Medical Deans
AUSTRALIA AND NEW ZEALAND

Submission to the House of Representatives Standing Committee on Health, Aged Care and Disability

Inquiry into access to and affordability of medical specialists in Australia

October 2026

About Medical Deans Australia and New Zealand

Medical Deans Australia and New Zealand is the peak body representing entry-level medical education and training in Australia and Aotearoa New Zealand. We support and advocate on behalf of our member medical schools, who contribute to healthy communities through the development of high-quality, work-ready, adaptable, and patient-focused future doctors.

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Executive Summary

Medical Deans Australia and New Zealand (Medical Deans) is the peak body representing entry-level medical education and training in Australia and Aotearoa New Zealand. As the first stage of the medical training continuum, medical schools play an important role in shaping the future medical specialist workforce through student admissions, clinical training and exposure to the full range of medical careers. Medical Deans welcomes the opportunity to contribute to this inquiry.

Access to specialist care across Australia is affected by persistent workforce shortages and maldistribution. This is most acute in rural, regional and outer metropolitan areas. Specialist workforce outcomes are shaped across the entire training continuum. Improving access to specialists therefore requires coordinated reform across the pathway from medical school through to fellowship. Training is central to the ongoing development of a highly skilled medical workforce practising the types of medicine the community needs, in the areas where they are needed. Training must be a core component of workforce and service planning, not an add-on.

Australia continues to rely heavily on internationally trained doctors. Evidence shows that recruiting students from underserved communities, training them locally, and enabling them to retain meaningful connections to their local community can markedly improve workforce distribution outcomes. This depends on integrated planning to ensure training opportunities across medical school, postgraduate training, and vocational training are coordinated and build on prior experience, rather than the supervision needs of different training stages competing for space and time. Achieving this requires coordination across governments, universities, prevocational training providers, specialist colleges and health services. Clear national leadership is needed to bring these stakeholders together and support long-term workforce planning.

Given Medical Deans' remit and expertise, our response is focused on point (a) of the inquiry's Terms of Reference: *Examine current access to medical specialists in cities, regional and rural communities, with consideration of workforce distribution, shortages, waiting times and barriers to recruitment, retention and training.* We have identified four key pillars of reform to move this objective forward:

* *Rebalance medical workforce supply and increase domestic self-sufficiency*
* *Reform junior doctor roles and distribution*
* *Increase postgraduate and vocational training capacity in areas of workforce shortages*
* *Embed generalism as a skill and a role for doctors across all specialties.*

Addressing the training pathway will make a significant contribution to rebalancing the distribution of Australia's medical workforce and enabling more Australians to access the specialist care they need where they need it.

Summary of recommendations

1. ***Rebalance domestic and international medical workforce supply***
   a. Develop benchmarks for the proportion of Australia's medical workforce sourced domestically and internationally
   b. Increase medical school places in existing programs through targeted CSP grant rounds aligned with geographic workforce need and pathways to specialties in shortage
   c. Implement the *National Medical Workforce Strategy* action to develop a national definition of medical workforce self-sufficiency
   d. Ensure medical student teaching and training activities are adequately funded by:
      i. increasing PIP (Teaching) Payments to GP and RG supervisors to $390 per session
      ii. requiring States and Territories to report on the distribution of Teaching, Training and Research funds under the *National Health Reform Agreements*, including distribution to hospitals in rural and regional areas.
      iii. identifying financial and non-financial supports that would enable more medical student supervision in private practice settings
   e. Remove restrictions on international students learning in, with and for rural communities through the RHMT Program.
2. ***Reform junior doctor roles***
   a. Coordinate investment across State and Federal governments (across public and private sectors) to increase prevocational and vocational training in areas of need, aligned to future workforce planning.
   b. Implement models of care that utilise the multidisciplinary healthcare team and emerging technology to reduce reliance on the prevocational doctor workforce in metropolitan hospitals and create further opportunities for prevocational doctors to work in regional and rural hospitals.
3. ***Training across diverse settings, formats and structures***
   a. Increase the delivery of vocational training in areas of need, particularly in rural, regional and outer metropolitan areas through collaboration on funding employment and training positions that work across multiple settings between the Commonwealth and state and territory governments.
   b. Support pilots of novel training approaches that make the most of the local health workforce for multidisciplinary supervision supported by technology-enabled supervision through investment by the Commonwealth Government.
   c. Encourage training accreditation bodies to support a broader range of training places that respond to local challenges with local strengths.
   d. Implement fair and consistent approaches to the recognition of prior learning experiences for unaccredited registrars across all specialty training.
   e. Develop standards for unaccredited registrars, in collaboration with State and Territory Health Departments, that include equitable approaches to rostering, leave and other entitlements, and minimum standards for ongoing training and professional development.
4. ***Embed generalism as a core skill for specialists***
   a. Support the creation and funding of specialist roles in areas of need with an explicitly generalist scope of practice, including removing unnecessary barriers to generalist specialists working to their full scope of practice.
   b. Support colleges and training providers to develop expedited training pathways leading to a generalist scope of practice that:
      i. work in tandem with recognition of prior learning for unaccredited registrars
      ii. provide opportunities for further upskilling and credentialling post fellowship, in line with community need and their areas of interest.

1. Rebalance domestic and international medical workforce supply

1.1. Australia is too reliant on doctors trained overseas

Successive Australian governments have addressed medical workforce maldistribution and regional shortages by importing medical talent from overseas. This has led to overseas trained doctors (OTDs) constituting an increasingly large component of Australia's medical workforce, and total numbers of OTDs tripled between 2003 and 2023[1]. In 2024, 59% of Australia's medical workforce was trained in Australia, and 29% trained overseas, with no data available for the remaining 12%[2]. In the same year, 55.5% of new AHPRA registered medical practitioners were trained overseas[3], while 57% of 2023's new medical practitioner registrants were trained overseas[4]. Modelling undertaken by the Department of Health, Disability and Ageing projects that the proportion of doctors working in Australia who were trained overseas will rise to 38% of the total workforce by 2048[5]. OTDs comprise a higher proportion of Australia's medical workforce than in most comparable countries. The average proportion of OTDs among OECD members is 19.6%; Australia's above average reliance on OTDs is the sixth highest in the OECD[6].

Australia benefits from bringing in a certain proportion of its workforce from overseas, and many communities would be without a medical workforce if not for OTDs. However, we need to consider the rising proportion of the medical workforce trained overseas and the implications for long-term workforce planning. This planning should consider the ethics of international workforce recruitment[7], the areas and specialties where OTDs practice, Australia's healthcare needs, and how to balance short-term solutions with long-term sustainability. Developing benchmarks or targeted ranges for doctors trained domestically compared with doctors trained overseas is a key first step toward sustainable solutions that meet patients' needs while respecting the training and ambitions of our health workforce.

We recommend:

a. *Develop benchmarks for the proportion of Australia's medical workforce sourced domestically and internationally*

[1] Department of Health, Disability and Ageing (2026) *Whole of Medical Workforce Supply and Demand Compendium Report*, p. 2, available at https://hwd.health.gov.au/resources/primary/whole-of-medical-workforce-compendium-report-june-2026.pdf accessed 8 September 2026
[2] Data sourced from Health Workforce Data https://hwd.health.gov.au/webapi/jsf/dataCatalogueExplorer.xhtml accessed 8 September 2026
[3] AHPRA (2025) *Annual Report 2024/25*, available at https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2025 accessed 19 May 2026
[4] AHPRA (2024) *Annual Report 2023/24*, available at https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2024 accessed 8 September 2026
[5] Department of Health, Disability and Ageing, *Op. Cit*., p. 3.
[6] OECD (2025) *Health at a Glance 2025* available at https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/international-migration-of-doctors_17ff3227.html accessed 19 May 2026
[7] As outlined in World Health Organisation (2010) *WHO Global Code of Practice on the International Recruitment of Health Personnel*, available at https://www.who.int/publications/i/item/who-global-code-of-practice-on-the-international-recruitment-of-health-personnel accessed 28 September 2026

1.2. Targeted domestic training can reduce this reliance

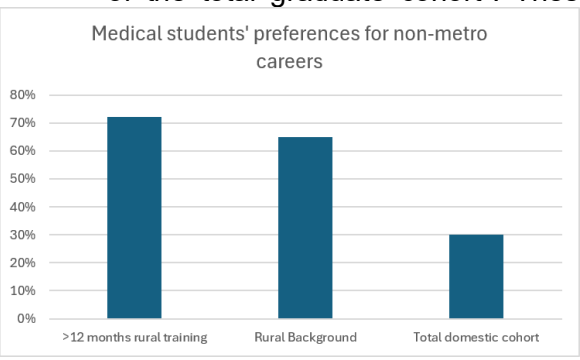
Despite the excellent contributions OTDs make to Australia's healthcare system, issues persist in the distribution of Australia's medical workforce, and many communities lack the healthcare they need. New solutions are needed to address this persistent problem.

Rebalancing the supply of doctors trained domestically and those trained overseas can help address persistent workforce maldistribution. Innovative, holistic approaches to workforce development are needed, including an increased focus on training doctors in and with the communities where they are most needed. Medical training begins in medical school, and as such, solutions to maldistribution need to begin with recruiting and training more domestic medical students. Every year, Australian medical schools turn away many highly capable prospective students who would make excellent doctors because of the limited number of places available.

> *"We turn away thousands and thousands and thousands of Aussies every year from medical school … they're all smart and they're all good people."*
>
> **Prof Michelle Leech**, Deputy Dean, Faculty of Medicine, Nursing and Health Sciences, Monash University
>
> Wilkes C (2025) **Eligible medical school candidates turned away in their thousands each year**, *ABC News*

Increasing medical school places need not increase the overall size of the future medical workforce. Increasing medical school places will allow Australia to reduce the number of OTDs needed each year to meet our health workforce needs. Such an approach is consistent with the *National Medical Workforce Strategy*, which recommended that reliance on OTDs be reduced through the development of a national definition of self-sufficiency[8].

Medical school experiences can significantly affect the type of medicine graduates subsequently practise. 65% of 2025 medical graduates from a rural background, and 72% of 2025 domestic graduates who completed more than 12 months of their medical degree in a rural area, indicated a preference for a career outside metropolitan areas, compared to 31% of the total graduate cohort[9]. These experiences translate into workforce outcomes after graduation. Multiple studies have found that students from rural backgrounds and those who completed extended rural placements are more likely to practise rurally after graduation than metropolitan students without significant medical school training in rural areas[10]. Increasing medical school places aligned with recruitment, training and education approaches associated with improved workforce distribution outcomes is an important component of a suite of policies that need to be developed to improve the geographic distribution of Australia's medical workforce. Recent Australian governments have supported this approach in small ways through medical Commonwealth Supported Place (CSP) grant rounds in 2022, 2025 and 2026, which prioritised rural and primary care outcomes. Now is the time to scale up these initiatives to begin working towards a rebalanced medical workforce supply. Medical Deans



[8] Department of Health (2021) *National Medical Workforce Strategy 2021 – 2031*, available at https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031 accessed 8 September 2026

[9] Medical Deans Australia and New Zealand (2026) *MSOD National Data Report 2026*, available at https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/ accessed 8 September 2026

[10] Pillen H, et al. (2026) 'Rural clinical training for Australian medical students: A scoping review of rural workforce outcomes', *Australian Journal of Rural Health*, vol. 34 no. 4, e70243. https://doi.org/10.1111/ajr.70243

calls for further CSP grant rounds that support geographic workforce priorities and strengthened pathways towards specialisation in areas of identified need[11]. These measures will also strengthen the future pipeline of specialists in areas and locations experiencing workforce shortages.

We recommend:

b. *Increase medical school places in existing programs through targeted CSP grant rounds aligned with geographic workforce need and pathways to specialties in shortage*
c. *Implement the* National Medical Workforce Strategy *action to develop a national definition of medical workforce self-sufficiency*

1.3. Fund medical education and training in underserved settings

Increasing medical school places needs to be complemented with increasing opportunities for quality placements in the communities and clinical contexts where workforce need is greatest. Students on rural placement often spend significant time learning in and from GPs and rural generalists through longitudinal integrated clerkships. This reflects the vital role these doctors play in providing healthcare to communities in regional, rural and remote Australia, and gives these students a broad education in rural healthcare with a strong focus on generalist skills. However, teaching payments to offset the financial impact on GPs and rural generalists of delivering meaningful teaching are inadequate, leading many GPs to reduce the amount of teaching they deliver. Increased investment in quality medical education and training in primary care is needed[12]. At the same time, investment in supervising medical students on placement needs to be equitably distributed across all hospitals, including regional and rural hospitals, so students on rural placement can spend time observing and participating in the work of hospital-based consultants in rural areas. This is vital if we are to encourage these students to consider and plan for careers as rural or regional hospital-based specialists, working in specialties and locations where their services are needed.

Correcting maldistribution across rural and metropolitan divides is an important priority for improving healthcare access and outcomes. At the same time, it is vital to consider distribution within metropolitan areas, especially in outer metropolitan hospitals and health services. The Expedited Specialist pathway has been filling gaps in outer metropolitan areas of need, but early evidence also shows that Specialist International Medical Graduates (SIMG) are 'being absorbed within existing workforce distribution patterns'[13]. Further reform is needed to ensure medical students can continue to be supported to learn in these settings, recognising that the existing workforce shortage challenges supervisory capacity. Specific investment to support and incentivise high-quality student training in non-GP specialist settings in outer metropolitan

[11] These areas and specialties could be identified by using the Commonwealth's *Districts of Workforce Shortage* for areas where specialists (currently anaesthetics, cardiology, diagnostic radiology, general surgery, obstetrics and gynaecology, ophthalmology, medical oncology and psychiatry) are in short supply (less than 3 Full-Service Equivalent per 100,000) and *Distribution Priority Areas* for areas where GPs are in undersupply based on multiple criteria including Medicare billings data.
[12] Medical Deans has outlined a series of reforms to the PIP (Teaching) Payment that compensates GPs and RGs for income lost during medical student placement supervision as well as a costing for increasing the PIP (Teaching) Payment. See Medical Deans Australia and New Zealand (2026) *Pre-Budget Submission 2026-27*, available at https://medicaldeans.org.au/md/2026/02/260129-MDANZ-Pre-budget-2026-27-Submission_FNL.pdf
[13] Medical Board of Australia (2026) *Expedited Specialist Pathway – Evaluation Report* p. 42, available at https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway/Guides-and-reports accessed 8 September 2026

areas, including community, hospital and private practice settings, is required to help address this maldistribution.

We recommend:

d. Ensure medical student teaching and training activities are adequately funded by:
   i. increasing PIP (Teaching) Payments to GP and RG supervisors to $390 per session
   ii. requiring States and Territories to report on the distribution of Teaching, Training and Research funds under the National Health Reform Agreements, including distribution to hospitals in rural and regional areas.
   iii. identifying financial and non-financial supports that would enable more medical student supervision in private practice settings

1.4. Better utilise international students trained in Australia

Now is also the time to consider how international medical students who graduate from Australian medical schools and intend to practise in Australia can be better utilised to address workforce maldistribution. These students have been trained in, with, and for Australia's healthcare system: they are familiar with Medicare, trained in Indigenous health and cultural safety, and know the specific risk factors that affect Australians' health outcomes. Medical Deans' data show that approximately 85% of Foreign Graduates of Australian Medical Schools (FGAMS) undertake internship in Australia[14]. Currently, FGAMS are subject to the same Medicare Moratorium as OTDs. They also receive lower priority in internship allocations compared to domestic graduates, which results in these doctors being more likely to be allocated rural internships[15]. However, under current policy settings, international students are ordinarily unable to take up opportunities to undertake rural training experiences in medical school funded through the Rural Health Multidisciplinary Training (RHMT) Program, which works against encouraging more of these doctors to have long-term careers based in rural areas[16].

We recommend:

e. Remove restrictions on international students learning in, with and for rural communities through the RHMT Program.

[14] This figure calculated by extracting MSOD respondents who self-report being international students between 2020 and 2025 (n=1581) and identifying which of these students appear on the AHPRA register with a date of first registration within 2 years of their graduation (n=1357).
[15] McGrail MR, et al. (2020) 'Exploring preference for, and uptake of, rural medical internships, a key issue for supporting rural training pathways' *BMC Health Services Research*, vol. 20, art. no. 930. https://doi.org/10.1186/s12913-020-05779-1
[16] McGrail, MR, et al. (2019) 'Rural work and specialty choices of international students graduating from Australian medical schools: Implications for policy', *International Journal of Environmental Research and Public Health*, vol. 16 no. 24, art. no. 5056. https://doi.org/10.3390/ijerph16245056

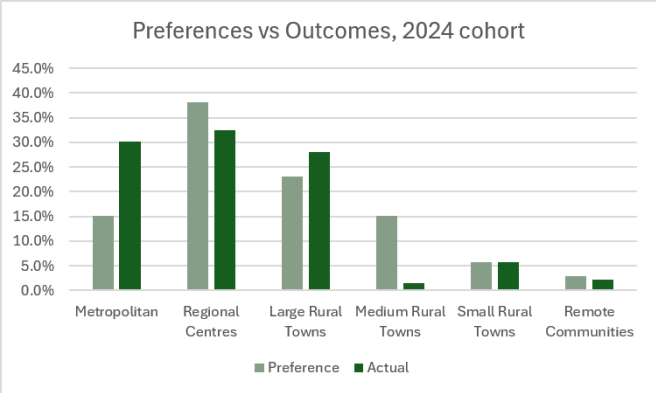
2. Reform prevocational doctor roles

2.1. Train prevocational doctors where they are most needed

Increasing opportunities for medical students to learn in, with and for the communities where we need more doctors to work after graduation is an important first step in improving the distribution of doctors across a range of specialties. However, as medical school is the first step in the long process of becoming a medical specialist, reform of the broader training pathway needs to be undertaken in order to maximise the likelihood of doctors working in the areas where their services are most needed.

Evidence shows that the strongest predictor of long-term rural workforce outcomes is completing an internship in a rural location[17]. Medical schools have a proven track record of building interest in rural careers. However, this interest needs to be matched with visible opportunities to work and train locally after graduation to realise the investments made in medical school.

85% of domestic students from rural backgrounds who completed at least 12 months of rural placement in the 2024 graduating cohort indicated a preference to work outside of metropolitan areas; however, in 2025, 30% of these students were in fact completing internship in metropolitan areas[18]. While it is not clear how many of these doctors will return to practice in rural areas subsequently, when read alongside evidence showing that rural internship is the strongest predictor of long-term rural workforce outcomes, such a finding is concerning.



Possible explanations for this include:

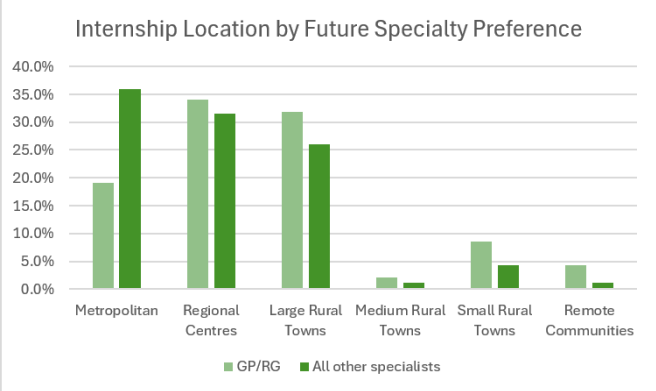
- Perceptions that rural internships will limit their training opportunities
- Absence of end-to-end training opportunities from internship to fellowship
- Scarcity (or perceived scarcity) of stable, ongoing employment opportunities post-fellowship.

These possible reasons are further supported when considering the differences in actual work location outcomes between those who indicated a preference to specialise as GPs or rural

[17] McGrail MR, et al. (2024) 'Evaluating the importance of rural internships to subsequent workforce distribution outcomes: An Australian cohort study', *BMJ Open*, vol. 14, e084784. https://doi.org/10.1136/bmjopen-2024-084784

[18] Data obtained from Medical Deans' data dashboard which links MSOD responses with AHPRA registration data. Available at https://app.powerbi.com/view?r=eyJrIjoiMjdiNTU2NWMtMmJjYy00MTBiLTg5NTgtNzg1OTE4ZjU4NGJhIiwidCI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9 accessed 11 September 2026

generalists and those who indicated a preference for another specialty. Almost twice the proportion of respondents who indicated a preference for a non-metropolitan, non-GP specialty are completing internships in metropolitan areas in 2025 compared with non-metropolitan GP or rural generalist preferences (35.9% other specialty compared to 19.1% GP/RG)[19]. This may indicate that pathways for GPs and rural generalists in rural areas are more visible or better established than those for many non-GP specialties.



While students interested in non-metropolitan careers cannot always translate those preferences into local employment outcomes, many rural and outer-metropolitan hospitals continue to struggle to fill internship positions. In the 2026 clinical year, NSW had 125 vacant intern positions, 67 of which were in rural hospitals[20]. Of the 58 metropolitan vacancies, outer metropolitan health services were overrepresented, with vacancies in Bankstown-Lidcombe and Campbelltown/Camden (5.5), Wollongong (13), John Hunter (13), Nepean (6) and Blacktown and Mt Druitt (2) accounting for more than two thirds of the metropolitan vacancies[21]. This supports the view that post-internship training and career outcomes contribute to the low take-up of rural, regional and outer metropolitan internships.

This shows an urgent need for further investment in prevocational and vocational training in outer metropolitan, regional and rural hospitals. This training should build on the logic of end-to-end rural training by developing connected pathways from medical school through prevocational training and into fellowship training, and with a view to future careers. This will require coordination between Federal and State governments and agencies, accreditation bodies, medical schools, and primary, secondary, and tertiary healthcare settings in public, private, and community-controlled models. Increasing the number of prevocational doctor positions in rural, regional and outer metropolitan settings may be part of this; however, increased prevocational roles need to be matched with increased vocational training posts in the same service to allow these doctors to undertake their training in, with and for the community. Consideration also needs to be paid to future workforce planning, including succession planning and anticipated increased demand, so doctors training in a rural, regional or outer metropolitan health service can be reasonably sure they will have a job in that service after fellowship.

[19] Data sourced from Medical Deans' data dashboard. For clarity, the denominator in this comparison is all 2024 domestic graduates from rural backgrounds who completed more than 12 months of rural placement, and the numerators are those who indicated a preference for a future career as a GP or RG and those who indicated a preference for any other specialty.
[20] HETI (2026) *Medical Intern Recruitment to NSW Prevocational Training Positions – Annual Report for the 2026 Clinical Year*. Available at https://www.heti.nsw.gov.au/__data/assets/pdf_file/0011/576767/Annual-report-on-Medical-Intern-Recruitment-to-NSW-Prevocational-Training-Positions.pdf accessed 11 September 2026
[21] *Ibid.*

We recommend:

a. *Coordinate investment across State and Federal governments (across public and private sectors) to increase prevocational and vocational training in areas of need, aligned to future workforce planning.*

2.2. Innovate models of care to rebalance prevocational doctor distribution

To support the implementation of the above recommendation, consideration should also be given to the work and function junior doctors perform, and how models of care can be adapted to better distribute this workforce without compromising patient care. Artificial intelligence (AI) has been identified as having the potential to assume tasks often delegated to junior doctors, including bureaucratic tasks[22]. AI-enabled administrative support tools may reduce the time junior doctors spend undertaking administrative and routine tasks, giving hospitals greater flexibility in the number of junior doctors they require.

Consideration should also be given to how best to utilise the multidisciplinary allied health team within hospitals and whether there are circumstances in which these clinicians can respond directly to patient need without needing an intervening junior doctor consultation. While there has been much discussion of expanding multidisciplinary teamwork through all healthcare providers being allowed to work to their full scope of practice in primary and acute care[23], it is timely to consider how this approach can be applied in hospital settings. Models of care that deliver more patient care directly through nurse practitioners and allied health clinicians may also help reduce the need for a large junior doctor workforce in inner metropolitan hospitals.

These two examples are suggested as possible ways to reduce reliance on junior doctors in inner metropolitan hospitals, which in turn may enable a greater proportion of prevocational doctor positions to be filled in outer metropolitan, regional and rural areas without reducing the services offered in high-demand inner metropolitan hospitals. These examples may also make it more achievable to create and fill prevocational doctor positions in outer metropolitan, regional and rural hospitals through the expansion of support and supervision services for these doctors. Such reforms and innovation could take time to implement and would require national coordination across operations, accreditation, training and funding. However, investigating these issues and proposing fit-for-purpose ways forward may make significant contributions to addressing a major barrier to more equitable distribution of the junior doctor workforce.

We recommend:

b. *Implement models of care that utilise the multidisciplinary healthcare team and emerging technology to reduce reliance on the prevocational doctor workforce in metropolitan hospitals and create further opportunities for prevocational doctors to work in regional and rural hospitals.*

[22] Mosch L et al. (2022) 'The medical profession transformed by artificial intelligence: Qualitative study', *Digital Health*, vol. 8 pp. 1-13, https://doi.org/10.1177/20552076221143903
[23] *Unleashing the Potential of our Health Workforce – Scope of Practice Review*

3. Training across diverse settings, formats and structures

3.1. Increase vocational training without overburdening a stretched supervisory workforce

One of the key findings of the Department of Health, Disability and Ageing's *Whole of Medical Workforce Supply and Demand study* is that despite growth in the total medical workforce outstripping demand, the modelling shows a deficit in the number of medical specialists by almost 10% by 2048[24]. It is predicted that the growth in the medical workforce as a whole will be concentrated in prevocational and career medical officer positions.

This strongly suggests that, across a range of specialties, we need to be training more doctors. Consistent with the themes of this response, these trainees should be trained in, with and for the communities where their services are most needed. They should be supported to build careers in the areas where they train. As far as possible, future workforce needs within a community should be considered when allocating training places to increase potential for succession planning and the maintenance of service provision.

It is also important to recognise that capacity to train in these areas is often limited. Quality teaching and supervision take time, and where services are in high demand, consultants have limited time to allocate to facilitate learning. We therefore need to explore ways to increase training delivery in rural, regional and outer metropolitan areas where these services are needed, without overburdening already stretched healthcare systems. Some ways to do this could include:

- Hybridised rotations where trainees work across both hospitals (public and private) and community settings
- Greater use of multidisciplinary supervision, including supervision by rural generalists in their areas of advanced skills training for vocational trainees, as well as supervision by the broader healthcare team
- Increased use of technology to support distance supervision.

These initiatives would then be complemented by short rotations to larger metropolitan services for exposures that cannot be guaranteed locally. Importantly, however, the trainee remains connected with their *home base* rural, regional or outer metropolitan health service, rather than being based in a metropolitan location and rotating out to rural.

The *Rural Psychiatry Training Pathway* (RPTS), developed by the Royal Australian and New Zealand College of Psychiatrists, provides a strong basis for rural training pathways in other specialties. Under the RPTS, registrar training is focused on generalist psychiatry to meet local communities' needs. Registrars have a rural home base from which they rotate into metropolitan training settings when necessary[25]. While the RPTS model is based on

[24] Department of Health, Disability and Ageing, *op. cit.*, p. 3
[25] The Royal Australian and New Zealand College of Psychiatrists (2021) *Rural Psychiatry Roadmap 2021-2031*, p. 13. Available at https://www.ranzcp.org/getcontentasset/f2adde4a-30dc-49c1-a959-a7543e757d34/dfc3d011-8f63-43f6-9ed8-4b444333a1d0/rural-psychiatry-roadmap-2021-31.pdf?language=en-AU Accessed 14 September 2026

psychiatric services for rural and regional communities, the same logic could be expanded to outer metropolitan communities.

To implement models like this at scale, registrars would need support to work and learn in a wider range of settings, including community health and outpatient clinics, private practice, and smaller hospitals. This would likely require changes to employment, accreditation and supervision models. One option to consider is exploring the existing Single Employer Model that has been used to support the continuation of employment benefits for GP Registrars across multiple employers[26]. Under a Single Employer Model, non-GP registrars could be employed by the local health service, with arrangements to allow them to work across a range of local services, including community health and private practice. The FATES program, which has funded projects by specialist medical colleges to adapt training for rural areas[27], could also be extended with a specific remit to invest in models of training that utilise multi-setting, multidisciplinary, technologically enabled learning and supervision.

We recommend:

a. *Increase the delivery of vocational training in areas of need, particularly in rural, regional and outer metropolitan areas through collaboration on funding employment and training positions that work across multiple settings between the Commonwealth and state and territory governments.*
b. *Support pilots of novel training approaches that make the most of the local health workforce for multidisciplinary supervision supported by technology enabled supervision through investment by the Commonwealth Government.*
c. *Encourage training accreditation bodies to support a broader range of training places that respond to local challenges with local strengths.*

3.2. Recognise and reward the experience of unaccredited registrars

Expanding training in this way will also give unaccredited registrars opportunities to complete training and attain fellowship in specialties of need. These doctors do important work and provide substantial clinical service; despite this, a 2020 review in NSW found that these doctors often work with varying levels of supervision and training, the expectations of their roles are often unclear, rostering practices are often inequitable, and they have differing access to various forms of leave[28]. There is a need to improve and clarify the remit of these doctors while also making it easier for them to progress into specialty training and complete fellowship. We need to adopt consistent definitions of accredited and unaccredited training and collect and report data on the number of doctors working in these roles. We should also implement consistent employment standards that include access to study leave, professional development, and feedback.

At the same time, it needs to be recognised that these doctors will come to specialty training already possessing much of the knowledge, skills and capabilities needed to practise in their chosen discipline. It is therefore appropriate to credit these doctors' prior learning so they can

[26] For more information see https://www.health.gov.au/our-work/sem-trials?language=en
[27] For more information see https://www.health.gov.au/our-work/fates/about?language=en
[28] NSW Ministry of Health (2020) *Review of Trainees in Unaccredited Positions: Discussion Paper*. Available at https://www.health.nsw.gov.au/workforce/culture/Publications/review-trainees-unaccredited.pdf accessed 14 September 2026

progress to fellowship more quickly and not be expected to start from scratch[29]. Not only is this fair, but it also will allow doctors to become fellows in specialties more quickly and with a reduced impact on supervisory capacity.

Such an approach to increasing the supply of accredited specialists in a short time would be planned to support generalist workforce outcomes, as discussed in more detail below. Such a model would also ensure that patient safety and fitness to practise remain key concerns of the education and training system through the explicit adoption of competency-based medical education. Competency-based medical education emphasises the outcomes of training or competencies a trainee develops over time spent in training or on particular rotations, through a developmental approach that makes use of targeted, personalised coaching and feedback[30]. Using this approach, the competencies unaccredited registrars have gained through clinical experience would be assessed, gaps in knowledge identified, and a training plan developed and implemented to address them. Further assessment would be undertaken to ensure that these gaps have been filled before the registrar attains fellowship and commences practice as a generalist within this specialty.

We recommend:

d. *Implement fair and consistent approaches to the recognition of prior learning experiences for unaccredited registrars across all specialty training.*
e. *Develop standards for unaccredited registrars, in collaboration with State and Territory Health Departments, that include equitable approaches to rostering, leave and other entitlements, and minimum standards for ongoing training and professional development.*

[29] Laurence JM (2026) 'Unaccredited medical training in Australia: From hidden problems to practical workforce solutions", *Internal Medicine Journal* vol. 56, no. 6, pp. 1091-1096 https://doi.org/10.1111/imj.70421
[30] Frank JR, et al. (2024) 'Competence by design: a transformational model of time-variable competency-based postgraduate medical education', *Perspectives on Medical Education*, vol. 13, no. 1, pp. 201-223. https://doi.org/10.5334/pme.1096

4. Embed generalism as a core role for specialists

In areas where non-GP specialists are in short supply, increasing the generalist specialist workforce will have the biggest impact on improving access to specialist services. Generalism is a philosophy of patient care rather than part of a generalist-specialist binary[31]. Generalist specialists are accredited specialists who work to a broad scope of practice and, as such, provide clinical services to treat the majority of presentations within that scope, as opposed to subspecialists who have narrowed their scope of practice to become expert in certain conditions or presentations. It has long been accepted that generalists can make significant contributions to filling gaps in existing healthcare services[32]. Therefore, increasing the number of specialists working to a generalist scope, especially in areas of workforce shortage, are likely to increase the local availability of the healthcare the local community needs, as most conditions within a discipline will be covered.

> *"Generalism is a philosophy of care that is distinguished by a commitment to the breadth of each discipline and collaboration with the larger healthcare team in order to respond to patient and community needs.*
>
> *Generalists are … characterised by a broad-based practice. Generalists diagnose and manage clinical problems that are diverse, undifferentiated and often complex. Generalists also have an essential role in coordinating patient care and advocating for patients."*
>
> **Report of the Generalism and Generalist Task Force**, Royal College of Physicians and Surgeons of Canada, July 2013

Australia's medical workforce is recognised as being too concentrated in sub-specialisations at the expense of generalist scopes of practice. The *National Medical Workforce Strategy* outlined six actions to 'build the generalist capacity of the medical workforce'. This included actions specifically targeted towards recruiting doctors into specialty training whose professional experience and capabilities aligned with generalist workforce outcomes, promoting generalism as an attractive career outcome and reducing stigma surrounding generalist careers, and incorporating greater generalist topics into existing CPD requirements[33]. Increasing access to the healthcare a community needs is best developed through a primary care workforce in which doctors are supported to treat a wide range of presentations in line with their training and experience while being able to explore areas of interest, supported by non-GP specialist doctors who work to a generalist scope, either on the ground or through regular fly-in trips. In turn, a smaller pool of subspecialists with deep expertise in a narrow area of a specialty will support their fellow specialists working to a generalist scope by receiving referrals or providing advice on complex cases, rare presentations and acute conditions.

Australia's model of rural generalism, which combines general practice medicine in primary care with emergency medicine and further specialty areas (such as surgery or psychiatry) primarily in hospital settings, is part of an international trend in policy solutions to meet the needs of rural and regional communities centred on generalism[34]. These doctors can and do form a local community of practice, working alongside non-GP specialists whose scope covers

[31] Kelly M.A., et al. (2026) 'Generalism as a cross-disciplinary practice in medicine: Mixed-studies systematic review', *Canadian Family Physician*, vol. 72 no. 1, pp. 42-50. https://doi.org/10.46747/cfp.720142
[32] Muddiman, S, et al. (2016) '"Black sheep in the herd"? The role, status and identity of generalist doctors in secondary care', *Journal of Health Organisation and Management*, vol. 30, no. 6, pp. 927-945, https://doi.org/10.1177/0951484816670416
[33] Department of Health, *op. cit.,* pp. 66-67
[34] Schubert N, et al. (2018) 'International approaches to rural generalist medicine: a scoping review,' *Human Resources for Health* vol 16, article number 62, https://doi.org/10.1186/s12960-018-0332-6

most clinical presentations within their discipline. An example would be a surgeon who has the training, experience and willingness to perform most of the routine procedures necessary to treat local presentations, and is connected to colleagues with a narrower scope from whom they can seek guidance and to whom they can refer specific cases when required. Importantly, this surgeon may have subareas of their specialty that interest them; they may complete further training or research in this subarea, similar to how a GP can pursue an area of special interest.

Specialists working with a generalist scope of practice would work alongside the competency-based medical education approach to unaccredited registrars outlined in section 3.2 of this submission. Doctors who attain fellowship through competency-based assessments could be guided into generalist roles within their specialty to help meet currently unmet demand. This would be a good career outcome for both the community and the individual doctor, increasing access to needed specialist services and giving the doctor a diverse caseload that requires them to utilise their skills and knowledge. However, this outcome does not prevent the doctor from later exploring subspecialisation if the community needs it.

Subspecialisation has a role in narrowly defined areas of medicine across clinical service delivery, research, and education and training. However, the number of doctors with this scope is far smaller than the number we need in a specialty working to a broad, generalist scope of practice. Specialists with a generalist scope can make the most significant impact on healthcare provision in underserved areas; as such, our healthcare training and workforce systems need to encourage more doctors to pursue these careers across public, private, and community-controlled settings.

Medical schools support students in developing an appreciation for generalism as a career option across a range of medical domains by placing them in longitudinal placements where they split their time between general practice and hospital-based practice. Students in the University of Wollongong's Graduate School of Medicine undertake a year-long longitudinal integrated clerkship where they spend two days a week in general practice, two days in a mix of emergency and general medicine, with one academic day per week focused on case-based learning[35]. This approach has been credited with contributing to that school's rural and generalist career outcomes.

Medical school exposure needs to be coupled with real-world training and employment opportunities to deliver meaningful outcomes. Government could support the expansion of the generalist workforce by creating hospital-based roles for specialists with a generalist scope of practice in areas where demand outpaces supply. Colleges and training providers could also support this by developing expedited training pathways for generalists. To ensure this investment has the best chance of success, barriers and restrictions on generalist specialists practising to their full scope of practice need to be reviewed and, if possible, removed. This includes restrictions on access to Pharmaceutical Benefits Scheme and Medicare Benefits Scheme items where this creates barriers or disincentives for generalist specialists to treat patients with conditions that are within their scope of practice, whilst ensuring that patient safety and outcomes remain the primary concern of the entire healthcare system.

[35] Medical Deans Australia and New Zealand (2024) *Developing Doctors for Rural and Regional Communities – University of Wollongong: Generalist Model*. Available at https://medicaldeans.org.au/md/2024/09/Medical-Deans_University-of-Wollongong_Case-Study.pdf

We recommend:

a. *Support the creation and funding of specialist roles in areas of need with an explicitly generalist scope of practice, including removing unnecessary barriers to generalist specialists working to their full scope of practice.*
b. *Support colleges and training providers to develop expedited training pathways leading to a generalist scope of practice that:*
    i. *work in tandem with recognition of prior learning for unaccredited registrars*
    ii. *provide opportunities for further upskilling and credentialling post fellowship, in line with community need and their areas of interest.*