Work-readiness and workforce numbers: the challenges

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We need clinicians prepared for work in a system of integrated, person-centred, affordable health care

Over the past 15 years or so, Australia has embarked upon what some might describe as a "courageous" solution for guaranteeing our medical workforce. Following a perceived shortage of doctors at the beginning of the 2000s, the number of accredited medical schools has grown from 10 to 20,[1] with another currently undergoing accreditation; the number of medical graduates has almost tripled from 1316 in 2001 to 3547 in 2015.[2] Increasingly large numbers of doctors have also been recruited from overseas to overcome shortfalls: 2820 temporary visas were granted during 2014–15 alone.[3] The per capita production of local medical graduates[4] and growth in the stock of foreign-trained doctors[5] are among the highest in the world.

Australia is also a leader in more sensible ways: establishing rural clinical schools and regional medical schools and increasing the numbers of rural origin and Indigenous Australian medical students. Clinical training for students has spread well beyond the traditional metropolitan teaching hospital. Rural sites are at the cutting edge of reforms, including community-engaged medical education, longer, integrated clinical placements, and inter-professional learning, resulting in some solid workforce outcomes.[6-8] The high levels of graduation and importation over 15 years have markedly increased doctor numbers. With 3.5 practising doctors per 1000 population (2014), Australia has more doctors per capita than Canada (2.6), the United States (2.6), New Zealand (2.8) or the United Kingdom (2.8), and exceeds the OECD average of 3.3 doctors per 1000.[4]

There is accordingly no overall shortage of doctors in 2017. But a regional hospital attempting to recruit an Australian-trained surgeon or psychiatrist, or a remote community looking for a broadly skilled rural generalist practitioner might beg to differ. Regional Australia remains heavily reliant on the provisional solution of importing medical labour, while growing numbers of domestic graduates jostle for internships and specialist training positions in the cities, swelling the ranks of an increasingly subspecialised metropolitan workforce. Joining them are many international recruits who move to cities after their obligatory period of service in rural areas is completed.

Factors that promote this situation include uncapped fee-for-service insurance systems, high volume corporate practice models, and the staffing and rostering proclivities of large hospitals. Threats to the system associated with the high number of city doctors include higher levels of inappropriate care servicing, fragmentation of care, yet more constraint on the scope of generalist clinical practice, and fiscal pain for taxpayers.

Increasing the number of medical graduates as a solution for workforce shortfalls has faltered because the job was only half done. Medical school, while important in itself, is the stepping-off point for further training: the first year as an intern, and then (after a period as a junior hospital doctor) years of training towards a fellowship in general practice or one of the 63 other recognised medical specialties. Australia has the second highest number of stand-alone specialty fellowships, after the US.[9]

As long as the funding, physical and cultural base for internship and subsequent training remains centred on big metropolitan hospitals and city practices, there be will no home-grown solution for securing our medical workforce. Even rurally inclined graduates who have trained in rural areas may feel obliged to join the race for city training positions,[6] which typically means years in a metropolitan training pathway. Meanwhile, life events intervene and become barriers to returning to rural communities.

These bottlenecks in clinical training are occurring at a time when responsibility for its support is unclear, given our regionally autonomous public hospital system, funded according to clinical activity.[10] With no transparent funding model for teaching and training, historical practices more or less prevail. Opportunities for interns, junior doctors and specialist trainees to train in private or non-government organisational settings remain limited.

What does all this mean for the work-readiness of an intern, or indeed of medical graduates at any point along the medical training continuum, including career-long learning?

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One view of work-readiness is that provided by surveys of graduates' own assessment of their preparedness for work as an intern in a large hospital, as described by Barr and her colleagues in this issue of the *MJA*.[11] Their study found that the graduates surveyed generally felt well prepared with respect to 44 specific capabilities, including patient-centred care, although there was also a small number for which they did not feel well prepared, such as providing nutritional care, using informatics, and cultural competency.

These findings raises the question of the utility of the medical internship model, a problem discussed in a 2015 Council of Australian Governments review, which concluded that the model was still of value, but could be improved to better achieve its goals.[12] For instance, although outcome statements for medical graduates and interns are a helpful guide for medical graduates and their supervisors, there is room for improving dialogue between universities and employers about work-readiness.

However, we believe there is a broader perspective from which to judge work-readiness: whether the training system (including internship) is producing sufficient numbers of clinicians ready for work that is aligned with community needs for integrated, person-centred, affordable health services for an ageing population that is experiencing higher levels of chronic disease.

To achieve this goal, we must ensure more equitable geographic distribution of specialist medical training, bolster clinical generalism, emphasise teamwork, and select individuals for further training on the basis of their propensity to serve community needs. We argue that these are the greater challenges for work-readiness and reform.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

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