Australian Medical Council**

An increasing number of Australian graduates complete part of their pre-vocational training in New Zealand (and vice versa). The two healthcare systems and medical training systems are very similar and it would be appropriate for training and registration in either country to be mutually recognized by regulatory and educational authorities in both countries. Significant reforms to New Zealand pre-vocational education, with a view to improving integration across the continuum of training, are currently under discussion by the New Zealand Medical Training Board, the Medical Council of NZ and other stakeholders, including the medical schools.

CPMEC strongly supports development of robust, relevant performance indicators which promote collaboration between the multiple groups contributing to health professional education and ensure that ***all*** of these groups are accountable for education and training. These performance indicators should be designed to reduce tensions and competition for resources between:

- service and training
- basic, pre-vocational and vocational training
- hospital-based and ambulatory training
- State and Federal Governments.

***Recommendation 3*. NHHRC should develop performance indicators that ensure that all groups involved in education and training are accountable.**

2 Increasing Training Capacity

There has been a major expansion of medical school places over the last 5 years. There were approximately 1600 graduates in 2005, and there will be almost 3000 in 2012. While this long overdue increase is very welcome, it will not have a significant impact on the medical workforce crisis unless there is a similar expansion of the number of pre-vocational and vocational training posts to allow these graduates to complete postgraduate training. Junior doctors are particularly concerned about the difficulty of expanding the number of Emergency Medicine rotations for interns. Completion of an Emergency Medicine rotation is currently a requirement for full registration by Medical Boards at the end of the intern year in most states.

The increased number of medical graduates creates opportunities to address some of the deficiencies of pre-vocational training. It should be possible to:

- create new positions in areas of workforce shortage in rural, regional and outer metropolitan Australia (This will be ineffective unless it is matched by provision of additional vocational training posts in these sites to attract trainees away from inner metropolitan teaching hospital based programs).
- create new positions in disciplines with workforce shortages, e.g. psychiatry, rehabilitation (This will be ineffective unless it is matched by provision of additional vocational training posts in these disciplines)
- provide exposure to ambulatory medicine, particularly general practice, which is currently missing from pre-vocational training. This could be achieved by expansion of the Pre-vocational General Practice Placements Program (PGPPP), by creation of new training posts in Super Clinics, or by extension of the Expanded Specialist Training Program to pre-vocational trainees. There are also excellent training opportunities in specialists rooms – this resource could be utilized if the program funding teaching in general practice, the Practice Incentive Program, was expanded to remunerate other clinicians working in ambulatory settings
- provide exposure to a range of common conditions which are primarily managed in the private hospital system, particularly conditions managed by elective surgery

- review jobs with unsafe workload and unsafe working hours and implement strategies to manage the risk, for example by providing additional staff for positions where interns and residents are overworked
- ensure that there is protected training time attached to all positions.

Recommendation 4. **Expansion of pre-vocational training posts should be targeted to:**

- **areas of workforce shortage in rural, regional and outer metropolitan Australia.**
- **disciplines with workforce shortages**
- **provide exposure to ambulatory medicine and the private hospital system**
- **achieve ACFJD learning objectives and provide protected training time**
- **manage the risk of unsafe workload and unsafe working hours**
- **provide research funding to the development of new training methods, modification of existing methods, evaluating the effectiveness of training, and evaluating assessment methods and effectiveness.**

This will only occur if:

- there is funding and timely planning for the additional training posts
- there is close collaboration between levels of government to allow pre-vocational trainees to move seamlessly between State funded hospitals and Commonwealth funded ambulatory health care sites (and possibly private hospitals)
- appropriate educational goals are set. These goals should be based on the ACFJD. It is critical that current funding of the ACFJD is extended to allow further development
- the new posts, including ambulatory care posts, are appropriately accredited.
- there is support for clinical supervisors, who will be required to take on a much larger supervisory role. This support should include access to professional development programs like Teaching on the Run and the Professional Development of Registrars program developed by CPMEC, which is now being provided to all registrars in Queensland and large numbers of registrars in other states.
- there is support for educational staff, especially Medical Education Officers (MEOs) in public hospitals. Current MEO funding per trainee is only a fraction of the funding provided for equivalent nurse educators.

Recommendation 5. Ongoing development and implementation of the ACFJD should be funded.

3 Integration and coordination of medical training and workforce planning

Australia's future health system needs robust medical workforce planning within the broader context of health service and health workforce planning.

Workforce shortages have been steadily worsening for at least a decade but there has been no serious attempt to systematically address the problem by a coordinated, targeted expansion of training programs. Current medical workforce planning is fragmented, suffers from a lack of timely, accurate and meaningful workforce data, and can favour short term sectoral interests over longer term community and broader health system needs.

The ageing of the population, the increasing burden of chronic disease and the rapid development of new effective medical interventions all mean that demand for health services will increase for the foreseeable future. An integrated (national/state/regional) medical workforce planning system based on timely and accurate workforce data and robust modelling of future demand is urgently required. At the pre-vocational level his will require regular consultation between both levels of government, workforce agencies such as MTRP and the National Health Workforce Taskforce, CPMEC and PMCs.

CPMEC is concerned that the performance indicators proposed by the Commission for Challenge 12, *Ensuring enough well trained health professionals and promoting research*, are

not linked to meaningful workforce planning benchmarks. The suggested indicators (number of graduating students, number of new graduates, number of accredited and filled clinical training positions and number of undergraduate placement weeks per 1000 population) reflect current activity. They do not take into account the quality of training provided and do not provide incentives to increase recruitment into areas or disciplines where there are significant workforce shortages, such as rural general practice and psychiatry.

Recommendation 6. **Performance indicators should be linked to workforce planning objectives.**

4 The relevance of training

There has been very little change to the way medical training is delivered, particularly at the pre-vocational and vocational levels, despite major changes to health care delivery.

Most prevocational and vocational training takes place in public hospitals, which are focussed on managing acute healthcare problems, even though the bulk of patient care takes place outside the public hospital setting and involves the management of chronic and complex health problems. More than half of elective surgery now takes place in the private system, including almost all surgery for some common conditions, yet very little pre-vocational and vocational training is delivered in private hospitals.

Recent attempts to expand training into community based and private settings are applauded by CPMEC. However, we are concerned that there have been very limited opportunities outside public hospitals at the pre-vocational level to date. The modest scale of these initiatives means that they have had only limited impact on vocational training. A contributing factor has been the reluctance of state health services to divert trainees to ambulatory settings because they are needed to staff public hospitals and because of concern about additional costs. See ***Recommendation 4***.

5 Recognition of clinical teachers

One of the most important attributes of the current medical training system is its reliance on the goodwill and support of clinicians who are involved in training the next generation of doctors. Much of teaching provided by this group is 'pro bono' and any payment for teaching is considerably less that the amount they would receive for the same time commitment in clinical practice. Australian medical education is critically dependent on the continuing contribution of clinical teachers, who are under increasing pressure because of higher workloads and financial pressures in the public health system,

CPMEC strongly recommends that these clinician teachers are explicitly recognised, encouraged and rewarded for taking an active teaching role or a leadership role in medical education. Methods of recognition and support should include:

- Payment (e.g. for directors of training programs)
- Recognition of the teaching role in the employment contract and inclusion of teaching as part of performance appraisals
- Access to professional development training in medical education, leadership and management skills
- Academic recognition by educational bodies such as universities, postgraduate medical councils and colleges.
- Administrative support for educational roles.

Despite the key role played by clinical teachers in the education of health professionals, there is a paucity of research on clinical teaching and clinical assessment. CPMEC and its constituent PMCs would value opportunities to work with clinical teachers, universities, colleges and clinical educators in other disciplines to identify effective clinical teaching and clinical assessment techniques.

Recommendation 7. **Clinical teachers should be recognised and rewarded by: realistic remuneration; inclusion of teaching in contracts and performance appraisals; access to professional development training; academic titles and administrative support.**

6 Simulation based clinical training

For obvious reasons of patient safety, invasive procedures and management of emergencies are best learnt in simulation settings on manikins rather than patients. Simulation is an excellent adjunct to (but not a substitute for) clinical supervision and training; it provides opportunities to develop and refine specific clinical skills in a safe environment, but is expensive to operate and is reliant on clinicians to deliver the training.

Only a minority of pre-vocational and vocational trainees are currently able to access clinical skills laboratories. Specific funding is needed to ensure simulation centres can play an important role in health professional training in clinical settings, not just on university campuses.

CPMEC strongly supports the coordinated development of clinical skills laboratories which are available for all levels of training (pre-graduation, pre-vocational, vocational and continuing) for trainees in all health disciplines.

Recommendation 8. **Australia should develop a coordinated network of clinical skills laboratories in clinical sites for use by trainees in all clinical disciplines.**

7 International Medical Graduates and Career Medical Officers

The Australian healthcare system is heavily dependent on IMGs. The majority of IMGs entering the Australian medical workforce do so as lateral entry prevocational trainees. It will take many years for the increased number of medical students emerging from Australian medical schools to complete pre-vocational and vocational training and it is clear that the nation will be dependent on IMGs for at least another decade. It is essential that the Australian public can be confident that they have been appropriately assessed and educated.

Despite the large number of IMGs recruited to work in Australia in recent years, assessment and training has been poorly coordinated and significantly under resourced. IMGs have generally been recruited to positions that Australian trainees are not prepared to fill and levels of personal, social, cultural and educational support have usually been inadequate.

CPMEC strongly supports the introduction of the new Competent Authority and Standard Assessment Pathways for IMGs but has significant concerns about the adequacy of funding and the level of preparation for the new process, particularly the introduction of the Standard Pathway on July 1, 2008.

CPMEC recommends:

- a much less complex and better supported recruitment pathway. This should include a ‘one stop shop’ to assist IMGs deal with the many agencies they are required to interact with.
- adequate resources to allow appropriate cognitive and clinical assessment at the time of recruitment to allow safe placement with appropriate supervision
- adequate resources for educational support to remedy any deficiencies identified in the assessment and to allow IMGs to progress to full registration.

Recommendation 9. **Rescources for IMGs should be significantly expanded to provide a well supported recruitment pathway, appropriate cognitive and clinical assessment at the time of recruitment, and educational resources to remedy any deficiencies identified**

CMOs play a vital role in service provision particularly in emergency departments, mental health services, and community health services. However, their educational opportunities are limited and poorly coordinated. The NSW Institute of Medical Education and Training is developing a Hospital Skills Program, to address this gap in the system. Similar programs should be available to CMOs in all states.

Recommendation 10. **CMOs should be provided with structured education programs**

8 Protecting and promoting the welfare of health professionals to ensure high quality patient care

Working in health is both rewarding and demanding. Doctors are vulnerable to stress related health problems as evidenced by the higher than expected prevalence of mental health disorders and the higher suicide rates.

Stress and burnout may arise from working long hours, having inadequate rest and relaxation time outside of work, as well as the pressures associated with the responsibility of clinical care and other work commitments such as teaching, research and administrative tasks. There is a growing body of research showing the links between stress, fatigue and medical errors.

Given the links between the health of the workforce and the quality of patient care, it is recommended that the Commission consider ways of incorporating a healthy, well supported health workforce into the performance framework of the Australian Health System.

There should also be greater emphasis on career evolution and development over a professional lifetime if the health system is to retain its skilled workforce. This comes back to the concept of the health system valuing its most important asset – people.

Recommendation 11. **NHHRC's performance indicators should include measures to improve and maintain the health and welfare of health professionals.**

Summary of Recommendations

Recommendation 1 **There should be explicit funding and accountability for all stages of training to end the 'blame game,' prevent cost shifting and protect the training continuum, including:**

- **Explicit funding for health service based training for: educational supervision and support, teaching facilities, clinical skills laboratories and professional development programs. This should include adequate funding of PMCs**
- **Clearly identified funding for medical schools which covers the costs of teaching**

Recommendation 2**. All pre-vocational training positions should be accredited and PMCs should be accredited by the Australian Medical Council**

Recommendation 3**. NHHRC should develop performance indicators that ensure that all groups involved in education and training are accountable**

Recommendation 4. **Expansion of pre-vocational training posts should be targeted to:**

- **areas of workforce shortage in rural, regional and outer metropolitan Australia.**
- **disciplines with workforce shortages**
- **provide exposure to ambulatory medicine and the private hospital system**
- **achieve ACFJD learning objectives and provide protected training time**
- **manage the risk of unsafe working hours**
- **provide research funding to the development of new training methods, modification of existing methods, evaluating the effectiveness of training, and evaluating assessment methods and effectiveness.**

Recommendation 5. **Ongoing development and implementation of the ACFJD should be funded.**

Recommendation 6. **Performance indicators should be linked to workforce planning objectives.**

Recommendation 7. **Clinical teachers should be recognised and rewarded by: realistic remuneration; inclusion of teaching in contracts and performance appraisals; access to professional development training; academic titles and administrative support.**

Recommendation 8. **Australia should develop a coordinated network of clinical skills laboratories in clinical sites for use by trainees in all clinical disciplines**

Recommendation 9. **Rescources for IMGs should be significantly expanded to provide a well supported recruitment pathway, appropriate cognitive and clinical assessment at the time of recruitment, and educational resources to remedy any deficiencies identified**

Recommendation 10. **CMOs should be provided with structured education programs**

Recommendation 11. **NHHRC' performance indicators should include measures to improve and maintain the health and welfare of health professionals.**

4. Appendix

Table 1 Groups and individuals with responsibility for the Australian medical education continuum

Phase	Responsibility
Basic medical education	Australian Medical Council (medical education standards and accreditation) Universities (curriculum, assessment, certification) Australian government (allocation and funding of student places) State health services (student clinical placements) Private hospitals (clinical placements) Clinicians employed in state health services (supervision and teaching of medical students – often on a "pro bono" basis) General Practitioners (supervision and teaching of medical students)
Prevocational Training (Postgraduate years 1 & 2)	State health services (employment of graduates +/- educational staff, predominately in public hospitals) Australian government (funding for general practice placements) Postgraduate Medical Councils (curriculum and education standards development, accreditation, workforce allocation) Hospital based clinicians (supervision and teaching of junior doctors) General practitioners (supervision and teaching of junior doctors) State Medical Boards (provide conditional registration at the commencement of prevocational training and general registration after successful completion of the intern year (PGY1))
Vocational training	Australian Medical Council (medical education standards and accreditation) State health services (employment of graduates +/- educational staff, predominately in public hospitals, allocation of training positions e.g. into training networks) Australian government (funding and oversight of general practice training, funding for other specialist training outside public hospitals) Colleges (training standards, curriculum, assessment, certification, accreditation of training programs/sites), including RACGP and ACCRM (standards, curriculum, assessment, certification for general practice training). NSW IMET (supporting the delivery of vocational training through training networks).

	Regional Training Providers (coordination of regional general practice training) Private hospitals (employ a small number of specialist trainees) Clinicians employed in state health services (supervise and teach vocational trainees) General Practitioners (supervise and teach vocational trainees) Clinicians employed in private hospitals (supervise and teach vocational trainees)
Continuing Professional Development	Colleges (set standards and monitor CPD; provide CPD activities) Medical Boards (require reports on CDP activities) Employing health services (provide support for CDP through study leave etc)