Medical Workforce Expansion Commitment & Capacity

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Four Views

- Australia
  - Brett Lennon
- Canada
  - Bates, Lovato, Jamieson & Buller -Taylor
- United Kingdom
  - Shelley Heard & Alan Crockart
- United States of America
  - Salzberg, Erikson & Yamagata

Agenda

- Brief summary of the 4 Medical Education system
- Answering the questions posed.
- Concluding remarks
- Next steps

- Areas deliberately avoided
  - Comparison of 4 health care delivery systems
  - Value judgments on Health Care delivery systems
  - Discuss physicians per population ratios

Demographics

- Aus
  - 15 school (5 new) 3 planned + 10 RCS
    - Undergrad entry with move to graduate noted
- Can
  - 17 schools (1 new) + 9 satellite/distributed
    - Graduate entry
- UK (England)
  - 27 schools (3 new)
    - Undergrad entry
- US
  - 125 allopathic & 20 0steopathic
    - Graduate entry

Increases

- AUS
  - 1300 grads in 2005 > 2100 by 2010
- CAN
  - 1663 grads in 2003 > 2150 by 2007
- UK
  - 4079 grads in 2005 > 5772 by 2010
- US
  - 15,632(1151) in 1980 > 15521(2510) in 2003
  - 5% to 8% next 10 years

Funding

- Aus
  - UG Government(s) & fees
  - PG , Central for FP, State for Specialists
- Can
  - UG – Provincial (Dept ed) & fees
  - PG - Provincial (Health)
- UK
  - PG & UG - Government
- US
  - UG mix state & private & fees (state 2/3 of MD)
  - Federal role re research and service provision (medicare)
  - Caped GME (challenge to increase total output!)

Duration

- AUS
  - 4.5 to 6 + 2 pre-voc. + 3 to 6 voc. (11-16.5 yrs)
- CAN
  - (4)+4 + 2 (3rd yr?)= FP (10 yrs)
  - (4)+4 + 5(7) = specialist (13 yrs)
- UK
  - 5(6) + 2 found + 3 = specialist (10 yrs)
  - 5(6) + 2 found + ?2 = FP (? 9 yrs)
- US
  - (4) + 4 + 3 (+ sub specialty) = physician (11+yrs)

Accreditation

- AUS
  - Australian Medical Council – UG
  - Postgrad Medical Educ Committee- states
  - Australian GP education (AGPE)
- CAN
  - UG – Liaison Committee on Medical Education & Committee on accreditation of Canadian Medical Schools - (joint US/CAN)
  - PG - CFPC & Royal College of Physicians & Surgeons
- UK
  - General Medical Council
  - Post-graduate Medical Training Education Board
- US
  - LCME -UG

Planning & Coordination

- AUS
  - Australian Medical Workforce Advisory Committee
  - Medical Specialist Training Steering Committee
- CAN
  - Watch this space, TF2, Universities, F/T/P, CPSC & Royal College etc
- UK
  - Chief Medical Officer, Medical Workforce Standing Advisory Committee
- US
  - Council on Graduate Medical Education ?

Significant changes

- Aus
  - 30% increase capacity
  - Change in pathway
  - New delivery models
- Can
  - Returned capacity
  - New delivery models
- UK
  - Increased capacity
  - Change in pathway
  - Flexibility & competency base
- US
  - 3% increase
  - DO increase

Undergraduate Challenges

- Finance
- Clinical capacity
- Academic Capacity
  - Staff
  - Infrastructure
- Role of Family Medicine
- Leadership
- Social Agenda

Finance

- Who pays and what…
- US, AUS & CAN – significant student component
- All – various levels of government funding
  - Area of potential tension in a federated environment
- Money used to drive change in UK & AUS
- Role of private vs public funding (US & AUS)

Capacity - Academic

- Infrastructure
  - Significant UK with 4 new schools, 8 eventually in AUS. RCS and UDRH, 1 new school in CAN and distributed/satellite campus, US 9 new MD since 1980, (3 proposed), 5 new DO schools
  - AUS challenge to use existing resources more efficiently
  - More than just new chairs in a room

Capacity -academic

- Faculty
  - UK reports 17% decline in lecturers, whilst some programs show marked increase in demand for teaching. 9% curriculum delivered by primary care
  - AUS actively recruiting faculty, home and abroad, and non-physician use
  - CAN reports lack of academic staff, esp basic sciences
  - Not sure if Governments understand the gap here.

Capacity - Clinical

- UK working hard to increase training sites and trainers, driven by their new MMC, Use of non traditional clinical sites. Medical quality vs productivity. Incentives to GP's for placements. Huge needs for placements. MMC help to develop educators
- AUS – competition for clinical space. Need to demonstrate sufficient clinical time. Distributed learning sites (RCS)
  - Role of private facilities
- CAN Bound to major teaching hospitals. Still apprenticeship model. Challenge ambulatory care & costs. Who pays for teaching?
- US teachers and Students opposed to increase, Deans fear reduced quality of intake and performance tables. Competition between teaching, research and clinical (teaching looses)

Other challenges

- Credibility (US)
- New lifestyle (need for more to do less)
- Feminization (more a PG)
- Visa trainees (CAN) sharing resources
- IMG reliance (all) a ‘cheaper’ option?
- Rural & aboriginal
- What are the needs and can we meet them this way?

Understanding and addressing the Challenges

- Distributed learning (CAN, AUS)
  - IT
  - Non traditional clinical sites
- Aboriginal access
- Rural access
- Placement of new university (all)
- Return of Service plans

- Are we answering the questions posed by the Challenges?

A curriculum for tomorrow

- UK – Central & collaborative change,
  - Communication, Research, Public Health & primary care
  - Physician who can adapt. Tomorrows doctors (2003) The New Doctor(2005)
- AUS – Discussion & debate. Issues identified
  - Communication, competency bases, chronic disease management
  - Preparation for indep. Practice and CPD
- CAN – discussions
  - Social accountability, Collaboration, Government influence to change
  - College of Family Physicians of Canada role
- US – scattered
- Others
  - Social accountability
  - Interdisciplinary
  - Competency based learning
  - Communication skills
  - Acute (UK) vs chronic (AUS)

Postgraduate Challenges

- Sub-specialization (super-specialization)
- Capacity
- Choice v need
- Planning

Duration of training

- UK – Modernizing Medical Careers
  - Two foundational years, 3 to 6 training years
  - Based on a generalist training, competency based, flexibility.
  - Need to wait a few years to see if successful
  - Emphasis on delivery of safe acute care
  - Role of Family Medicine

Duration of training

- AUS – Pre-vocational years (2) then Vocational years
- Autonomy of colleges to determine duration
- Pro-bono educators – sustainable?
  - Seems like the MMC but not centrally managed

Duration of training

- US & CAN
  - Both use a matching service
  - Concerns from Government re duration
  - Role of sub specialist in general hospial

Choice v Need

- Who determines what we train
  - Physician choice
  - Public need
  - Hospital program need
  - Provider need

Capacity

- CAN – 1:1 (call for 1:1.2) ratio
- US – reality of 1:1.38 ratio (IMG role)
- UK – selection process under development (important given pressures)
- AUS – role of Advisory Committee , significant over capacity at present (may change) – GP 25%

Conclusions - AUS

- National Strategy & Planning
- Investment in Infrastructure
- Rural strategy
- Review of training
- Move to competency base
- College monopoly
- Private vs Public
- Role of University in Post grad
- Aboriginal strategy
- Return of service
- Mode to graduate entry
- IMG dependance

Conclusions - CAN

- Strong role of university in UG & PG
- Use of IT
- Commitment to expansion
- New delivery Models
- Federal / provincial
- Lack of National planning
- Slow curriculum change
- Short FM training
- Dependency on IMG’s

Conclusions - UK

- National Strategy
- Financial Investment
- MMC initiative
- Curriculum development
- Competency based
- Emphasis on adaptability
- Volume of clinical content
- Not evaluated
- Capacity issues
- National PG planning

Conclusion - US

- Responsiveness of Osteopathic schools
- Greatest potential
- Large PG capacity
- Lack of national strategy
- IMG reliance
- Credibility of message
- Effect on the rest of us

Next steps ?

- Collaboration first step
- Global advisory role?
  - Clarify the message to Governments
  - Share the initiatives & evaluations
  - Articulate the Clinical & Academic needs
  - Recognize the existence of a global workforce
  - Answers to our IMG reliance
  - Are we even asking the right questions?
    - Physicians or Health Care Providers

Thank you

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Question 1 - Responsiveness

- When faced with a rapidly changing medical field, including changes to the workplace as well as to work life expectations, how can educational institutes, Universities and Colleges, position themselves to be leaders in innovation so as to appropriately address these changes. Can educational institutes indeed produce tomorrows physicians or are the physicians of tomorrow actually only the product of yesterdays physicians, working with today's physicians in today's reality?

Question 2 - Capacity

- Academic faculty (and infrastructure) appears to be an important rate limiting step in the various workforce expansions. However, when faced with a publicly perceived clinical shortages and gaps in service, how can the case for significant investment in academic development, including research, be advanced. The case not only being presented to our elected leaders, but more importantly the electorate that put them there, who may only be able to see the clinical shortages.

Question 3 - Planning

- At a time when, more than at any other time in history, physicians have become a global commodity, even to the stage where they have been publicly traded for oil, is it too late to work towards a global physician resource plan? It is evident that local and regional planning, within countries is ineffective, it remains to be seen if national planning is anymore effective. How could a global planning framework be advanced?

Question 4 – Commitment

- Faced with a complicated reality that has too few physicians for an increasing number of position, important rate limiting capacity challenges such as faculty and clinical experience and perhaps finite resources, when do we say that perhaps the goal we are pursuing is unattainable and too costly for society? Is medical workforce expansion just too costly a solution for today's society?