30 September 2021

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Via email: community.affairs.sen@aph.gov.au

Dear Senator Askew,

Re: Inquiry into the provision of General Practice and related primary health services to outer metropolitan, rural, and regional Australians

Medical Deans Australia and New Zealand (Medical Deans) values the opportunity to provide input into the Senate Inquiry into the provision of General Practice and related primary health services to outer metropolitan, rural, and regional Australians (the Inquiry). Medical Deans is the peak body representing professional entry-level medical education, training and research in Australia and New Zealand. Our members are the 23 medical schools across the two countries, whose focus is on planning for, identifying, developing, and supporting the medical graduates our communities need.

Medical Deans welcomes the aims of this Inquiry. The need to improve the geographical distribution of our medical workforce, a re-balancing of the disciplines in which they choose to work, and an expansion of the settings in which they train, has long been a focus for our members. The need for more doctors choosing careers in general practice and as general specialists is clear; as is the need for well-considered and connected policies to address the maldistribution that sees oversupply of doctors in some city centres and dire shortages in rural and remote Australia and outer-metropolitan corridors of population growth.

While we have seen a number of areas where long-term investment and a clear focus has delivered some improvements – notably the investment in Rural Clinical Schools that has enabled substantial regionally-based medical education, the Specialist Training Program that has supported some increase in postgraduate training places outside large tertiary hospitals, and some of the initiatives supporting general practice training – a long-standing issue has been the lack of policy that spans the different medical training stages and addresses the whole training continuum. Too many health workforce initiatives focus solely on one aspect without considering how to leverage the outcomes to support another stage. For example, whilst the increased support for regional medical education has helped medical schools in their work to seek and foster interest in students for regional and rural practice – with over a third of respondents to our annual survey of final-year students expressing a

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preference for a future career working outside a capital city[1] – the lack of regional postgraduate training places means we lose many of these students to the city once they graduate. This is at a time when personal and professional networks are being developed and roots established – experiences that directly influence future career choices. We need this to change.

These long-standing issues have only been compounded by the impact of the COVID-19 pandemic. International and interstate border restrictions as a result of the COVID-19 pandemic have left these communities without access to locum staff and the IMGs they rely on. This acute shock on top of our chronic issue has highlighted the fragility of our current model of relying on international labour to fill workforce shortages, especially in general practice, regional, rural and remote areas.

What is needed is a substantial pipeline of domestic-trained doctors wanting, well-prepared for, and helped into primary care and generalist consultant careers in rural and regional areas and those outer metropolitan areas facing significant population growth. We need to invest now in co-designing targeted and connected pathways so those medical students aspiring to become (General Practitioners (GPs) are supported and enabled to do so, and choose to practice in the locations they are most needed. We need to take a system-wide approach, with coordinated action across the continuum of medical education and training and multiple programs. Merely tweaking existing education and health workforce programs in isolation will not deliver the outcomes required.

a) The current state of outer metropolitan, rural, and regional GPs and related services

Our health system remains too hospital-focused

There is widespread recognition that Australia needs to make strategic and long-term investments in primary care and general practice, including addressing the long-standing and complex issues that lead to the maldistribution of our healthcare workforce.

Evidence is clear that a strong and well supported primary care system is associated with better health outcomes and lower overall national health care costs[2]. However, Australia's health care system remains overly reliant and focused on hospital-provided care. Medical education and training is also primarily undertaken in hospital-based settings, which limits the exposure for our students to experience and envisage a future career in general practice and community-based care, sustains the 'hidden curriculum' that promotes sub-specialty careers in large tertiary hospitals, and limits our students' ability to train in and for community-based practice.

Our population's health needs are changing, and Australia's health and medical education and training systems need to respond. People are living longer, with increasingly complex and comorbid conditions. In Australia, between 2017 and 2057, the number of people aged over 65 will more than

[1] Medical Deans Australia and New Zealand (2020) MSOD National Data Report 2015-2019 https://medicaldeans.org.au/md/2020/08/2020-MSOD-National-Data-Report_2015-2019-Full-report.pdf
[2] Australian Government Department of Health (June 2008) Does better primary health lead to better health? https://www1.health.gov.au/internet/publications/publishing.nsf/Content/health-oatsih-pubs-linkphc~health-oatsih-pubs-linkphc-systems~health-oatsih-pubs-linkphc-systems3

double[3]. 60 per cent of the population over 65 years of age report having two or more chronic conditions[4]. It is clear that patients and the health system overall would benefit from a shift to far more healthcare services being provided in community and residential settings.

Too little medical training takes place in community-based settings

It is not surprising then that our medical training pathways are very hospital-focused, with medical graduates' next stage of training being based in hospitals as interns. Medical students and prevocational trainees need to be learning in all the environments where health care is provided, and be able to envisage a rewarding and fulfilling career in community-based practice. Longitudinal and well-supported clinical experiences in non-hospital environments allow students and prevocational trainees to apply and further develop their skills in a range of settings with a diverse patient mix, particularly as these are the settings where we need more doctors to be working. It also provides access to positive role models for students and trainees to aspire to. Put simply, you cannot be what you cannot see[5,6].

As the National Medical Workforce Strategy Scoping Framework notes, "*Medical students are disproportionately exposed to subspecialist doctors during training*", despite GPs making up 31 per cent of the medical workforce[7]. Similarly, prevocational training structures continue to overemphasise hospital-based care with far less time spent in community settings[8,9]. This is also the case for other community-based health services, including residential aged-care, mental health services, the disability sector, and the Indigenous community-controlled health sector where this is their desire.

We urgently need investment to increase the capacity for quality training and supervision, and develop sufficient and sustainable approaches that enable and support training as part of health care practice's business models.

Another important issue is the lack of cohesive training pathways for graduates and trainees interested in a general practice career. Unlike training paths based in hospitals, GP trainees need to

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[3] Australian Government Department of Health, National Medical Workforce Strategy Scoping Framework, July 2019 (page 21). https://www1.health.gov.au/internet/main/publishing.nsf/Content/Health%20Workforce-nat-med-strategy

[4] Department of Health, National Medical Workforce Strategy Scoping Framework, July 2019 (page 21). Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/Health%20Workforce-nat-med-strategy

[5] Fuller L, Beattie J, Versace V. Graduate rural work outcomes of the first 8 years of a medical school: What can we learn about student selection and clinical school training pathways?. Aust J Rural Health. 2021;29:181–190. https://doi.org/10.1111/ ajr.12742

[6] O'Sullivan B, McGrail M, Russell D, et al. Duration and setting of rural immersion during the medical degree relates to rural work outcomes. Med Educ. 2018;52:803-815

[7] Australian Department of Health (2019) National Medical Workforce Scoping Framework. Page40

[8] In 2019, 77 per cent of respondents to the Medical Training Survey in Australia reported they were training in a hospital compared to 23 per cent in a community setting. Medical Board of Australia and AHPRA (19 February 2020) Medical Training Survey 2019.

[9] We recognise and support the proposed changes by the Australian Medical Council in their consultation on the National Framework for Medical Prevocational Training to remove mandatory rotations and introduce greater flexibility for rotations in prevocational training including across different settings.

contend with a loss of continuity of service benefits, such as maternity and long service leave, and are required to apply for jobs on a 6-monthly basis without an overarching employment contract. These issues have long been recognised as detracting trainees from choosing GP training and need to be addressed.

General Practice and primary care is insufficient and inequitably distributed

Australia's primary care system delivers outcomes that are among the best in the world, but GPs are in undersupply and inequitably distributed[10]. The rate of people reporting not having a GP nearby as a barrier to seeing one was 2.5 times as high for outer regional areas and 6 times higher for remote and very remote areas, when compared to major cities[11]. Whilst the proportion of GPs in major cities increased by over 4 percent from 2014 and 2019, the numbers declined in inner and outer regional, remote and very remote areas over the same period of time[12]. We know rural and remote communities have more difficulty accessing care when they need it. They have fewer medical practitioners, disproportionately rely on overseas trained doctors (often referred to as 'International Medical Graduates' or IMGs), and have to wait longer to see a GP compared to people in major cities[13].

As well as the recognised shortages in rural and regional areas, population growth in the urban corridors and outer metropolitan areas of our major cities is placing significant pressure on our urban health networks. The population of western Sydney alone is expected to grow by nearly half a million between 2016 and 2036[14]. Melbourne is projected to have a population increase of 1 million in the next 10 years, increasing from 5.2 million in 2020 to 6.2 million in 2031[15].

New hospital infrastructure in outer metropolitan Sydney and Melbourne is already underway and will have a draining effect on the regional and rural health care workforce. New hospitals need doctors at scale and there are concerns that these needs in outer metropolitan areas will compete for health care professionals and staff with country towns and remote regions.

This scale of growth adds pressure on an already stretched, and in many cases exhausted, primary care workforce in these areas who are often also facing unique challenges. For example, residents in the south-western Sydney Local Health District have higher levels of socioeconomic disadvantage

[10] Primary Health Reform Steering Group recommendations to inform the Primary Health Care 10 Year Plan.
[11] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 15 September 2021, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health
[12] Australian Department of Health General Practice Workforce providing Primary Care services in Australia (17 June 2020), Sheet 2: General Practice Workforce providing Primary Care services, Australia, Remoteness Area - Statistics by calendar year. https://hwd.health.gov.au/resources/data/gp-primarycare.html
[13] Royal Australian College of General practitioners (2020) General Practice Health of the Nation 2020. https://www.racgp.org.au/health-of-the-nation/chapter-2-general-practice-access/2-2-gp-workforce
[14] Greater Sydney Commission (March 2018) Our Greater Sydney 2056: Western City District Plan. Page 27 https://www.greater.sydney/western-city-district-plan/introduction
[15] Australian Centre for Population Health (2020) Population Statement, Capital city and rest-of-state projections: https://population.gov.au/data-and-forecasts/data-and-forecasts-dashboard-statement-capital-city-ros.html

and lower rates of private health insurance[16]. Many rely on publicly funded essential services provided by GPs with about 80% of GP practices in south-west Sydney bulk billing[17]. The rates of hospitalisation and chronic conditions for residents in the south-western Sydney Local Health District are among the highest in NSW[18], highlighting the need for more preventive care, early intervention services, and ongoing long-term support. Given the higher rates of potentially avoidable hospitalisations, community-based primary care services are critical to delivering better health outcomes for these communities and to alleviating the strain on public hospitals and waiting times.

Communities in these growth corridor areas are often very diverse, with about 43% of the south-western Sydney Local Health District being born overseas, and almost 10% speaking English "not well or not at all"[19]. Almost half of GPs in south-western Sydney are bilingual and provide services in a language other than English[20]. Publicly funded GPs are clearly central to the delivery of affordable, accessible and tailored health services to these communities; however, it also means filling GP vacancies in these areas can be difficult.

It is important to note that these areas in Sydney have been at the centre of NSW's recent COVID-19 outbreak, adding significant pressure on the GP workforce to support their communities and rapidly deliver vaccinations. Growing a sustainable primary care workforce in these areas will be critical to not just providing the essential day-to-day services, but having sufficient capacity to be able to respond again to any health crises in the future.

General Practice is under great strain

There are multiple reports from leading rural doctor, general practice and primary care organisations about the current and worsening state of general practice and the impact on the GP workforce. The low and dropping morale[21]; increasing numbers intending to leave[22]; and personal impacts on those involved. Fewer new doctors are choosing GP training pathways[23] although our annual survey of final year medical students indicates stability in the number of graduates considering this career when

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[16] South Western Sydney Primary Health Network (2018) Our Health. An in-depth study of the health of the population now and into the future. .
https://www.swslhd.health.nsw.gov.au/pdfs/SWS%20Our%20Health%20in%20depth.pdf
[17] Ibid (2018). Page 43.
https://www.swslhd.health.nsw.gov.au/pdfs/SWS%20Our%20Health%20in%20depth.pdf
[18] South Western Sydney Primary Health Network (2018) Our Health. An in-depth study of the health of the population now and into the future. Page 2.
https://www.swslhd.health.nsw.gov.au/pdfs/SWS%20Our%20Health%20in%20depth.pdf
[19] Ibid., 2018. Page 1.
[20] Ibid., 2018. Page 43.
[21] 'COVID pushing rural healthcare to the limit' (9 Sept 2020) Medical Republic
https://medicalrepublic.com.au/covid-pushing-rural-healthcare-to-the-limit/34210
[22] National Council of Primary Care Doctors (21 Sept 2021) GPs are in the trenches: more investment is needed in delivering care on the frontline. Available: https://www.rdaa.com.au/documents/item/1666
[23] Deloitte Access Economics (commissioned by Cornerstone Health Pty Ltd) (2019) General Practitioner Workforce Report 2019.

they leave medical school[24]. With over a third of GPs aged 55 years and over[25], there are concerns about the numbers seeking to retire, with reports about the difficulties in finding GPs to take on their practice. Western NSW Primary Health Network report their concerns that 41 small towns in Western and Far West NSW risk not having a practising GP within the next 10 years[26]. Being able to take time away from the practice is reportedly getting more difficult[27], and the international and interstate border closures caused by COVID have effectively cut off inter-state and fly-in fly-out locums. The decrease in overseas trained doctors migrating to Australia since the pandemic[28] has compounded this issue.

Crisis in academic General Practice

There is also a workforce crisis in academic general practice – it is an ageing workforce which is not replenishing at the required rate. This is having multiple, serious flow-on impacts including: reduced capacity to train new GPs, with subsequent impacts on hospital-based care that come from a stressed and under-resourced primary care sector; limited capacity for research into and led by general practice; a loss of skills to translate research evidence into practice within primary care, and to teach the skills of reflection and evaluation in continuous quality improvement.

The loss of focus on this issue also sends an incorrect but very strong signal to medical students and doctors in training that general practice lacks rigour and has limited academic standing, risking the loss of the best and brightest students to other disciplines. There are significant benefits to the individual and the whole health system for doctors to progress "portfolio" careers that integrate clinical practice, research, and teaching; and students and interns need to see these GP role models following and excelling in academic careers, so they can envisage themselves in such a role.

The role of scholarship, education and research within the health workforce, and in particular the primary care and rural medical workforce, cannot be overstated. Medical educators, clinician researchers and clinical leaders are vital to sustaining and improving our medical training, and to improving our health systems overall.

There is an urgent need for better coordinated and supported clinician researcher and medical educator career pathways, running from medical school through to vocational training, to provide sufficient opportunities for students and early-career doctors to explore whether this is a future for them, without it causing a delay – real or perceived – to their progression through to fellowship.

We cannot afford to lose graduates interested in general practice and rural careers because of a perceived or actual lack of opportunities for scholarship, research and leadership, alongside clinical

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[24] Medical Deans Australia and New Zealand (2020) MSOD National Data Report 2015-2019 https://medicaldeans.org.au/md/2020/08/2020-MSOD-National-Data-Report_2015-2019-Full-report.pdf

[25] Royal Australian College of General Practitioners (2020) Health of the Nation Figure 22. https://www.racgp.org.au/health-of-the-nation/chapter-2-general-practice-access/2-2-gp-workforce

[26] https://www.parliament.nsw.gov.au/lcdocs/submissions/69976/0346%20Western%20Health%20Alliance%20Limited.pdf

[27] National Council of Primary Care Doctors (21 Sept 2021) GPs are in the trenches: more investment is needed in delivering care on the frontline. Available: https://www.rdaa.com.au/documents/item/1666

[28] Rural Doctors Association of Australia (27 Aug 2021) Border blocks crumble rural health workforce. Available at https://www.rdaa.com.au/documents/item/1622

practice. Ensuring these pathways are accessible and promoted to rural students and trainees, especially those with a keen interest in general practice, is vitally important to ensure they do not have to make an unnecessary choice between pursuing careers in research and clinical practice. Technology is enabling and supporting a revolution in remote working for many industries. We need to leverage the significant shift to remote supervision and telehealth as a result to the COVID-19 pandemic to enable and embed visible opportunities for rural-based research, accessible to rural clinicians.

b) The current state and former Government reforms to outer metropolitan, rural, and regional GP services and their impact on GPs, including policies such as:

i. **the stronger Rural Health Strategy,**

ii. **Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,**

iii. **GP training reforms, and**

iv. **Medicare rebate freeze.**

Train doctors from, in, and for the regions they're needed

Evidence shows that training students from, in, and for rural communities positively impacts their interest in and preference for a rural medical career. Recruiting preferentially from areas (such as rural or regional, or from the surrounds of a medical school campus), providing a clear mission and mandate for providers to grow the local workforce, embedding within the curriculum elements directly related to the health needs of their communities, and providing access to inspirational role models – whether alumni, near peers, or clinical teachers – has been demonstrated to foster a preference to work in these areas.

Long-term Government investment through the Rural Health Multidisciplinary Training (RHMT) Program has been instrumental in enabling universities to establish and support a network of Rural Clinical Schools (RCSs) and University Departments of Rural Health (UDRHs) for an increasing number of medical and other health professional students to undertake a substantial proportion of their medical school training in regional and rural areas; in some instances, their whole program.

The Final Report[29] from the independent evaluation of this Program stated that "*the RHMT program has been an appropriate response and important contributor to addressing rural workforce shortage. After two decades it is a strong foundation for rural health workforce training and research in rural, remote and regional areas which is now considered routine*." The Program has greatly contributed to medical schools' work in fostering a desire and preparedness in their graduates to practice rurally. However, given the persistent shortages, it is clear that this preference at the point of graduation is not sufficient to generally translate into future career choices.

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[29] Australian Government Department of Health (2021) Evaluation of the Rural Health Multidisciplinary Training (RHMT) Program 2019-2020 https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-rhmt-evaluation

Increased medical training in community-based settings

We urgently need more investment in, and more flexible approaches to, building high quality training and supervision capacity in general practice and across primary care, new ways of funding medical student placements, and a commitment to enabling and promoting community-based training as a substantial part of prevocational training.

The existing Teaching Payment, paid through the Practice Incentive Program (PIP), reimburses GPs for teaching medical students to a maximum of 2 sessions per GP per day. The reimbursement rate of $200 per session has not increased since January 2015 and is no longer a sufficient incentive to encourage GPs to commit to supervising students. New, specific funding mechanisms are required to provide adequate and sustainable rates of reimbursement for GPs to train and supervise students and trainees; recognising this may also require capital funding to enable practices to establish additional consulting spaces.

The quality of that early training experience is vital. Exposing students and trainees to poor experiences not only impacts their training, but is likely to actively discourage them from pursuing that path. However, the current workforce required to provide high quality supervision is the same workforce that is over-stretched and exhausted. We must not try to impose yet more burden and pressure on GPs, instead what is needed is support, investment and a sustainable model.

In addition to an increase in funding support for supervisory roles, medical schools, specialist colleges and health services should explore opportunities to train supervisors across training environments. Despite differences in the training, remuneration and recognition of supervisors, the core responsibilities of a supervisor are similar across all stages of the training continuum. Especially in regional and rural areas, supervisors often provide supervision for a range of different medical students, trainees and IMGs. We need to explore how we can increase supervisory capacity whilst removing much of the administrative burden associated with meeting the separate accreditation standards by each accrediting body, to be considered an eligible supervisor.

Increase regional postgraduate medical training to stop losing our new doctors to the cities

We need more postgraduate training to be undertaken in the regions, to allow gradates interested in pursuing a rural career to continue their medical training without having to relocate to the city during these formative years. As noted earlier, the Medical Deans annual survey of final year students[30] reveals a strong interest in a future career based outside a capital city, with over a third stating this as their preference, yet we continue to lose too many to the cities where the majority of intern placements are based. The system of prevocational training is also heavily weighted towards ward rotations in larger hospitals, limiting opportunities for exposure to general practice and other primary care services such as non-acute mental health services. The early postgraduate training period is recognised as being a time when personal and professional networks are formed, relationships developed, and roots laid down. These “pull” factors have a significant impact on attracting graduates and early doctors towards careers in non-GP or hospital-based specialties.

[30] Medical Deans Australia and New Zealand (2020) MSOD National Data Report 2015-2019 https://medicaldeans.org.au/md/2020/08/2020-MSOD-National-Data-Report_2015-2019-Full-report.pdf

Successive Government policies in this area have often been developed looking only at individual stages of the training continuum. They have not sufficiently taken a coordinated and aligned approach that considers and addresses the significant interconnection across the complex and lengthy medical training pipeline that influences medical specialty decision making. The Stronger Rural Health Strategy provided a series of budget measures focused on effecting change, however did not make any connection between them. For example, while it recognised the importance of increased provision of medical school education in regional areas (through its ongoing support of the highly effective RHMT Program and the establishment of the Murray-Darling Medical Schools Network) there was no associated policy to connect these students to postgraduate medical training in rural and regional areas once they graduate. This long-recognised gap needs to be addressed. There needs to be a concerted, sustained and coordinated drive to actively facilitate students who indicate a preference for rural practice to find an appropriate path for their training that enables them to stay in the regions and build the connections, skills and experiences to retain and grow their desire for a rural career.

Whilst there are a range of GP-training initiatives, many are individual programs not connected across the pipeline. They do not provide adequate investment in building the necessary training capacity and infrastructure needed, nor address the fundamental funding reform needed to support general practice to be involved in and contributing to training. What is also lacking is the recognition that students and trainees – especially for regional training and future careers – need active help and support to find paths through the training options that would lead to a general practice career or one based in a region of workforce need. This is a crucial gap.

Collaborative regional governance of training is key to growing the rural workforce

There are many challenges unique to regional, rural and remote areas when it comes to workforce planning, models of care, and models of practice. For these reasons, Medical Deans has long advocated for a 'flipped' training model in regional and rural Australia, whereby trainees are based in the regions and rotate into larger centres if needed for certain elements of their training. To make this a reality we need to move away from applying metro-centric approaches in these areas and develop a model that empowers and enables those working in and for the regions to develop, allocate, support and manage the rural medical training pipeline.

Building the capability and capacity of regional and rural Australia to train its doctors needs to be done by those working in and for these very regions; it cannot be directed and managed from the city. The increase in regionally-based medical education has been substantial and successful because it has been locally established and embedded. It requires a lot of on-the-ground work which cannot be done or directed from the city including:

- understanding local and regional workforce needs and gaps;
- building capacity and assuring quality;
- facilitating regional training and career choices for students, junior doctors and trainees;
- seeing and capitalising on opportunities;
- ensuring best use of resources; and
- tapping into long-standing trusted relationships and connections.

Underpinning all of this is a vital, regional brokerage role fundamental to finding local solutions to local issues, and able to work across the various clinical settings and disciplines.

Supporting this regional model at a state level is crucial, with trans-regional rotation arrangements, support for preferential paths and 'regional merit' in candidate selection, and connections across health services. At a national policy level, there needs to be active support of flexible models of practice, accreditation and funding, national workforce data and planning, and primary care reform.

Regional Training Hubs (RTHs), established in 2017 with limited funding, have demonstrated some early success in supporting the transition of medical students into rural prevocational training, however their remit was constrained to a faciliatory role. The Final Report from the independent evaluation of this Program recommended increased attention be given to RTH's role in "*working with other stakeholders to progress generalist (GP and non-GP) pathways in the future, given the reliance of rural communities on a primary care and the Generalist workforce*"[31]. The evaluation also noted the importance of the "*co-design of medical training and employment strategies at jurisdiction and regional levels*" on regional workforce outcomes.

There is an opportunity to build on this early success and re-design RTHs' role to work in a structured collaboration that can provide what is sorely needed – actively progressed, and locally managed and accountable, rural training paths from medical school through to fellowship and employment. They would have a clear mandate to effectively connect and integrate education, medical workforce and social and community needs and they would have a tangible influence on rural training posts, training capacity and design across the training continuum, ensuring these align with the needs of their communities. It also provides an effective lever for Government to hold stakeholders to account for outcomes delivered. Shared governance enables shared responsibility across the continuum. It promotes necessary collaboration to make sure the needs of our local communities and future doctors are at the forefront of medical education and workforce planning.

The importance of region-led governance is referenced in the Productivity Commission's Inquiry Report into Mental Health which recommends Government enable "*regional decision making, founded on comprehensive regional level planning of needs and services to eliminate gaps in care*"[32]. It is also reflected in Recommendation 3 of the draft recommendations to inform the Primary Health Care 10 Year Plan, to prioritise structural reform in rural and remote communities "*to support a community connected approach built around the strengths of rural and remote communities*"[33]. The National Medical Workforce Strategy Scoping Framework also identified the potential to *"scale up regional and rural training hubs for specialist training"* as a strategy to be further explored[34].

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[31] Australian Government Department of Health (2021) Evaluation of the Rural Health Multidisciplinary Training (RHMT) Program 2019-2020 https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-rhmt-evaluation

[32] Productivity Commission (2020) Inquiry Report into Mental Health, Volume 1. Page 56.

[33] Primary Health Reform Steering Group (2021) Discussion Paper to inform the development of the Primary Health Reform Steering Group recommendations on the Australian Government's Primary Health Care 10 Year Plan. Page 18.

[34] https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A398D58837F631ACA2583F8007D1CC7/$File/FINAL%20-%20WORD%20-%20NMWS%20Scoping%20Framework%20-%20July%202019.pdf

The recently updated World Health Organisation 'Guideline on health workforce development, attraction, recruitment and retention in rural and remote areas'[35] provides a useful, evidence-based framework to address the challenges discussed in this submission. Across of all its recommendations it notes that "*Interventions should be interconnected, bundled and tailored to the local context*" recognising that local coordination and adaptation is key to success. More specifically, "*interventions should be determined by considering the relevance, acceptability, feasibility, affordability, effectiveness and impact of the recommendation in the local context*", and community stakeholders need to be involved in the planning, implementation and evaluation.

It is clear that we need to empower our regions and provide them with the appropriate infrastructure and authority to make the necessary decisions to plan for, attract, recruit, train, employ and support a sustainable pipeline of GPs and specialists where they are needed most.

Attractive and fulfilling careers

The pervasive issues that affect graduates' choice of specialty need to be addressed if we are to positively influence and impact their decisions. Factors that are known to impact career choices include:

- access to positive and meaningful exposure to general practice and community-based care early in medical training;
- visible, positive role models throughout training;
- lower renumeration for general practice compared to other medical specialties, exacerbated by the freeze on Medicare rebates;
- the 'hidden curricula' that promotes sub-specialisation and city-based practice,
- the influence of home and family commitments;
- work/life balance; and
- the perception of a hierarchy of medical specialties[36].

Medical Deans supports the calls for urgent reforms to address the workload and business pressures on many GPs, including a need for differing models of practice and funding.

No matter what is done to support students and graduates to train in and for general practice, unless a career as a GP is seen to be viable, fulfilling, appropriately rewarded, and supported – and enables GPs to incorporate other career elements including as an educator, researcher and leader – then our new doctors will continue to make other choices.

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[35] World Health Organisation (2021) Guideline on health workforce development, attraction, recruitment and retention in rural and remote areas. https://www.who.int/publications/i/item/9789240024229

[36] Thistlethwaite, J., Kidd, M.R., Leader, S. (2008) Enhancing the choice of general practice as a career, Australian Family Physician. Vol.37, pages 964-968.

c) The impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural and regional Australia

Impact of border closures

Whilst Australia has not faced the high number of COVID-19 cases seen in other countries, the impact of the pandemic has been significant on many areas of the health workforce, not least on doctors working in rural Australia. Disruption to international travel caused by the COVID-19 pandemic has created an acute shock on top of the chronic problem of doctor shortages in general practice and in Australia's rural and regional areas, as typically we have relied on recruiting significant numbers of IMGs to fill workforce gaps. The current policy framework reflects this, including the Temporary Skills Shortage visa arrangements administered by the Department of Home Affairs and the provisions under Section 19AB of the Health Insurance Act that impose a ten-year moratorium on IMGs billing Medicare in locations other than designated Distribution Priority Areas (for GPs) or Districts of Workforce Shortage (non-GP specialists).

IMGs make a valuable contribution to health care in Australia. Indeed, without them, many country towns would have no doctor at all. Since the policy was introduced over 20 years ago, the proportion of IMGs as part of the rural general practice workforce in rural and regional areas has increased. During 2005-2009, 59% of GPs in large regional or rural areas were IMGs, increasing to 66.7% in small rural or remote areas during the same period[37]. This was a marked increase from the early 1990s where only 39.1% of GPs in large regional or rural areas were IMGs, and 31.9% in small rural or remote areas[38]. Needless to say, our regional and rural communities now heavily rely on IMGs for access to critical general practice and primary care services.

Given this disproportionate reliance on IMGs, our regional and rural communities have been the most adversely impacted by the COVID-19 border restrictions. Over recent months, overseas recruitment has become increasingly difficult, limiting the capacity for rural and remote communities to fill GP vacancies and to recruit locums to alleviate workloads for GPs. Where some migration has been able to be undertaken, we understand the costs of recruiting and transporting the doctors and their families to Australia have skyrocketed.

Building a domestic-trained workforce, practicing in the locations and specialties needed

The Department of Health's Medical Workforce 2018 Factsheet[39] notes that 6,513 first time (i.e. new) registrants entered the medical workforce that year. At the end of 2017 Australian medical schools graduated 3,475 students into the workforce, meaning that over 3,000 of the new doctors were trained overseas. It is time for Australia to re-think and re-plan its approach to producing a sustainable and appropriate medical workforce.

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[37] O'Sullivan, B., Russell, D.J., McGrail, M.R. et al. Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. Hum Resour Health 17, 8 (2019). https://doi.org/10.1186/s12960-018-0339-z
38 O'Sullivan, B., Russell, D.J., McGrail, M.R. et al. Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. Hum Resour Health 17, 8 (2019). https://doi.org/10.1186/s12960-018-0339-z
[39] Australian Government Department of Health (2018) 'Doctor in focus'. https://hwd.health.gov.au/resources/publications/factsheet-mdcl-2018-full.pdf

Analysis of national health workforce data[40] indicates that there is substantial and ongoing movement of Australia's IMG workforce from regional locations into metropolitan practise. In 2019 IMGs comprised 31% of the medical clinical workforce overall with 74% based in metropolitan areas. IMGs also make up 92% of the growth in stock of qualified GP specialists in major cities each year, in part a result of the interaction between international labour recruitment policies and the design features of the Australian General Practice Training program. Whilst IMGs have provided a crucial lifeline for our rural communities, it is clear that many move to the city after completing their moratorium. In effect, the 'temporary fix' of overseas recruitment for the regions is ultimately contributing to the growth of medical labour in major cities and not resolving the issue it was aimed to address.

COVID-19 has shone a light on how unsustainable this reliance on overseas labour is, and our vulnerability to global disruption. Given the scale of IMGs arriving each year, it is clear that we need to have an open discussion on the contribution of domestic-trained doctors to our future workforce, and the benefits of investing in a self-sufficient and sustainable domestic-trained medical workforce. However, the model of simply increasing supply and hoping this overflows out to the regions does not work. To ensure that any investment provides the outcome required – of a workforce equitably distributed to meet the needs of our rural and outer-metropolitan populations, and working in the clinical disciplines our communities need – we need in parallel to co-develop and implement a new and deliberate approach to the medical training continuum; one that is designed with the required end in mind and that is connected and aligned through every stage of the training pipeline.

d) Any other related matters impacting outer metropolitan, rural, and regional access to quality health services

Lessons learned from previous policies and initiatives

The Prevocational General Practice Placements Program (PGPPP) was a 10-year program designed to address the declining interest in general practice[41]. PGPPP provided funding for PGY1 or PGY2 trainees to undertake a supervised 12-week rotation in a general practice setting in outer metropolitan, regional, rural and remote areas. When the program was closed in 2014, GP training programs were oversubscribed by approximately 800 places. In the same year, approximately 65% of PGPPP places were in RA2-5 areas.

The program's outcomes demonstrated the positive impact of community-based experiences on the career choices of new doctors. Whilst the program was considered financially unsustainable, it did provide valuable lessons about what works – a structured and managed program with sufficient investment in infrastructure, supervision and renumeration, enabling high quality, clinical training experiences in general practice during internship. Given the sector's support for the program[42] and

[40] Data extracted from the National Health Workforce Dataset available at https://hwd.health.gov.au/

[41] Commonwealth of Australia, Senate Community Affairs Legislation Committee (22 October 2014) Pages 169-170.

[42] Both the Australian Medical Association and the Royal Australian College of General Practitioners proposed similar, adapted models of the PGPPP after its closure in 2014.

its outcomes, it provides a useful model to consider in co-designing a new program to provide high-quality experiences in primary care with the appropriate support for learning while working. The changes to the John Flynn Prevocational Doctor Program announced in the 2021-22 Budget provides some funding to enable a similar model to the one discussed above, and it is promising that the number of rotations are being expanded from 440 to 800[43]. We look forward to seeing the outcomes in the coming years.

The Commonwealth Government's Australian General Practice Training program (APGT) has been the main training pathway to a General Practice career and a Fellowship of one of the two GP Colleges (the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine). AGPT was implemented in 2001 and followed a comprehensive Ministerial review of General Practice Training in 1998.[44]

It is worth noting that the initial model emphasised collaborative regional delivery of GP training. A government entity, General Practice Education and Training Ltd (GPET), was established to commission delivery of GP training through a national network of 24 'Regional Training Consortia', involving collaboration between Rural Clinical Schools, medical schools, Divisions of General Practice, and Aboriginal community-controlled health services.[45] In developments over the two decades since, the Department of Health has assumed the commissioning and oversight role as GPET was wound up in 2014. The regional training provider network has been consolidated to nine mostly state- or territory-based Regional Training Organisations (one of which is James Cook University based in regional Queensland). Unusually for a program of its size and policy importance, the Australian General Practice General Practice Training program is yet to be externally reviewed for impact or value. Meanwhile further reform of AGPT to a 'College-led' model is anticipated[46], following a Ministerial announcement in October 2017. The workforce policy objectives of the AGPT program remain unclear.

To better meet current and future community needs, we need to better align Australian Government investments in GP training more closely with other health workforce program, to achieve stronger connection and coordination across the stages of the medical training continuum. As stated earlier, it is also vital for this and other programs to align with the Primary Health Care 10-Year Plan that is in development[47] and the National Medical Workforce Strategy.[48]

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[43] Australian Government Department of Health (2021) Budget 2021-22: Guaranteeing Medicare – John Flynn Prevocational Doctor Program https://www.health.gov.au/sites/default/files/documents/2021/05/guaranteeing-medicare-john-flynn-prevocational-doctor-program.pdf

[44] Ministerial Review of General Practice Training. General Practice Education: The Way Forward. Canberra: Department of Health and Family Services, 1998.

[45] Trumble SC. The evolution of general practice training in Australia. Med J Aust 2011; 194 (11): S59

[46] Transition to College-Led Training Advisory Committee. https://www.health.gov.au/committees-and-groups/transition-to-college-led-training-advisory-committee. Accessed September 30 2021.

[47] Primary Health Reform Steering Group Established. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/primary-health-reform-steering-group-established. Accessed September 30 2021.

[48] National Medical Workforce Strategy. Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/Health%20Workforce-nat-med-strategy. Accessed September 2021.

Health professional training embedded in community models of practice

Education and training needs to be embedded within the clinical practice model for it to be effective for both the student/trainee and the health service; it cannot be an add-on. However, many community-based services – in particular, mental health services such as Headspace – are not set up in a way that enables health student training to be undertaken in their practice. In addition to mental health, aged care, rehabilitation and palliative care services have a similar fragmentation of services and many are established around the model of visiting specialists or remote medical input, with no structure or resourcing that would support students in having a role in the healthcare team or for students to be provided with a guided and supported learning experience. This is a particular challenge for smaller rural sites (MMM3-7).

New approaches need to be considered and developed that embed the training of our doctors, nurses, allied health practitioners, and Aboriginal and Torres Strait Islander Health Practitioners within the practice model and within the health care team. As well as supporting high-quality training and encouraging some to start on the path to a career in community-based practice, students and early-career doctors make a valuable contribution to patient care and to the practice's health care team. This has become increasingly clear with students being closely involved with the health workforce response to the COVID-19 pandemic and the surge workforce that has been needed.

The Assistants in Medicine (AiM) role piloted in NSW in 2020 and reinstated again in 2021 is one example of how this can be achieved. The AiM role allowed final-year medical students in NSW to opt in and work part-time as part of a health care team in participating NSW hospitals (up to 32 hours per week paid at 75 per cent of a NSW Medical Intern salary). The goals were two-fold: for students to be ready to provide additional medical workforce when needed (for example in cases where junior doctors were quarantined due to COVID-19 exposure); and to enable the continuation of the students' clinical training placements during the pandemic. Both medical schools and health services had shared responsibility for the students' learning. The AiM Evaluation found that "*The AiM role was effective in achieving the intentions of the program and was also valued by the medical workforce and medical schools as an opportunity to further integrate students in the team and utilise their skills and capabilities in managing the workload*"[49].

While the context of hospital-based training is different to community-settings, this example demonstrates the power of effective partnerships, the multiple benefits of embedding training within models of practice, and the value of student contributions to delivering patient care. It is vital that developing and supporting effective practice models that enable this are part of our strategies going forward.

Training Tomorrow's Doctors

Medical Deans recently released a Discussion Paper, *Training Tomorrow's Doctors: all pulling in the right direction*. This paper sets out our vision for a medical education and training continuum that leads to an adaptable and supported workforce with the required capabilities, and in the right

[49] New South Wales Health (2021) Assistant in Medicine Evaluation Report, NSW Ministry for Health. Pg22

numbers, right places, and right specialties to serve the needs of the people of Australia and New Zealand. The paper highlights five key areas to help drive towards this, including:

- **Generalist skills at the forefront of being a doctor** – preparing our future doctors for medical careers that are based in healthcare teams and working across traditional care boundaries, with the skills and experience to adapt to ongoing disruption and innovation, and in models of care that support all health practitioners to work at the top of their scope of practice;

- **Connected and aligned training pathways that effectively support key transition stages** – identifying and facilitating opportunities to train in areas of workforce shortage;

- **Learning in and for our communities** – with sufficient opportunities to apply and further develop skills and interest in the community-based settings where healthcare is most commonly provided and most sorely needed;

- **Doctors working in the right places and the right disciplines** – within an education and training system that actively supports paths to careers in the regions and specialties where they're most needed, and facilitated by effective workforce planning and policy making;

- **A healthy workplace culture and environment** – vital to underpin all this, with embedded systems that safeguard patient care and the health of students and doctors.

Our submission reflects many of the areas explored in this Discussion Paper, which provides further background and detail on our views on the challenges involved in the education and training of the general practice and the primary care workforce, and the opportunities to improve its distribution.

Learning from COVID: changing medical training and healthcare provision for good

Whilst the COVID-19 pandemic continues to cause immense challenges for everyone – with the health impacts to patients, the workload and pressures on the health services, and the significant disruption to health students' training and progression – such a scale of disruption provides a unique opportunity for step-change and fundamental improvement.

Earlier this year Medical Deans' released a report – '*Changing for Good: What we Learned in 2020*' – which charts how medical schools responded to the impacts of COVID-19, and explores the question 'Which of the new ways of working do we want to keep and build on into the future, and which do we never want to see again?'. In 2020, we saw COVID-19 drive a complete re-think of some elements of medical training previously considered sacrosanct, a rapid acceleration in the adoption of technologies, and the forging of stronger, more widespread partnerships and collaboration. In many cases, these sudden and massive changes created strong potential for lasting improvements – not only in how (and where) we train our medical students, but how and where we provide health services to those in need.

With the shock to our health workforce caused by travel restrictions, partnerships strengthened by shared challenges and needs, and the increased regionalisation enabled by technology, we have an opportunity to re-think how we plan for and deliver the health services our communities need now

and in the future. The two fundamental aspects to that are, the effective design, right location, attractiveness, and long-term viability of those healthcare services; and securing a sufficient pipeline of domestic-trained doctors wanting, well-prepared for, and helped into careers in the locations and specialties where we need them to work.

Concluding comments

It is clear that our health system needs to be re-balanced to provide a greater proportion of health care services in community-based settings. As well as general practice, investment is needed to grow the capacity of Aboriginal and Torres Strait Islander community-controlled health services, and other community settings including mental health services, residential aged care, palliative care and the disability sector.

To do this – so that our communities, our health care practitioners, and our health system overall can benefit – we need to do more than a scatter of separate, short-term initiatives. We need to re-think our approach and ensure that:

- general practice is properly supported as a viable and rewarding career;
- models of practice for community-based care are developed that are sustainable;
- students and new graduates are exposed to high-quality training in the settings we want them to choose to work; and
- doctors in training are actively supported in finding paths through to working in the disciplines and regions our communities need.

Medical schools are already progressing many of these initiatives, and are committed to working in partnership with all stakeholders – including postgraduate training providers, health services, regulators, consumers, Indigenous leaders and communities, and government – to help drive and support these important reforms.

If you would like further information on any of the points made in this submission, please do not hesitate to contact Ms Helen Craig, CEO of Medical Deans, at hcraig@medicaldeans.org.au or on 02 8084 6557.

Yours sincerely,

Richard Murray

President
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