

Teaching, learning and research: essential elements of health care and the next Australian Health Care Agreements

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Abstract

Australian Health Care Agreements must set out the roles and responsibilities of the Australian, state and territory governments in ensuring the provision of appropriate clinical placements for the additional medical student allocation. The roles of universities and public and private health agencies must also be specified.

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SAFE AND HIGH QUALITY hospital services are dependent on the recruitment and retention of health professionals with qualifications and expertise appropriate to their work. Public hospitals play a key role in the basic education and training of these professionals in addition to later vocational and specialist training and continuing professional education. Hospitals in turn rely on these activities to underpin quality improvement and the evidence base for practice. Involvement in health professional teaching constitutes the basis for the teaching hospital status of an increasing number of public hospitals — a status which is important for recruiting and retaining high calibre staff at all levels. While these teaching and learning functions, together with research, have been integrated with service delivery, increasing funding pressures on health and education services have resulted in decreased support and

emphasis on teaching and research in acute care settings. Further, while education and training have always been part of the responsibility of the acute care system, they have not been explicitly acknowledged, and statements relating to education, training and research were absent from the two most recent Australian Health Care Agreements.

These trends exacerbate current workforce shortages which, while global and evident in all health professions, are compounded in Australia by maldistribution adversely affecting outer urban, rural and remote areas.

In the last 12 months, workforce shortage has been a major concern in the health care system, resulting in a Productivity Commission Research Report¹ and the deliberation of the Council of Australian Governments (COAG).² In response to the Productivity Commission Report, COAG proposed far-reaching changes to the health system and, in particular, has initiated new programs to meet health care workforce needs. Over 2800 additional health professional places were announced in 2006; comprising 1036 nursing; 431 mental health nursing; 210 psychology; 573 allied health and 605 medicine.

While this most recent allocation of 605 medical student places will be phased in over the next 2 years, there have been smaller increases in student numbers through a series of ad hoc processes over the past 5 years. In 2000, the existing medical schools graduated about 1300 domestic students and 300 full fee-paying overseas students. An additional 100 Medical Rural Bonded Scholarship places were allocated in 2002, but the number of graduates remained essentially stable over subsequent 4 years.³ However, changes to visa arrangements for full fee-

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paying overseas students from 2004 have resulted in an additional 100–130 graduates entering the Australian medical workforce rather than leaving Australia on completion of their degrees.

The first planned increase in domestic medical student places came as a result of the Australian Medical Workforce Advisory Committee (AMWAC) considerations of workforce numbers. AMWAC had demonstrated shortfalls in all medical specialties studied over the previous 5 years and recommended increases in vocational training positions.⁴ Consequently, 234 additional medical student places were allocated in 2004. At the same time, the Australian Government allowed universities to enrol domestic fee-paying students up to 10% of the number of their allocated Commonwealth Supported Places (CSPs). Therefore, by 2005 there was the potential of universities enrolling about 2100 domestic students although the actual enrolment numbers were 1800 with about 300 fee-paying overseas students.

Early in 2006, domestic student fee-paying places were increased to a maximum of 25% of each university's CSPs. A further change in 2006 was the increase in the proportion of CSPs which were designated as Bonded Medical Places; 25% of all places were designated as Bonded Medical Places in addition to the 100 places with Medical Rural Bonded Scholarships.

Therefore, with the new places allocated to mid 2006, there will be potentially 2600 domestic students enrolled in 2007,⁵ rising to 3500 in 2010. In addition to these increased students and graduates from Australian universities there has been steady rise in the number of international medical graduates entering the health care system each year to fill vacant hospital and community positions at both training and vocational levels. For example, in 2006 there were 241 international medical graduates in PGY 1 and 2 positions.

The unprecedented increase in student and trainee numbers has given rise to major concerns about adequacy and quality of training positions, quite apart from related concerns which have surrounded the creation of new medical schools and the increase in bonded places. University

medical schools, colleges, clinical teachers in the health service, the Australian Medical Association and the Australian Society of Medical Students have all questioned the ability of the education and health care systems to provide adequate clinical training places for the students and adequate intern and vocational training positions for those who graduate. The July 2006 COAG communiqué, in which the additional medical (and nursing) places were announced, stated that in accepting the increased number of places the states and territories had "agreed to guarantee to provide high-quality clinical placements and intern training for Commonwealth-funded medical and nursing students".² (p. 2) To date, no mechanism has been established to operationalise these guarantees. It has been stated anecdotally that there are sufficient places available, but there are limited planning frameworks in place to substantiate this. Some jurisdictions have progressed planning processes for increased medical student numbers. For example, the Western Australian Department of Health Services has collaborated with the University of Western Australia and University of Notre Dame Australia to look at clinical placements for the projected number of medical students over the next decade. Further, the Western Australian and Queensland governments have given undertakings that there will be sufficient intern places available for all students graduating in their respective states. While these and other planning processes are at various stages of development in state and territory jurisdictions, there is no national overview of the requirements or places available. There are a number of piecemeal approaches to explore the potential of student placements in community and private health settings similar to those for placement of vocational trainees in the private sector, which has been the subject of an AHMAC Review.

If the COAG allocation of new places and the agreements are to be effective in meeting workforce need, formal agreements and concrete plans are urgently required to specify the responsibilities of the Australian state and territory governments (especially the Departments of Education, Science and Training, and Health and Ageing),

and universities and health agencies, including the private sector. The Australian Health Care Agreements are important instruments in this process, and the opportunity must be taken to explicitly acknowledge the role of the acute care system in supporting education, training and research. Further, these agreements must lead to jurisdictional requirements for hospitals to fund education, training and research in addition to their service delivery components. These commitments also need to be expressed in contracts with all medical staff from interns to staff specialists and visiting medical officers. The increased numbers of places will address workforce numbers, but further action is required to ensure all students and trainees have access to clinical education which will enable the future workforce to deliver safe and good quality health care.

Competing interests

The author declares that he has no competing interests.

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