Medical Deans
AUSTRALIA AND NEW ZEALAND

7th March 2022

Robyn Kruk AO

Independent Reviewer, Health Practitioner Regulatory Settings

Via email: HealthRegreview@finance.gov.au

Dear Ms. Kruk,

Independent review of health practitioner regulatory settings

Thank you for the opportunity to provide comment into your review of the regulatory settings relating to health practitioner registration and qualification recognition for overseas trained health professionals and international students who have studied in Australia.

Medical Deans Australia and New Zealand (Medical Deans) is the peak body representing the 24 university medical schools in the two countries, whose responsibility is to develop a future medical workforce attuned to, skilled in, and well-prepared to meet the healthcare needs of our communities. We will therefore focus our comments on the context within which our members operate and the policies that would best support their contribution to Australia's health workforce priorities – i.e., discussion question 2, current policy strengths and weaknesses.

The single most important national medical workforce priority is the development of a sufficient supply of Australian-trained medical graduates who want, and are supported, to pursue regional and rural careers, and careers in general practice and other specialties in undersupply such as psychiatry and generalist specialties.

To drive this, we need to **substantially expand medical student places** whilst at the same time implement policies and changes across the training pipeline that apply best evidence for producing greater numbers of rural and primary care doctors:

- **scale up intern and junior doctor posts in primary care and rural locations**, aligned with the boost in supply,
- **invest in the primary care sector** as a high quality teaching, training and research (TTR) system, and
- establish integrated, regionally-based post-graduate training capacity – **Regional Training Collaboratives**

Invest in our domestic-trained graduates

The contribution overseas trained doctors make to Australia is significant and must be genuinely valued and supported – without them many of our rural towns would have no doctor at all, and Australia benefits greatly from the increased diversity, perspectives and experience they bring to our workforce, health system and society. However, our current health workforce policies are overly reliant on Australia's ability to recruit sufficient numbers, exposed in the last few years as highly vulnerable and ethically questionable in the face of global shocks such as COVID-19, and also their sustained practise in areas of workforce need, which data shows is often not the case.

The situation has become such that we bring in as many overseas trained doctors as we graduate domestic medical students. The most recent Department of Health and Aged Care published data[1]

[1] https://hwd.health.gov.au/resources/publications/factsheet-mdcl-2018-full.pdf, page 4

that includes the origin of the doctor's primary medical qualification shows that in 2018 there were 6,513 first time medical practitioner registrants, in the year where there were 3,025 Australian trained domestic medical graduates and 450 international graduates. This is not an appropriate balance. Our review of the AHPRA Medical Register data for 2021 shows that a third of Australia's medical workforce was trained overseas[2].

National health workforce data[3] indicates that there is substantial and ongoing movement of Australia's IMG workforce from regional locations into metropolitan practise, with 2021 data showing three quarters (76%) are working in major cities (MM1[4]) and a further 11% in areas within 20km road distance of a town with a population greater than 50,000 (MM2). In effect, the 'temporary fix' of overseas recruitment for the regions is ultimately a major contributor to the rapid growth of medical labour in metropolitan areas.

Increase postgraduate training in the regions and primary care

Data from our annual survey of medical graduates (the Medical Schools Outcomes Database, MSOD[5]) shows just under 40% state a desire for a career working other than in a capital city, however this is not translating once they leave medical school. Multiple factors are involved and a broad, strategic and sustained approach needed - however the availability of quality training opportunities in the regions is fundamental.

Aligned with the boost to medical graduates, we must increase the number of intern and junior doctor positions in the regions and in primary care. We have had strong indications of support for this from jurisdictions and strongly urge further discussions between the Federal and state and territory governments to enable more specific planning to be progressed. However, we need to change the way we promote these posts to graduates, considering what would make them attractive to and a preferred choice of graduates. This will require changes to our thinking and processes, and to changing the culture and 'hidden agenda' that diminish the status and professional rewards of rural practice in the eyes of our students.

There is huge potential for a wider use of tele-supervision to support teach and supervision of students and junior doctors and other health professionals. For example, in Far North Queensland, connections between Mackay and Thursday and Palm Islands are used to support rostered teaching and feedback sessions between individual junior doctors and specialist supervisors as well as sessions with the whole health team discussing cases and learning opportunities. This enables students and junior doctors to have uninterrupted and regular access to a wide range of supervisors, and supports the learning across and from the wider multidisciplinary health team.

Regionally-based, integrated model for building and supporting local training capacity

In parallel, we need to move to a regionally-based and integrated model of building and sustaining local training capacity and workforce development initiatives. We need to ensure connections across the stages of training, moving away from the current siloed approach. One clear opportunity is to

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Note: we suggest asking the DoHAC to provide more recent data as this is not available on their recent dashboard or reports.

[2] AHPRA medical registration data for 2021 shows that of the 121,806 doctors registered to practice in Australia and working here (i.e., excluding the 0.8% working overseas and the 3% who didn't state their location of practice) 34% received their primary medical qualification overseas.

[3] National Health Workforce Data Set, available at https://hwd.health.gov.au/

[4] Using the Modified Monash Model https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

[5] Medical School Outcomes Database (MSOD) – Graduates' preferred location of future practice https://app.powerbi.com/view?r=eyJrIjoiNzA3YzcwMjctMzQxMi00ODBiLWJkZGYtZjBmNmRmYjI5OGU4Iiwid CI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9

leverage the substantial and successful investment by successive governments in universities' Rural Clinical Schools (and University Departments of Rural Health) and open them up to partnerhips with health services and medical colleges responsible for postgraduate training.

In the regional context, it is vital for trainees feel connected and supported within a community and the network of colleagues, supervisors and training support personnel. Initial modest investments in this through the Regional Training Hubs component of the Australian Government's Rural Health Multidisciplinary Training program (RHMT) is a step in the right direction. The further development of integrated regional medical support for trainees at all stages will assure positive experiences and graduate confidence in regional training and career choices.

More medical graduates should train outside of the traditional training environment of major metropolitan public hospitals.[6] In practise, a key barrier to this is the reliance of large hospitals on the labour of junior doctors and specialist trainees to meet their service demands, without reference to the needs of the community for specialist workforce. A better deployment of medical workforce requires adaptation of current models of care, including consideration of expanded roles for non-medical clinicians.

Invest in teaching, training and research in primary care

In 2021, 60% of specialist GPs in clinical practice were Australian medical graduates - down from 65% in 2014. The IMG specialist GP workforce is growing rapidly compared to the domestic graduate GP workforce. The average growth in the stock of domestic graduate GPs in clinical practice was only 119 per year over the period 2014 to 2020, compared to 504 average annual growth in the stock of IMG GPs over the same period. Moreover, 78% of the growth of the IMG GP specialist workforce was into major cities over the period. The ongoing domestic GP labour shortage of GPs – particularly in the regions - is the continuing impetus to recruit doctors from overseas to work as GPs, most of whom end up in major cities.[7]

Much more must be done to encourage and enable domestic-trained graduates to progress a career in general practice, particularly in the regions. A key element of reform is the need for greater exposure and connection to high quality primary care and community-based healthcare settings for health and medical students and doctors in training.

Funding reform is needed to enable teaching and training to be embedded into the clinical and business practices of primary care, and recognise and reinforce the importance of multidisciplinary health care.

For domestic graduates in 2022, general practice was still the top preferred specialty, with just under 20% (14.7% selecting GP, and a further 5.1% selecting the rural generalist GP sub-specialty). This figure has remained fairly stable over the last decade[8].

Despite the need for more doctors to work in general practice, we retain a hospital-dominated, city-centric approach to medical training. The maxim '*you cannot be what you cannot see*' applies here very strongly. Once students graduate, they move to a solely hospital environment and lose sight and

[6] National Medical Workforce Strategy 2021-2031. www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031

[7] National Health Workforce Data Set, available at https://hwd.health.gov.au/

[8] Medical School Outcomes Database (MSOD) – Graduates' preferred specialty of future practice https://app.powerbi.com/view?r=eyJrIjoiMzEyNjRmYjAtOGFlMS00MWQzLWI0Y2UtYmVlMTgyOTM4NDQ3IiwidCI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9&pageName=ReportSection5e5459dc898591506e79

connection with primary care, becoming ensconced in the strong culture of hospital medical careers and sub-specialisation.

The new National Framework for Prevocational Medical Training coming into effect in 2024, and its move away from traditional clinical rotations, provides an opportunity to have a stronger focus on the knowledge, skills, and experiences being sought from that stage of training rather than the setting. For example, data shows that more than half of the presentations to general practice are for mental health issues, which would provide a valuable and rich training experience. Currently, the majority of exposure to mental health care for students and interns is the public hospital acute medical health unit. Recognising the abilty for junior doctors to learn specialty skills in a generalist clinical setting will enable a pivot to more training to be in community and primary care settings.

We also need to recognise and address the stark imbalance in the funding of TTR between the hospital and primary care sectors. Our brief review of the allocation of Australian Government funds by the Independent Health and Aged Care Pricing Authority indicates that approximately $2.2BN was allocated for TTR within acute public hospitals in 2023. The total funding provided to primary care is unclear, with the data seemingly no longer published by Services Australia, however we suggest it is would be a fraction of this. It is worth noting that the last increase to the Practice Incentives Program - Teaching payment was in 2015, when it increased to $200 for each half-day (noting a rural and remote loading is available for eligible practices). This is insuffient for its purpose, and the model of funding too inflexible. Whilst teaching and training in hospitals rightly embraces a multidisciplinary approach, the funding model for general practice is based on the premise that the training can only be "given by a GP" – disregarding the teaching that could be provided by practice nurses, allied health professionals, or GP registrars working at the practice and and reducing the pool of potential supervisors. This also undermines the importance of the interprofessional practice that students are learning during their studies and reinforces unhelpful professional silos.

A multi-faceted approach, focused on the end in mind

The National Medical Workforce Strategy provides a clear diagnosis of the issues we are facing with our health workforce, and outlines some high-level areas that need to be addressed. These need to be fleshed out further into a clear set of aligned and connected strategies for it to progress in the direction and to the timeframe needed.

We have attached for your information a brief summary of four points to progress improvements in the areas of greatest concern. We would be happy to continue discussions on these issues and trust that this perspective is of use to your review.

Yours sincerely,

Professor Richard Murray

President

Medical Deans Australia and New Zealand

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Medical Deans' 4-point plan

The single most important national medical workforce priority is the development of a substantial supply of Australian-trained medical graduates who want, and are supported, to pursue regional and rural careers in general practice, rural generalist medicine, and consultant medical practice.

Medical schools are committed to continuing to grow their capacity to offer high quality and substantial regional medical school training – end-to-end where possible – and increase the focus on and profile of primary care and generalist practice within their curriculum, medical school culture, and career development suport of their students.

Based on our and other data, medical schools' experience and insights, and wide-ranging discussions and consultations with health workforce stakeholders, we recommend the following 4-point plan:

1. **Expand professional entry medical training places, to invest in developing the doctors we need:**
    a. A substantial boost in medical CSPs
    b. Support for end-to-end regional medical programs
    c. Admissions procedures and program structures that apply best evidence for producing rural and primary care workforce outcomes
    d. Clinical training emphasis on rural and community-based settings, including primary care, ACCHSs, small-town hospitals as well as community mental health, aged care, and the disability sector

2. **Invest in the primary care sector as a high quality 'teaching, training and research system'**
    a. Balance investments in teaching, training and research in primary care with that made for tertiary hospitals
    b. Embed teaching within the business and clinical models of primary care; must be a core aspect of primary care funding reform

3. **Scale up intern and junior doctors posts in primary care and rural locations, aligned to the boost in supply**
    a. Deploy additional graduate supply into primary care and rural health services
    b. All graduates to have quality prevocational training experience in primary care / rural / community-based settings
    c. Progressively reform the use of junior doctors in service roles in large public hospitals

4. **Establish integrated regionally-based post-graduate training capacity – Regional Training Collaboratives**
    a. Comprehensive and connected support for transitions from medical school to prevocational, GP specialist and consultant specialist trainng
    b. Regionally informed and managed development of training capacity and quality, career support, and support for trainees in difficulty
    c. Leverage and build on Rural Clinical School / Regional Training Hub investment
    d. Important regional conduit for health workforce program investment (e.g., STP, RJDTIF etc.)