Medical specialist education and training in Australia

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Is it heading in the right direction?

The preceding article by Clarke and Morgan (*page 685*) discusses a new form of education and training for medical specialists in Australia. The programs at the Australian School of Advanced Medicine at Macquarie University have pre-Fellowship (general specialist training) and post-Fellowship (sub-specialist training) components.[1] Here, I concentrate on the former. Both the formal university involvement and the new funding model proposed in the article have major implications that warrant widespread discussion.

The authors imply that the university environment will enhance the educational experiences of trainees, but they have not provided supporting evidence. If it is true that the new model of training will result in better outcomes than our current system of medical college training in hospitals, should we consider other alternatives? In Canada, most specialist training programs are contracted to university medical schools and affiliated hospitals by the Royal College of Physicians and Surgeons of Canada.[2] Would this be a better approach for Australia? Alternatively, should there be competing programs?

Traditionally, medical specialist education and training has been seen to be both a public good and a benefit to the individual, with costs shared between the Australian taxpayer and trainee. For almost all trainees employed in public hospitals, the taxpayers' costs have been met by hospital budgets. It has not been possible to separate out the costs of specialist training because most training is directly associated with patient care.[3] There has been considerable debate as to whether the additional costs are significant and whether the benefits to the system outweigh the costs. Undoubtedly, trainees incur costs — unpaid overtime, fees to the specialist colleges, and fees for courses, attending lectures and meetings and the like.

The Commonwealth Government, with some understandable ambivalence from state governments wishing to protect the public hospital workforce, is seeking greater private-sector involvement in specialist training. The reason is not only to cater for increased numbers of medical graduates, but because many essential learning experiences in most specialties are now available only in the private sector.[4] These include less complex elective surgery, such as stripping of varicose veins, repair of bunions, and plastic surgery procedures, much of dermatology, rheumatology and endocrinology, and management of patients with anxiety and less complex depressive disorders. Funding remains contentious.

The sums initially suggested by the Commonwealth Government during the discussion process would have barely covered salaries and on-costs for trainees. Indirect costs to hospitals and supervisors are substantial. The presence of trainees in operating rooms would be likely to lead to a 30% slow-down, reducing the income of both hospitals and supervisors. In the case of ambulatory consulting, the income of supervisors would be affected by about the same percentage. There will be other costs, including office space, access to computers and journals, medical indemnity insurance, consulting rooms, and administrative support staff. These costs may well be equivalent to about 50% of the salary and on-costs per trainee and so not too dissimilar to the fee proposed by Macquarie University.

If these costs are not met by government, it is unclear how private hospitals will recover them. Some surgical trainees may be able to claim assistant fees from Medicare, but the issuing of Medicare provider numbers for physician trainees seems unlikely. Would private health insurance funds view funding for specialist training as a legitimate additional hospital cost? Would some not-for-profit hospitals be prepared to cover part of the cost as a community service, even though margins for hospitals able to provide appropriate experience are probably not great? Would for-profit private hospital providers be interested? Private hospitals gain no direct financial benefit.

If the proposal outlined is successful, it may well represent the model for funding these additional costs — the trainee pays. This may become a disincentive for trainees to seek essential private-sector experience.

However, it has even wider implications. Almost certainly, in the 1990s, one of the drivers for identifying costs of medical specialist training in public hospitals was a desire by some politicians and bureaucrats to recover at least part of those costs from trainees or their colleges, effectively the same source. If the Macquarie venture succeeds, this issue will almost certainly be revisited.

Therefore, the proposal described by Clarke and Morgan could lead to a fundamental change in the way specialist training is paid for in Australia — to more user-pays funding — and this may well influence recruitment, training opportunities, and the quality of training, among other things. Just as we need to question increased university involvement, we must ask ourselves if this funding model is a direction in which we want to go. What are the advantages and what are the disadvantages?

Competing interests

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