MDANZ submission to the consultation on Australia's Primary Health Care 10 Year Plan 2022-2032

1. **What is your name?** Helen Craig
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3. **Are you responding as an individual or on behalf of an organisation?** On behalf of an organisation
4. **What is your organisation type?** Peak/Professional Body
5. **What is your organisation name?** Medical Deans Australia and New Zealand
6. **Do you consent to being named as having provided a submission to this consultation process?** Yes
7. **Do you consent to your submission being published on the consultation hub?** Yes

RESPONSES TO SURVEY QUESTIONS

8. Please provide your response to the listed actions under reform stream 1: Future-focused health care - Action area A: Support safe, quality telehealth and virtual health care. (300 word limit)

With reference to ensuring education and training content and delivery reflects changes in virtual care and decision supports, we emphasise that this needs to focus on the competencies required for healthcare students and practitioners to be literate, capable and confident in digital health matters and able to recognise and respond to the disruption and benefits offered, rather than being limited to training on current-day technologies and systems. Whilst current elements are of course important in terms of current practice, a broader perspective is needed to ensure students and practitioners are prepared with the skills to adapt to, utilise and navigate the evolving digital health landscape as new technologies and models of care are introduced; including the impacts of likely changes technology will trigger to the role and tasks doctors are expected to perform.

Primary care could and should be playing a far more substantial role in training our next generation of healthcare professionals, and a greater and better use of digital technologies offers opportunities to drive this.

We suggest two particular additional short-term actions to both deal with long-standing issues and further leverage opportunities to progress this stream:

- access to eHealth systems for medical students, enabling them to more fully contribute to the workforce during their clinical placements and be better prepared for their transition into practice; and
- a greater leveraging of telesupervision to expand health training capacity; enabling increasing numbers of health professionals to train in rural and remote areas and in other community based settings where access to in-person supervision can be limited.

9. Please provide your response to the listed actions under reform stream 1: Future-focused health care - Action area B: Improve quality and value through data-driven insights and digital integration (300 word limit)

Feedback on this section is covered by our response to Q.8.

10. Please provide your response to the listed actions under reform stream 1: Future-focused health care - Action area C: Harness advances in health care technologies and precision medicine (300 word limit)

Feedback on this section is covered by our response to Q.8.

11. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area A: Incentivise person-centred care through funding reform, using VPR as a platform (300 word limit)

Primary care funding reform must include a focus on increasing the capacity to train our future health workforce. The training of students and trainees must be embedded within the practice's clinical service model and culture for it to be effective for both the student/trainee and the health service; it cannot be an add-on. A move to VPR is a key opportunity to integrate the funding of training within the practice funding model, and fully realise the opportunity for students/trainees to have invaluable longitudinal experience of providing ongoing care to patients.

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
- community-based placements as a substantial part of prevocational training, shifting our focus from the dominance of hospital-based experiences to students training in and for the community-based settings where healthcare is most commonly provided and most sorely needed.

New, specific funding mechanisms are required that provide adequate, sustainable reimbursement for GPs to train and supervise students and trainees; and, where needed, capital funding for practices to establish additional consulting spaces. The current 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 sufficient for GPs to undertake this vital work.

The quality of early training experiences is vital. Poor experiences not only impacts students' and trainees' learning, but can actively discourage them from pursuing that career. We need to ensure we are not imposing yet more burden and pressure on already over-stretched GPs – what is needed is support, investment, and a sustainable model.

12. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area B: Boost multidisciplinary team-based care (300 word limit)

A key element in supporting effective multidisciplinary care is providing valuable multidisciplinary learning experiences for health students. Increasing interprofessional education is a priority for medical schools, and having more opportunities to follow this up with work-based placements and training that are based in multidisciplinary teams would help further develop the application of their learning and help inculcate team-based thinking as students move into practice.

Including in this Plan an additional, explicit aim to grow opportunities for multidisciplinary learning experiences, with associated actions, would ensure this opportunity is not lost. The actions should include consideration of more flexible approaches to the accreditation of training places and supervisor models, and further leveraging technology.

Whilst it is good that the National Medical Workforce Strategy is referenced, this Plan would benefit from being clearer on how these two align and connect – they need to be integrated, otherwise there is a risk they could be implemented in a parallel but separate manner and we lose opportunities to co-design vital elements and develop a shared and mutually supportive model.

13. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area C: Close the Gap through a stronger community controlled sector (300 word limit)

Growing the Indigenous Medical workforce is a priority for medical schools, as is educating and supporting non-Indigenous medical students to ensure they are culturally safe and technically capable to the level required for graduation.

The ability for medical students to spend time working with and caring for Indigenous patients and families – in community settings as well as hospitals – is an important and invaluable aspect of their work-based learning. Along with students of other health professions, they benefit greatly from being able to experience, learn and contribute to Aboriginal Community Controlled Health Services (ACCHS). Our annual survey of final-year medical students (the Medical Schools Outcomes Database) shows the continuing interest in students wanting Indigenous health to be a part of their future career; 53% last year, increasing from 41% 5 years ago[1].

However, the ability for many ACCHS to incorporate student learning within their services is limited. The Plan needs additional actions and resources for those ACCHS who wish to grow their training capacity, so that medical and health professional education can be a core part of their service model.

Progress is being made in growing the Aboriginal and Torres Strait Islander medical workforce, with Aboriginal and Torres Strait Islander medical students comprising 3.2% of this year's domestic cohort and graduating numbers nearly doubling since 2016[2]. However, sustained support and work is needed to ensure the "Aboriginal and Torres Strait Islander health workforce continues to grow". We could not see any actions in this Plan directly linking to this aim. We again reiterate that, while we strongly support the Strategy's action to "implement the … National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework", clearer statements are needed on where this Primary Care Plan connects and can both benefit from and support the Framework.

14. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area D: Improve access to primary health care in rural areas (300 word limit)

[1] https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/
[2] https://medicaldeans.org.au/data/

We strongly support the actions listed, however stress that more is needed to drive the development of new doctors wanting to, well-prepared for, and helped into rural primary care practice, including:

- regional governance of rural training – the majority of this work needs to be done locally, and cannot be driven or managed from the city;
- a collaborative and aligned pipeline approach to medical training – moving from our siloed approach to policy that addresses each stage of training separately, to a sustained supply-chain perspective with each stage connected into, supporting, and leveraging the work done by others;
- trainees retaining continuity of service benefits, such as parental leave, and afforded comparable benefits when training in primary care to those provided for hospital-based roles;
- the crucial role of rurally-based GP mentors and supports during training and in particular during key transition points – not only to inspire and teach, but to provide the support needed for those experiencing difficulties during their training; and
- opportunities afforded by technology and the step-change driven by the COVID-19 pandemic to better leverage new and more flexible approaches, for example the greater acceptance of tele-supervision to expand regional training.

New doctors must be able to pursue a well-rounded and rewarding career, and this must include more opportunities in primary care and rural practice to develop a career combining clinical practice with teaching, research and leadership roles. Not only do we need a sufficient GP academic workforce to teach, support and inspire our new cohort of rural GPs and rural generalists, but we need to stop losing some of our best new doctors to city-based careers due to a lack of opportunities and support for rural GP academics. The funding reforms proposed must address this.

15. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area E: Improve access to appropriate care for people at risk of poorer outcomes (300 word limit)

Nothing further to add.

16. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area F: Empower people to stay healthy and manage their own health care (300 word limit)

Nothing further to add.

17. Please provide your response to the listed actions under reform stream 3: Integrated care, locally delivered – Action area A: Joint planning and collaborative commissioning (300 word limit)

“Delivering regionally and locally integrated health service models” – as stated in Stream 3 – is dependent on having the workforce the community needs. This Plan needs to include appropriate actions to integrate the training of future doctors within its proposed approach to restructuring, realigning, and reforming the funding of primary care services – recognising this fundamental importance.

The proposed joint planning and collaborative work outlined in this Plan provides a significant opportunity to better connect medical training across the sectors and across the stages. As "PHNs and LHNs are best placed to understand the needs of regional and local populations" so are rurally-based health profession education providers – such as Rural Clinical Schools – best placed to contribute to and connect education and training to local needs and capacity. Within sufficient focus on this, we will not achieve the "robust local workforce" the Plan refers to and relies upon.

The increase in regionally-based medical education has been substantial and successful because it has been locally established and embedded. The proposed RACCHS offer a similar opportunity to embed clinical training within its new practice business model and enable more teaching in and for these new rural practices, and connect students and trainees into a network of mentors, supports and future colleagues.

18. Please provide your response to the listed actions under reform stream 3: Integrated care, locally delivered – Action area B: Research and evaluation to scale up what works (300 word limit)

We need to grow our clinician-researcher and clinician-educator workforce, particularly in primary care and rural settings. Unless we have those with the appropriate skills and experience, the desired research cannot be undertaken and growth in regional training cannot be delivered. There is an acknowledged crisis in academic general practice – it is an ageing workforce, 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 due to a stressed and under-resourced primary care sector; limited capacity for research into and led by general practice; a loss of skills to translate evidence into practice within primary care, and to teach the skills of reflection and evaluation in continuous quality improvement.

For many, being able to combine clinical practice with research, teaching and/or leadership contributes strongly to their career satisfaction. We cannot afford to lose graduates interested in general practice and rural careers because of this lack.

Explicit aims and actions need to be included:

- GP training pathways and roles, extending from medical school through postgraduate training, that enable graduates to explore a career as a clinician researcher/educator;
- students to be incentivised to pursue research and teaching-related degrees (e.g. an honours year or a Masters);
- national targets for clinician researchers (including an initial target of at least five per cent of medical graduates to enter a research training pathway leading to a PhD); and
- introduction of other critical enablers, including mentoring schemes, careers promotion initiatives, and targeting of research and education training opportunities to those likely to progress this career path.

Connecting RACCHS with the rural medical education infrastructure would also provide the ideal context to grow the capacity to train and support rurally-based primary care clinician-researchers and clinician-teachers.

19. Please provide your response to the listed actions under reform stream 3: Integrated care, locally delivered – Action area C: Cross-sectoral leadership (300 word limit)

Medical Deans strongly supports the collaborative and cross-sectoral approach being proposed, and would be pleased to contribute to this work as it progresses given the role our future doctors play in primary care and the importance of the connection between health services and workforce development.

20. Please provide any additional comments you have on the draft plan (1000 word limit)

Medical Deans strongly supports this proposed 10 year Plan, however we note with concern the lack of connection with the development of the future health workforce. Whilst we acknowledge there is mention of the implementation of the new health workforce strategies, this is insufficient. Developing the future health workforce is a shared responsibility of training providers and health services, and the education and training to ensure Australia has the future doctors needed must be integrated within the system – it cannot be added on or implemented in a separate, parallel manner.

Teaching and training new doctors must be an intrinsic aspect of the practice's culture and way of working. When this is in place, we see the benefits. Studies reveal the contribution students and graduates make to patient care and to the broader healthcare team[3], and the experience of the NSW Health's Assistant in Medicine demonstrates how students were able to be rapidly and effectively deployed into the COVID-19 medical surge workforce to supplement the existing junior medical workforce – this was possible as hospital services are designed with education and training in mind, and existing connections between the services and medical schools provided a strong basis for this model. Services where training is not part of the practice's model of care or culture were not able to tap into the significant potential of this soon-to-graduate clinical workforce.

Medical Deans' has recently released a range of discussion papers, which set out our views on the future of medical education and training and our health workforce development. We invite these to be considered and hope they contribute to the thinking and work to progress these vital primary care reforms. We would welcome the opportunity to further discuss any ideas in these papers or our submission.

> **Training Tomorrow's Doctors: all pulling in the right direction** 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 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:
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> - Generalist skills at the forefront of being a doctor
> - Connected and aligned training pathways that effectively support key transition stages
> - Learning in and for our communities
> - Doctors working in the right places and the right disciplines
> - A healthy workplace culture and environment

[3] Molloy E, Lew S, Woodward-Kron R, Delany C, Dodds A, Lavercombe M, Hughson J. Medical student clinical placements as sites of learning and contribution. Melbourne: University of Melbourne; 2018 https://medicaldeans.org.au/md/2021/09/MDANZ_Clin-placements-as-sites-of-learning-and-contribution_Feb-2018.pdf

Changing for Good: what we learned in 2020. The impact of COVID-19 on medical schools in Australia and New Zealand charts the early impacts of COVID-19 on medical education in Australia and New Zealand. It explores members' views of how we might build on some of the innovation and collaboration that occurred, to embed and further drive improvements in medical education and training.

Whilst the impact of the pandemic on medical education was immense and costly – both financially and personally for everyone involved – such a scale of disruption provided a unique opportunity for step-change. Medical Deans and medical schools want to capitalise on the resourcefulness and innovation of 2020 in the ways highlighted in this report.

The transition from medical school to internship is a crucial time for medical students – and also a time of high stress and anxiety levels for many. Creating a Culture of Support for medical students and graduates transitioning to practice considers how medical schools, students and hospitals can work together to ensure students feel safe to share information with their new employers about their individual physical and mental health support needs when they transition to practice.