Medical Deans

AUSTRALIA AND NEW ZEALAND

Pre-Budget Submission 2025-26

December 2024

EXECUTIVE SUMMARY

Medical Deans Australia and New Zealand (Medical Deans) is pleased to make this submission to the Australian Government for consideration as part of the 2025-26 Budget.

As the peak body representing the 24 university medical schools across Australia and Aotearoa New Zealand, Medical Deans supports its members in their work to recruit and train the medical graduate workforce needed by Australian communities.

We see an important and timely opportunity for the Government to adopt two reform proposals in the 2025-26 Budget that would help to address the chronic medical workforce challenges Australia is experiencing, particularly in rural and regional areas, and general practice. Our two proposals align with recommendations already made to the Government in 2024, in the Working Better for Medicare Review Report, the General Practice Incentives Expert Advisory Panel Report and the Scope of Practice Review Final Report.

Proposal 1.
Increase the domestic medical workforce by funding additional medical school places, targeted to areas of workforce shortage.

Despite a heavy, and growing, reliance on International Medical Graduates (IMGs), Australia continues to experience chronic medical workforce shortages in rural and regional areas, in general practice, and in certain non-GP specialties. Most recently, we are seeing unprecedented vacancy rates in medical internships across state/territory health jurisdictions.

In support of growing calls for a national medical workforce self-sufficiency target, Medical Deans proposes a staggered increase of an average of 250 medical school places (MSPs) per year over four years – 1,000 places in total. Most importantly, the new places would be awarded to existing medical schools with *demonstrated capacity to contribute to the workforce outcomes Australia needs*, in particular, more doctors practising in primary care and rural/regional locations. Additional one-off funding would be provided to the successful schools for the upfront infrastructure needed to support the new medical places.

Student commencements	**2026**	**2027**	**2028**	**2029**	**2030**
Additional MSPs **(average per year)**	0	250	250	250	250
Cumulative increase in MSPs	0	250	500	750	1000

Funding	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**2029-30**	**Cumulative Cost**
New medical school places	$0	$7,687,500	$15,759,375	$24,230,039	$33,114,387	**$80,791,301**
One-off Infrastructure costs (**average per year**)	$25,000,000	$25,000,000	$25,000,000	$25,000,000	$0	**$100,000,000**
Total cost	**$25,000,000**	**$32,687,500**	**$40,759,375**	**$49,230,039**	**$33,114,387**	**$180,791,301**

Proposal 2.
Increase the General Practice Incentive (Teaching) Payment with immediate effect, and reform the scheme to support multidisciplinary training.

The need to transition more healthcare services out of hospitals and into community-based care is widely acknowledged in Australia, and one of the foundational pillars that will support the transition is more teaching and training in primary care. However, medical schools struggle to find enough clinical training placements for their students in general practice, whilst interns train almost exclusively in hospitals.

The most commonly cited barrier to increasing clinical training placements for medical students in general practice is the inadequate incentive provided through the Practice Incentive (Teaching) Payment.[1] Medical Deans recommends that the Government reform the PIP Teaching scheme through a two-stage process:

(i) ***An increase in the PIP (Teaching) Payment with immediate effect***, to begin to expand access for medical students to GP placements

(ii) ***Establishment of a review,*** as recommended by the 2024 General Practice Incentives Expert Advisory Panel Report, *to* ***reform the PIP scheme to support training and supervision by multidisciplinary teams in primary care.***

We recommend **an additional spend of $25.9 million in 2025-26** to:

- increase the PIP (Teaching) Payment per session
- stimulate a modest growth (5%) in the total number of PIP-supported GP training sessions for students in primary care in 2025-26.

This would be a one-off expenditure by the Government, with an appropriate calculation for incentive payments to multidisciplinary teams in primary care from 2026-27 onwards to be determined by the recommended review of the PIP Teaching scheme.

1. Additional Medical School Places

Growing workforce challenges

Australia currently brings in more international medical graduates (IMGs) than we train and graduate domestically. In the ten months to April 2024, a total of 4,699 IMGs registered to begin practising in Australia[2], whereas just 3,608 medical students graduated in Australia in 2023[3]. Despite this heavy, and growing, reliance on IMGs, *Australia continues to experience chronic and substantial medical workforce shortages in certain locations and medical specialties*.

For example:

- The longstanding shortage of doctors in rural, regional and remote Australia continues despite Government policy settings designed to channel overseas trained doctors into these areas. Almost three-quarters (74%) of IMGs are working in metropolitan areas,

[1] Medical Deans surveyed NSW-based member medical schools in April 2024, and the inadequacy of PIP (Teaching) Payments emerged as the major barrier to more GPs hosting medical student placements
[2] The Hon Mark Butler MP, *Record numbers of doctors, nurses and health professionals moving to Australia [Media Release]* 23 Jun 2024
[3] Medical Deans Data Dashboard

and they make up approximately one third of the growth in the metropolitan medical labour market each year[4].

- Similarly, the shortage of GPs in Australia continues to climb: the Department of Health and Aged Care (DoHAC) estimated a shortage of 2.466 full-time equivalent (FTE) GPs in 2024, increasing to around 3,900 in 2028, and to over 8,900 in 2048.[5]
- Most recently, we are seeing unprecedented workforce vacancies in the earliest phase of medical practice – internship.[6]

It is clear that Australia's increasing reliance on IMGs is not solving its medical workforce challenges.

Another consideration is that Australia cannot rely on a steady supply of IMGs. The National Medical Workforce Strategy (NMWS)[7] points to the recent covid epidemic as an example of how depending heavily on IMGs exposes Australia to the risks associated with unpredictable push and pull factors operating in the global labour market. While recognising IMGs as an important part of the medical workforce, the NMWS calls for the development and progressive achievement of a national self-sufficiency target as the pathway to medical workforce reform.

The call for national self-sufficiency is repeated in the Working Better for Medicare Review Report 2024, Recommendation 20[8]:"*There should be a national self-sufficiency target ...[to] guide the progressive reduced dependency on IMGs, coupled with growth in domestic medical school places targeted to best address current shortages. DOHAC should progress this as a priority.*"

This recommendation makes clear the link between a national target and an increase in domestic medical school places.

Role of medical schools

Medical schools can and do help to address systemic workforce challenges by *providing more opportunities for students to learn in, and for, the locations and specialties where doctors are most needed*.[9] Some examples from the evidence base for this trajectory are provided below:

- *Rural medical workforce outcomes*: The tracking of medical students who work rurally after they graduate consistently shows the importance of selecting medical students of rural background/rural interest and supporting extended placements in rural

[4] Data extracted from the National Health Workforce Dataset, https://hwd.health.gov.au

[5] https://hwd.health.gov.au/resources/primary/gp-supply-and-demand-study-compendium-august-2024.pdf

[6] For example, in NSW in 2024, there were 94.5 vacancies remaining at the end of all recruitment processes, and '*the National Audit process identified that the number of available intern positions in Australia for the 2024 clinical year exceeded the number of applicants.*' See Health Education and Training Institute (2024), *Medical Intern Recruitment to NSW Prevocational Training Positions: Annual Report for the 2024 Clinical Year*, Sydney, Australia

[7] National Medical Workforce Strategy 2021-2031 P. 41. https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf

[8] P. 41. https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf

[9] https://medicaldeans.org.au/md/2024/09/Medical-Deans_University-of-Wollongong_Case-Study.pdf

communities as part of their training[10]. For example, a recently published study by Deakin University, tracking graduates over eight years, found that graduates who had completed a one-year rural training placement and a regional rural clinical school year were **seven times more likely to be working rurally** than those who had trained in metropolitan areas[11].

- *GP medical workforce outcomes*: Medical programs with a generalist focus in their curricula and clinical training programs have tracked an increased percentage of medical graduates going on to specialise as GPs. For example, research by the University of Wollongong (which has a sustained focus on developing doctors with generalist medical skills) showed that at ten years or more post-graduation, UOW graduates were **57% more likely to specialise in general practice** (43% of UOW graduates) when compared with all Australian medical graduates[12].

The Australian Government began to harness this capacity for medical schools to contribute to desirable workforce outcomes in 2023, with 80 new medical school places awarded to schools to train students in rural areas, along with capital funding for new regional training facilities. These additional places were a welcome addition, but a significantly larger increase is needed to develop and sustain the graduate medical workforce Australia needs.

The staged introduction of additional medical school places would progressively re-balance Australia's medical workforce toward a more appropriate level of domestically trained doctors

Medical Deans is not proposing that the additional medical school places should replace the use of IMGs; IMGs would remain a significant component of Australia's medical workforce, particularly to address shorter-term workforce needs. Instead, the staged introduction of additional medical school places would progressively re-balance Australia's medical workforce toward a more appropriate level of domestically trained doctors.

At the same time it would address the ongoing maldistribution of the medical workforce by targeting new places to workforce outcomes. Despite broad acknowledgement that we need to shift the focus of healthcare out of the hospital and into the community, the ever-expanding hospital demand for junior doctors means that interns and junior doctors cannot be freed up to work and train in primary care. *Targeting a substantial new stream of new medical school places to primary care would break that cycle and progressively help achieve the medical workforce reform needed.*

Additional medical school places

Medical Deans proposes that the Government fund the staged introduction of 1,000 new medical school places (MSPs) over four years, *targeted to existing medical schools with demonstrated capacity to contribute to workforce outcomes*.

[10] Matthew R McGrail et al, *The pathway to more rural doctors: the role of universities*, 2023 https://onlinelibrary.wiley.com/doi/full/10.5694/mja2.52021

[11] Deakin Graduate Workforce Outcomes.AJRH (1).pdf

[12] https://medicaldeans.org.au/md/2024/09/Medical-Deans_University-of-Wollongong_Case-Study.pdf.

We have based the proposal of 1,000 new places over four years on discussions with the larger state health jurisdictions about their workforce needs, and their capacity to train additional domestic medical students and graduates in areas of workforce need: primary care, and rural and regional areas.

The staged introduction of 1,000 new places would allow the actual number of new places allocated each year to be flexible – and potentially to be revised if an agreed national self-sufficiency target was developed by Australian governments. It would also allow for the progressive rollout of the increased teaching and training capacity needed to support the new places. It may be that a smaller number of places is allocated in the first two years – and a higher number in later years – to ensure that the requisite training capacity is available in primary care and rural/regional areas to support workforce outcomes.

The Government would make an additional capital investment of $100 million over four years, linked to the new MSPs, for the expanded training infrastructure required. This one-off funding would cover additional staffing for curriculum development, costs associated with onboarding new placement sites, and any new physical infrastructure needed to facilitate the teaching and training of medical students in areas of workforce shortage (i.e. rural and regional areas, primary care). The level of funding would align with the different needs identified by individual schools in their bids for new places, rather than being pro-rated across schools based on the number of new MSPs allocated.

A welcome by-product of this capital investment would be its contribution to two key health system reform directions endorsed by the Government:

- *Encouraging multidisciplinary team-based training* (e.g. medical students learning in teams alongside nurses and other health professionals in primary care)
- *Using digital technology to cross geographical barriers* (e.g. rural students learning synchronously alongside students based on metropolitan campuses).

Medical schools awarded the new places would *work closely with the state/territory health services and state/territory postgraduate medical education councils in their catchments to progressively connect the training pathway for their additional graduates into prevocational training opportunities in primary care, and rural and regional areas*. Deepening connections into postgraduate training would capitalise on the foundational work done by medical schools.

Proposal 1.

The Government to invest in 1,000 new medical school places over four years: A notional average of 250 new medical school places to be allocated per year, commencing in the calendar year 2027, with the actual number of new places allocated each year dependent on the capacity to provide training in target workforce areas. The total number of places awarded over the four years to be capped at 1,000.

One-off investment in infrastructure to be tagged to the additional medical school places: A total investment of $100 million – a notional average of $25 million per year, beginning in 2025-26 – to be allocated to the schools awarded additional MSPs, according to the extra teaching and training infrastructure required to support the new places.

Student numbers	2026	2027	2028	2029	2030
Additional MSPs	0	Average 250	Average 250	Average 250	Average 250
Cumulative increase in MSPs	0	250	500	750	1000

Funding	2025-26	2026-27	2027-28	2028-29	2029-30	Cumulative Cost
New MSPs	$0	$7,687,500	$15,759,375	$24,230,039	$33,114,387	**$80,791,301**
One-off Infrastructure costs	Average $25,000,000	Average $25,000,000	Average $25,000,000	Average $25,000,000	$0	**$100,000,000**
Total cost	**$25,000,000**	**$32,687,500**	**$40,759,375**	**$49,230,039**	**$33,114,387**	**$180,791,301**

Assumptions

- Cost to the Commonwealth of medical school places is $30,000 per place in 2027 and increases by 2.5% each year
- Funds are allocated to new places and infrastructure over the four years on an average basis; the actual expenditure per year would depend on the bids for new places from medical programs, and the associated capital investment required.

2. Immediate Increase in General Practice Incentive Training Payment

Shortage of clinical training placements in general practice

Australia's hospital-centric medical teaching and training system does not align with the reality that the majority of healthcare services are provided in the community, and that demand for primary care services is increasing significantly[13]. Patients develop long-term relationships with their GPs, and GPs provide the majority of preventative health support and longitudinal medical care. As the population ages, and co-morbidities rise, the demand for community-based health services will only increase.

> ***Medical schools struggle to find enough clinical training placements for their students in general practice, and interns train almost exclusively in hospitals.***

Medical Deans is concerned that while the need to shift the centre of gravity in health care away from hospitals and toward community-based care is well recognised, the parallel need to increase teaching and training opportunities in primary care has been overlooked.

Currently, medical schools struggle to find enough clinical training placements for their students in general practice, whilst interns train almost exclusively in the hospitals where they are employed. For example, although general practice is the focal point for the treatment and management of women's health, medical students and junior doctors do most of their clinical

[13] The number of GP Medicare services provided in 2021-22 was almost 20 per cent higher than for 2018-193.

learning about women's health in acute care – in O&G rotations in hospitals. The same imbalance applies across multiple medical disciplines.

The result is that our medical students and new doctors are not getting the foundational clinical training in primary care that would best equip them to meet the health needs of Australian communities, now and in future.

Missed opportunities to role-model GP careers

Our hospital-centric training system is contributing to the current shortfall and looming crisis in GP workforce numbers.[14] Clinical training experiences and role modelling play a big part in steering medical students along their career pathways in medicine. Without access to quality GP clinical placements, a percentage of medical students and junior doctors who might otherwise have pursued a career in general practice are choosing non-GP specialties which they have experienced, and seen positively role-modelled, during their hospital training.

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Australia cannot afford to continue along this path of lost opportunities. Just as we need to shift more health care into primary care services, our medical students and junior doctors must be immersed in quality teaching and training in general practice and other community-based services.

Pathway to change

The inadequate incentive provided to GPs through the PIP (Teaching) Payment is the most commonly cited barrier to increasing clinical training opportunities in general practice for medical students. The level of this teaching payment has not been increased for almost a decade.

Fortunately, there is significant capacity to expand training in primary care: In 2023, PIP (Teaching) Payments were provided to just over a quarter of accredited general practices,[15] highlighting the opportunity to recruit this substantially untapped capacity to train our future doctors.

Currently, the PIP (Teaching) Payment guidelines stipulate that payments are made on the basis of a three-hour session under the supervision of one GP. However, this one size fits all approach is no longer fit for purpose:

- Multidisciplinary healthcare teams hold enormous capacity to contribute to teaching and training alongside GPs, yet these healthcare professionals (e.g. nurses) are currently not eligible to share in PIP (Teaching) payments.

[14] The Royal Australian College of General Practitioners' 2022 Health of the Nation survey reported that 25% of respondents stated an intention to retire within 5 years, up from 18% the previous year.
[15] National Health Funding Pool Annual Report 2022-2023, p. 43

- The payments are based on an observational model of teaching which is too restrictive to adequately reimburse GPs who use a variety of teaching and supervision methods (e.g. cascade training) to facilitate student learning.

The 2024 Review of General Practice Incentives Expert Advisory Panel Report acknowledged that current PIP (Teaching) Payments are not sufficient to support quality teaching in general practice and, importantly, that eligibility requirements need to be broadened to support training by multidisciplinary teams[16]. The Expert Advisory Panel recommended a review be established to quickly resolve and implement[17] a holistic approach to supporting quality teaching, training and supervision in primary care moving forward.

Medical Deans supports the Expert Panel's position and recommends a two-stage reform process:

(i) *An immediate increase in the PIP (Teaching) Payment, through the 2025-26 Budget,* to begin to expand access to GP placements.

(ii) *Establishment of a review, as recommended by the Expert Advisory Panel, to develop a holistic approach to supporting quality teaching, training and supervision in primary care in future*, including that:

- Payments reflect the costs of teaching and supervising in primary care[18]
- Payments are extended to include non-GP primary care professionals who provide training and supervision (e.g. nurses)
- General practices are required to meet quality standards for teaching and supervision
- Appropriate support is provided for innovative teaching models, such as GP centres of excellence
- More support is provided for mentoring and training of early-career healthcare providers and GP registrars.

It is critical that both of the proposed reforms are implemented: *An immediate increase in the PIP (Teaching) payment will not solve the structural problems associated with the program (e.g. eligibility rules); the review is essential to make the program fit for purpose.*

Proposal 2.

Medical Deans recommends an additional spend of **$25.9 million in 2025-26** to:

- increase the PIP (Teaching) Payment per session
- stimulate a modest growth (5%) in the total number of PIP-supported GP training sessions for students in primary care.

This would be a one-off expenditure, with an appropriate calculation for incentive payments from 2026-27 onwards determined by a review established by the Government.

[16] Ibid, p.35
[17] Ibid
[18] Note: this includes a continuation of the current practice of rural loadings

Increase PIP (Teaching) payment from $200 to $300 per session	
	2025
Increased cost of existing sessions (225,000 x $100)	$22,500,000
Cost of additional sessions (11,250 x $300)	$3,375,000
Total additional spend	**$25,875,000**

Assumptions

- 225,000 existing eligible teaching sessions per year, based on an average total spend of $45million and a cost per session of $200
- Increasing the payment amount per session will result in a 5% increase in the number of eligible teaching sessions per year (11,250 additional sessions)

Contacts

Medical Deans thanks the Government for this opportunity to discuss the challenges that exist in relation to the teaching and training of Australia's medical workforce. Should you have any queries or would like to discuss this submission, please contact **Professor Michelle Leech (President)** and **Professor Stuart Carney (Vice President)** via email president@medicaldeans.org.au.

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