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Ms Penny Shakespeare
First Assistant Secretary
Health Workforce Division
Department of Health

Dear Ms Shakespeare

Re: Advice from the Australian Indigenous Doctors' Association on the Specialist Training Program review

The Australian Indigenous Doctor's Association (AIDA) is grateful for the opportunity to contribute to the Department of Health's review into the Specialist Training Program (STP). As you would be aware, we recently corresponded in depth on the STP when AIDA submitted our survey results and analysis to your department in the context of future funding for the STP.

AIDA regards the current review process as a useful opportunity to engage our key stakeholders and membership for input into identifying key issues in the STP review as they apply to the experience of the Aboriginal and Torres Strait Islander medical workforce. As such, we have sought input from our Board and various members who offer particular insights and expertise in the application of the STP, and these views have informed our response below. Please note that our submission has been developed around specific issues of relevance to AIDA and the views and expertise of our members; we have not attempted to address all questions in the Discussion Paper.

The current design of the Specialist Training Program

With regard to possible changes to the aims and objectives of the STP, with a focus on maintaining and growing the programme in the future, AIDA makes the following comments:

- As per Table 1: *Funded posts by college and state and territory* in the Discussion Paper, AIDA notes there is a greater need in some areas for more funded positions, particularly the Northern Territory, Western Australia, Tasmania, and the Australian Capital Territory. Considering the geographical distribution of vocational training positions also provides an opportunity to consider how these might affectively align with particular health needs of Aboriginal and Torres Strait Islander communities such as ophthalmology, dermatology, physicians (cardiology, endocrinology, oncology, palliative medicine, and nephrology particularly), and critical care.

In doing so, the benefits are twofold:

- to increase our Aboriginal and Torres Strait Islander workforce and foster career development of AIDA and its members through mentorship and professional development opportunities; and
- to improve the health and wellbeing of urban, rural, and remote Indigenous Australians through service provision and greater access to training opportunities that foster development of culturally sound non - Indigenous clinicians.

- AIDA supports the Australasian College of Dermatologists' (ACD) program for an identified Aboriginal/Torres Strait Islander dedicated position and recommends a similar model be expanded

to all colleges. We note that the growth of programs such as this one in other fields of medicine is limited by hospital-based recruitment and would benefit from a national and centralised process such as the ACD has.

- Most specialty training (such as surgeons, physicians, and the advanced training positions of these roles) are recruited through hospitals which may not consider specific needs of the Aboriginal and Torres Strait Islander health workforce, and do not prioritise Indigenous applicants. AIDA recommends that there is a greater focus on local recruitment filling these positions with Indigenous applicants as this has the potential to provide long term benefits to the health workforce and improve patient outcomes. While AIDA notes the potential difficulties with allocating one Indigenous position per network, we maintain the importance of allocated funding for Aboriginal and Torres Strait Islander specialty trainees. Linking this with state hospital recruitment campaigns would strengthen the initiative. The CPMC recently verbally advised AIDA that there are approximately 55,000 medical specialists nationally. AIDA is aware of approximately 57 Indigenous fellows and 30 Indigenous registrars. The shortfall in parity is 1,563 medical specialists.
- AIDA understands that there are statistically greater numbers of Aboriginal and Torres Strait Islander doctors working in general medicine, as rural and remote generalists, and as general practitioners. We note that there is a significant need to enable further specialty training, both in the context of growing the Aboriginal and Torres Strait Islander workforce, and aligning appropriate specialist medical care and expertise with the actual health needs of Indigenous communities.

Funding

With regard to funding STP positions, AIDA advocates for ongoing funding to ensure consistency in education and training opportunities for specialist trainees. This will also enable long-term workforce planning which is an integral element to achieving parity of Aboriginal and Torres Strait Islander doctors.

Identified STP positions, once funded, should be prioritised and guaranteed for a set number of years before review. Reviews every three to five years, rather than annually would enable a great sense of stability for people considering applying for these places. AIDA notes that there are many prevocational trainees interested in identified STP positions, but as the funding for these places is subject to regular review, there is a tendency to feel despondent about the future likelihood of these positions. Given the relatively small number of Aboriginal and Torres Strait Islander medical graduates each year, AIDA notes that if a position is not filled one year, there are likely to be other interested and suitably qualified candidates at a later intake.

AIDA also notes the potential benefits that could arise from an increase in funding for training in community placements. This is particularly relevant for Aboriginal Community Controlled Health Organisations and remote clinics due to the potential improvements to specialty medical and surgical services that could eventuate. This additional support could also contribute to improving non-Indigenous understanding of sociocultural and health issues facing Indigenous people.

Identified Aboriginal and Torres Strait Islander training positions and supporting trainees of an Aboriginal or Torres Strait Islander background

To ensure the development of the Aboriginal and Torres Strait Islander medical workforce into the future, we recommend the establishment of dedicated Aboriginal and Torres Strait Islander specialist training positions across all medical colleges. The current under-representation of Aboriginal and Torres Strait Islander medical specialists across all medical fields supports the argument that dedicated positions should not be tied to predicted areas of undersupply but be established across all the specialist medical colleges.

Feedback from one of our members who has been in a STP placement notes that they would not have joined the highly competitive training program without identified funding. This member also noted that many Aboriginal and Torres Strait Islander students and graduates are not in a position to compete with high achieving colleagues fortunate enough to have the right connections, academic support, research experience, and clinical exposure. Sitting final exams also places a significant financial burden on trainees, and the possibility of failure can be a significant barrier to undertaking exams. Identified positions such as these equilibrate the disparate pathways into and out of medical school.

Further, from a student perspective, dedicated training positions play a big role in motivating students through medical school. This initiative offers students insight into possible future pathways, especially as selection for speciality training is very competitive. This can feel overwhelming for Aboriginal and Torres Strait Islander students as they often face many more complex barriers to their medical education, and many lose hope of training with the more coveted colleges. Having identified training positions within the specialty colleges offers a clear, tangible goal that students and junior doctors can aim towards and focus their study and work towards.

AIDA maintains that Aboriginal and Torres Strait Islander doctors should be prioritised with targeted funding, but there could also be another stream that provides consideration to those from rural or remote backgrounds who are intending to serve in these areas. On this point, it is important to note that these kind of measures are intended to improve the workforce in areas of need, and are less useful if they are taken by trainees who return to urban areas after a short period of rural or remote work. One suggestion could be the creation of a bonded position for Indigenous and non-Indigenous doctors to ensure returned service.

Supporting a culturally safe workforce

Cultural safety issues, such as racism and discrimination, have a significant impact on the level of participation of Aboriginal and Torres Strait Islander people in health professions, the tertiary sector and medical school and must be addressed. AIDA has corresponded at length on this issue, however we would like to emphasise once again that when Aboriginal and Torres Strait Islander health professionals and students work and study in culturally unsafe environments they are more likely to witness or experience racism and discrimination. This experience has ramifications both for growing and retaining the current Aboriginal and Torres Strait Islander health workforce and for attracting and recruiting more young people into medical universities and ultimately into a career in medicine.

Aboriginal and Torres Strait Islander health professionals play an important role in improving health outcomes, given their unique ability to align clinical and socio-cultural skills to improve access to services and provide culturally appropriate care for Aboriginal and Torres Strait Islander people. This has been demonstrated within the medical profession, where Indigenous doctors have contributed to improved health outcomes for Aboriginal and Torres Strait Islander patients by providing clinically competent medicine in a culturally safe way. For example, Hayman et al. (2014) cite an increase in Aboriginal and Torres Strait Islander patients under a culturally safe model of primary health care from 12 in 1994 to over 3000 in 2008.[1] This reinforces the importance of supporting Aboriginal and Torres Strait Islander people to become health professionals as well as supporting existing health professionals to retain the current health workforce.

It is also important that members of the non-Indigenous mainstream health workforce play their part in delivering equitable services for Aboriginal and Torres Strait Islander people. This is clearly evidenced by statistics from the *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF 2014) which reports that Aboriginal and Torres Strait Islander peoples had lower rates of hospitalisations with a procedure recorded compared with non-Indigenous Australians, and they also had lower rates of elective surgery. Further, the HPF 2014 reported discharge from hospital against medical advice was eight times the rate for Indigenous Australians compared with non-Indigenous Australians. In mainstream health care, there is often a low degree of experience in working with Aboriginal and Torres Strait Islander people, limited cultural competency and clinical focus is often on specific health conditions rather than on comprehensive care.

AIDA recommends that cultural safety training be incorporated in the medical education and training curriculum to provide health professionals, including overseas trained doctors, with the knowledge and skills to adapt their practice to improve patient engagement, improve health care outcomes and embed culture in the provision of health care services to Aboriginal and Torres Strait Islander people. Further, we emphasise that training in cultural safety is most effective when it is ongoing, meaningful and immersive rather than a once off online module. Best practice education and training in cultural safety should share responsibility across all involved stakeholders including colleges, universities, receiving hospitals and facilities, and include collaboration with local communities.

The future of the STP

AIDA notes the number of specialist training positions has increased from 360 in 2010 to 900 in 2015; this represents a significant investment by the Australian Government in training the future specialist medical workforce. As we have noted in our previous submission on this issue – AIDA advocates for improved data collection to identify Aboriginal and Torres Strait Islander trainees in these positions. We recommend that future training positions supported by the Australian Government identify Aboriginal and Torres Strait

[1] Hayman, N, Askew, D and Spurling, G, (2014), 'From vision to reality: a centre of excellence for Aboriginal and Torres Strait Islander primary health care', *Medical Journal of Australia,* 200 (11): 623-624

Islander trainees and where they are undertaking their training. This requirement would be strengthened by being made a contractual obligation of the specialist medical colleges or any organisation being funded to manage either these programs or in receipt of Australian Government funding.

We note that Aboriginal and Torres Strait Islander doctors are under-represented across all medical specialties. AIDA members have concerns that with the growing number of Australian medical graduates, entry requirements for specialist training programs are becoming increasingly competitive. This is sometimes disproportionate to what is actually required to successfully complete the training program.

Further, AIDA advocates that population parity should extend across all fields of medicine. In 2015 Aboriginal and Torres Strait Islander doctors do not constitute three percent of the fellows and trainees of any medical specialty college. Too many colleges have never yet had an Aboriginal and Torres Strait Islander trainee much less a fellow within their college. To the best of our understanding, of the 15 medical colleges of the Committee of Presidents of Medical Colleges, eight have an Aboriginal and/or Torres Strait Islander Fellow(s), three currently have only Trainees/Registrars and four have never had a Trainee/Registrar.

It is important to consider this issue in the context of potential over and under-supply of medical specialists in Australia. Some medical specialties that are considered to be over-supplied still do not have enough Aboriginal and Torres Strait Islander doctors within the college as trainees or fellows to bring their numbers up to parity. AIDA advocates that change is necessary and that the issue of parity needs to be addressed now and into the future.

The Emergency Medicine Training Program and the STP

AIDA notes that the current review of the STP is also considering the integration of the Emergency Medicine Training Program with the STP. The Discussion Paper highlights some of the possible advantages of integration such as simplified administration, removal of inconsistencies and enhanced capabilities to address workforce shortages. In addition to these broad suggestions, we would also like to highlight a number of other potential benefits of the integration of these two programs. These include:

- potential for improved and increased services to rural and non-metropolitan communities;
- the establishment of possible partnerships with tertiary centres to enable ease of patient transfer and communication;
- potential combined employment and learning opportunities for Australasian College of Emergency Medicine (ACEM) fellows to enable tertiary and non-tertiary roles across different campuses, hospitals and/or regions. For example - 0.2-0.5 EFT could be undertaken at a regional centre and the remainder at a tertiary site;
- more regional roles in critical care services across hospitals;
- access for smaller community centres to train with and receive education from ACEM and individual fellows of ACEM, leading to increased leadership opportunities and relevant policy and guideline development;

- increased potential for scholarships that support and develop regional trainees with access to education, conferences and further study opportunities; and
- potential for regional centres to provide, develop and provide specialist services (for example - toxicology) that are traditionally only available at tertiary or quaternary centres.

In addition to these benefits, AIDA would also like to acknowledge the complexity of integrating these two programs and make note of the following adverse possibilities that may arise for Emergency Medicine trainees under a new regime. These include:

- lack of support for annual leave and conference leave entitlements when requested due to unfilled positions / understaffing in regional areas;
- limited critical care services within the regional hospital, which could lead to difficulties in coordinating transfer to specialist services;
- potential de-skilling of trainees without adequate and meaningful exposure to critical care patients;
- reduction in opportunities to seek Continuous Professional Development points due to limited access to research, accredited events and development of procedural skills;
- inconsistent teaching and limited expert specialty field education (for example - neurosurgery teaching outside of metropolitan hospitals) across different hospitals, networks and regions. This has the potential to leave trainees at a disadvantage;
- excessive requirements for on call arrangements where the department is understaffed;
- under recognition of workplace and lifestyle stressors;
- potentially limited quality secondary and tertiary education centres or universities;
- reduced opportunities to attend ACEM State Faculty meetings, reduced communication and education opportunities due to distance, travel time and rostering constraints;
- adverse impacts on family and home life, for example through conscription of ACEM fellows and trainees into areas traditionally underserviced when ACEM fellows and trainees already have mortgages, schooling, family and other networks established in an area; and
- under-resourcing of emergency departments with expectations of improving or maintaining key performance indicators.

Finally, AIDA would like to note the following potential benefits for the STP if it were to adopt aspects of how the Emergency Medicine Training Programme is delivered.

- The ACEM training program is nationwide in training (and extends to New Zealand) and provides trainees and fellows with a number of opportunities for education and support.
- The ACEM training program allows flexibility in full time or part time training, duration of rotations and specialty rotations across a number of sites without conscription into specific areas.
- The provision of standardised consistent education and experience is vital to provide trainees and fellows with relevant vocational satisfaction.

AIDA is grateful for the opportunity to offer out input into the STP review process. We would be happy to further engage with you regarding any of the above issues should this be useful. Please direct further queries to Ms Kate Thomann, Chief Executive Officer, AIDA on (02) 6273 5013 or by email at Kate.Thomann@aida.org.au .

Yours sincerely

Dr Kali Hayward
President AIDA

9 October 2015