# Special Commission of Inquiry into Healthcare Funding

## Statement of Dr Linda MacPherson

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| **Name:** | Dr Linda MacPherson |
| **Professional address:** | 1 Reserve Road, St Leonards, New South Wales |
| **Occupation:** | Director, Workforce Reform, NSW Ministry of Health |

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

## A. INTRODUCTION

2. My name is Dr Linda MacPherson. I am the Director, Workforce Reform within the Workforce Planning and Talent Development Branch of the NSW Ministry of Health (**MOH**). I was appointed to this role in October 2023. In my role I support the work of the Health Workforce Taskforce, which is responsible for the oversighting implementation of the *Independent Review of Regulatory Setting Relating to Overseas Health Practitioners* (**the Kruk Review**)and the National Health Practitioner Ombudsman recommendations concerning accreditation of medical training sites, as well as other national workforce projects.

3. Prior to this role, I was a Medical Advisor from November 2006 to December 2023 at NSW Health, which involved:

   a. providing advice and leadership on medical workforce policy matters, including on intern policy and medical college accreditation issues,

   b. being a jurisdictional representative on national committees including the Medical Workforce Reform Advisory Committee, National Medical Workforce Steering Committee, Australian Health Practitioner Regulation Agency (**Ahpra**), and Medical Board National Medical Training Survey Steering Committee,

   c. being the MOH representative on the State Physician Training Council, Psychiatry State Training Council, and Rural Generalist State Council,

   d. being the project lead on medical workforce projects including development and implementation of the Your Training and Wellbeing Matters Survey of junior medical officers in NSW Health, and Assistant in Medicine role for final year medical students,

e. engaging with external stakeholders including medical colleges, medical schools, the Medical Board of Australia and Ahpra.

4. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0050.0001**).

## B. SCOPE OF STATEMENT

5. This statement is provided in response to a letter of 23 May 2024 issued to the Crown Solicitor's Office, and also Issues Paper 1/2024. It addresses the topics set out in those documents relevant to my role.

## C. NATIONAL REGISTRATION AND ACCREDITATION SCHEME

6. The *Health Practitioner Regulation National Law* (**the National Law**) as in force in each state and territory establishes various entities that operate within the National Registration and Accreditation Scheme (**the National Scheme**), including Ahpra, the Australian Health Practitioner Regulation Agency Board (**Ahpra Board**), National Boards, and health/performance panels.

7. The National Law is not a Commonwealth law. Instead, it is enacted and implemented by each state and territory parliament having passed nationally consistent legislation. Queensland is the host jurisdiction, and the National Law is set out in a schedule to the *Health Practitioner Regulation National Law Act 2009* (Qld). Other jurisdictions have enacted either corresponding legislation or legislation applying the Queensland legislation in their jurisdiction. Any proposed amendments to the National Law must be approved by the Ministerial Council and passed by the Queensland Parliament and other state / territory parliaments where required.

8. Ahpra supports the work of the National Boards. Ahpra's functions include managing applications for registration of health practitioners and maintaining a public register of health practitioners.

9. The National Boards for each profession set national registration standards and approve accreditation standards and programs of study.

10. NSW and Queensland are co-regulatory jurisdictions under the National Law. In other states and territories Ahpra receives and investigates complaints about health practitioner performance, health and conduct. In the two co-regulatory jurisdictions the complaints are managed by the relevant co-regulatory agency, which in NSW is the Health Care Complaints Commission and/or the relevant health professional council.

**(i) Medical Board of Australia**

11. The Medical Board of Australia:

    a. registers medical practitioners and medical students,

    b. develops standards, codes and guidelines for the medical profession,

    c. investigates notifications and complaints about medical practitioners although, in NSW, complaints management is carried out by the Medical Council of NSW and the Health Care Complaints Commission,

    d. where necessary, conducts panel hearings and refers serious matters to Tribunals although, in NSW, matters relating to conduct, performance and impairment are referred to the Medical Council of NSW and matters about misconduct can also be referred to the Health Care Complaints Commission to investigate and take action,

    e. assesses international medical graduates who wish to practise in Australia, and

    f. approves accreditation standards and accredited courses of study.

12. All medical practitioners must be registered with the Medical Board of Australia to practise in Australia.

13. Registration standards are approved by the Ministerial Council.

**(ii) Australian Medical Council**

14. The Australian Medical Council is an independent national standards body for medical education and assessment. The Australian Medical Council is appointed under the National Law as the external accreditation authority for medicine. The Australian Medical Council is responsible for accrediting education providers and their programs of study for the medical profession.

15. The Australian Medical Council accredits medical schools and provides accreditation reports to the Medical Board of Australia. The Medical Board of Australia may then approve, or refuse to approve, the accredited program of study as providing a qualification for the purposes of general registration. Successful completion of an approved program of study from an accredited medical school program qualifies a person for general registration.

16. The Australian Medical Council assesses postgraduate medical councils that accredit intern training programs in each state and territory under the national standards framework for intern training. The Health Education and Training Institute (**HETI**) is the approved postgraduate medical council in NSW.

17. The Australian Medical Council accredits specialist medical colleges and provides accreditation reports to the Medical Board of Australia. The Medical Board of Australia may then approve, or refuse to approve, the accredited program of study as providing a qualification for the purposes of specialist registration. Successful completion of an approved program of study in a recognised medical specialty from these accredited specialist medical colleges qualifies a person for specialist registration.

18. Three reviews related to the national registration and accreditation of medical practitioners have recently been undertaken or are underway. They are:

    a. the *Independent Review of Regulatory Setting Relating to Overseas Health Practitioners* (**Kruk Review**) discussed at paragraph 19 below. A copy of the Final Report is at exhibited to this statement (**MOH.0010.0051.0001**),

    b. the *Independent Review of Regulatory Complexity of the National Registration and Accreditation Scheme* (**Complexity Review**) discussed at paragraph 30 below, and

    c. the *Independent Review of the Procedural Aspects of Accreditation Processes by the National Health Practitioner Ombudsman*. In early 2020, Health Ministers agreed that an independent review should be undertaken into the procedural aspects of the accreditation processes and the National Health Practitioner Ombudsman was commissioned to complete this review. A copy of the Terms of Reference of the review are exhibited to this statement (**MOH.0010.0052.0001**). Part one of the review focussed on the findings and recommendations regarding specialist medical training site accreditation. The Part One Report: *Processes for progress, A roadmap for greater transparency and accountability in specialist medical training site accreditation,* dated October 2023 (**the Ombudsman Report**), is discussed at paragraph 112 below and a copy is exhibited to this statement (**MOH.0010.0053.0001**). The review's findings in relation to the accreditation of programs of study and education providers, and the assessment of overseas qualified practitioners, will be provided in a subsequent report.

**(iii) Kruk Review**

19. On 30 September 2022, National Cabinet announced an independently-led, rapid review of Australia's regulatory settings relating to health practitioner registration and skills and qualification recognition for overseas trained health professionals and international students who have studied in Australia. Ms Robyn Kruk AO was appointed to lead the review.

20. On 6 December 2023, National Cabinet endorsed the Final Report of the Kruk Review (**the Kruk Report**). The Kruk Report made 28 recommendations across five broad reform areas:

    a. Improve the applicant experience (Recommendations 1 - 8),

    b. Expand fast track registration pathways (Recommendations 9 - 16),

    c. Improve workforce data and planning (Recommendations 17 - 20),

    d. Increase flexibility, while ensuring safety and quality of care (Recommendations 21 - 24), and

    e. Enhance regulator performance and stewardship (Recommendations 25 - 28).

21. Implementation of the recommendations aims to make it simpler, quicker and more cost-efficient for international health practitioners to work in Australia.

22. The Health Workforce Taskforce is responsible for the implementation of the Kruk Report recommendations over the next 18 months to June 2025. The Health Workforce Taskforce membership includes officers from the Commonwealth, and all state and territory jurisdictions.

23. The Health Workforce Taskforce reports to the Health Chief Executives Forum (**HCEF**) and:

    a. Provides advice and recommendations to the HCEF and Health Ministers' Meeting (**HMM**) regarding actions to address priority workforce challenges for the health workforce across the health, mental health, aged care, and disability sectors.

    b. Coordinates and oversights implementation of HMM agreed strategic priority actions relating to health workforce.

c. Develops and coordinates targeted implementation of national workforce strategies.

d. Oversees the national legislation regulating health practitioners.

e. Engages with regulatory bodies and other intergovernmental governance groups to inform, progress and implement priority initiatives and strategies.

24. Ahpra and the Medical Board of Australia are progressing work on the development of expedited registration pathways for specialist international medical graduates. Jurisdictions identified general practitioners (**GP**s), anaesthetists, obstetricians and gynaecologists, and psychiatrists as the priority for the first tranche of specialties for the expedited pathway.

25. The Medical Board of Australia is consulting on the proposed changes that will be made to the current specialist registration standard to enable the implementation of the new pathway and set out the requirements that applicants must meet. A copy of the draft standards are exhibited to this statement (**MOH.0010.0054.0001**).

26. The new expedited pathway will be an additional route to registration for international medical graduates with specialist qualifications. Currently internationally trained medical specialists must apply to the appropriate medical college for assessment of their specialist qualifications. The expedited pathway will be available to applicants who have been deemed to hold a qualification which is substantially equivalent or based on similar competencies to an approved specialist qualification for the specialty. The Medical Board of Australia will develop and publish a list of qualifications that it considers are substantially equivalent or based on similar competencies to an approved specialist qualification for the specialty. The expedited pathway will not require a college assessment of the individual applicant. The Medical Board of Australia draft standard states that applicants will be required to undertake a period of supervised practice in the specialty and a comprehensive orientation to the Australian healthcare system, which includes cultural safety training.

27. The expedited pathways will decrease the time to specialist registration for eligible internationally trained medical specialists and will provide greater certainty for both the internationally trained specialist and employers that they will be registered and able to practise in their specialty.

28. It is expected that the general practitioner expedited pathway will be implemented from October 2024, with anaesthetics, obstetrics and gynaecology and psychiatry expedited pathways to be in place by December 2024.

29. Work has commenced on the development of national Allied Health, Maternity and Nursing Workforce Strategies as recommended in the Kruk Report (recommendation 18).

**(iv) Complexity Review**

30. In response to media concerns raised about the National Scheme and its management of professional misconduct by health practitioners in 2023, Health Ministers agreed to undertake an independent review of the national registration and accreditation scheme regulatory systems and processes.

31. Ms Sue Dawson has been appointed as the Independent Reviewer to lead the review of the regulatory complexity of the National Registration and Accreditation Scheme.

32. The overarching objective of the Complexity Review is to identify areas of unproductive and unnecessary complexity within the National Scheme and recommend changes that will improve regulatory outcomes for health practitioners and the community. The Terms of Reference are exhibited (**MOH.0010.0055.0001**). The co-regulatory jurisdictions (NSW and Queensland) are out of scope for elements 1-3.

## D. MEDICAL TRAINING IN AUSTRALIA

33. It takes on average 10 to 20 years from the time a doctor enters medical school to become a qualified medical specialist in Australia.

34. There are three stages of training:

    a. completion of an Australian Medical Council accredited university medical program,

    b. completion of prevocational training which is the first two postgraduate years after university and includes the internship year leading to general registration, and

    c. completion of an Australian Medical Council accredited medical college training program leading to Fellowship (specialist) qualifications.

35. The time taken to obtain specialist qualifications is dependent on several factors including the length of the university medical program, the length of the specialist training

program, and the time between completing prevocational training and entering specialty training.

36. Many doctors work in positions not accredited for specialist training (unaccredited positions) after completing the second postgraduate year and before entering specialist training. This means that they may start specialist training in their fourth or subsequent postgraduate year.

37. Some doctors may choose not to apply for specialist training or may not be successful in gaining entry to a specialist training and will work as unaccredited registrars, career medical officers or as locums.

38. The *National Medical Workforce Strategy 2021 – 2031*, a copy of which is exhibited to this statement (**MOH.0010.0056.0001**), notes that medical graduates are generally older, graduating with more debt than previous generations and have partners and families. In 2019 the average age of medical graduates was 28 years, with less than 50 per cent under the age of 25 years, compared to historically when most graduates were under 25 years of age. Further, in 2019 the average age of newly qualified specialists was 38 years with more than half of all new specialist aged between 35 and 44.[1]

39. Doctors have shorter medical careers than previous generations and so may be more attracted to highly remunerated specialities and medical locum work when deciding on postgraduate training and work options.

## E. UNIVERSITIES

40. There are eight approved university medical programs operating in NSW that vary in course length from four to six years. These are:

    a. Charles Sturt/Western Sydney Universities Joint Medical Program (5 years),

    b. Macquarie University (4 years),

    c. University of Notre Dame Sydney (4 years),

    d. University of Sydney (4 years),

[1] National Medical Workforce Strategy 2021-2031 page 11, © 2021 Commonwealth of Australia (Department of Health), permission to use the material under the Creative Commons AttributionNonCommercialNoDerivatives 4.0 International Licence

e. University of New South Wales (6 years),

f. University of Newcastle/ University of New England Joint Medical Program (5 years),

g. University of Wollongong (4 years), and

h. Western Sydney University (5 years).

41. Universities are funded by the Australian Government. The number of Commonwealth Supported Places (**CSPs**) in medicine are capped and set out in the funding agreements between the Commonwealth and universities. The current total number is set out in the table below.

| University | Total number of designated Commonwealth supported places medicine (EFTSL) | Maximum number of domestic graduates per year |
|---|---|---|
| Charles Sturt | 148 | 0 |
| University of Newcastle | 532 | 108 |
| University of New England | 300 | 60 |
| University of New South Wales | 1,183 | 199 |
| University of Sydney | 895 | 227 |
| University of Wollongong | 276 | 69 |
| Western Sydney | 501 | 101 |
| University of Notre Dame Australia (Sydney & Fremantle campuses) | 632 | 212 |

EFTSL: equivalent full-time student load

42. The number of domestic annual completions (graduates) for each NSW university course in medicine in 2024 is outlined in the above table. I note the University of Notre Dame's figure is for both Sydney and Fremantle campuses . The funding agreement states that the university must not change its designated course in medicine in ways that will change the number of domestic annual completions for the course or courses.

43. Macquarie University does not have any CSPs. Macquarie has domestic full fee paying and international full fee-paying medical students.

44. Universities with CSPs in medicine are not allowed to have **domestic full fee-paying students** in medicine.

45. The University of Notre Dame Australia is a private catholic university with a medical school across two campuses - Fremantle and Sydney. It has CSPs in medicine. The Commonwealth funding agreement states that it must not admit more than 52

commencing domestic full fee-paying students to its course or courses of study in medicine.

46. Under the funding agreements between the Commonwealth and each university, from 1 January 2021, each university medical program must allocate 28.5 per cent of all commencing CSPs in medicine to Bonded Medical Program students for the calendar year.

47. The Bonded Medical Program is an Australian Government program that provides a CSP in a medical course at an Australian university. In return, bonded participants commit to work in an eligible regional, rural and remote area for 3 years after they complete their course.

48. Universities with CSPs in medicine can admit **international full fee-paying medical students**. The number of international full fee-paying medical students admitted is determined by individual university medical schools. There is no cap on the number of international full fee-paying medical students that can be admitted.

49. The number of domestic and international full fee-paying medical graduates by university for 2023 in NSW is shown in the table below:[2]

| University | CSP Bonded | CSP non-bonded | Domestic full fee paying | International full fee-paying | TOTAL |
|---|---|---|---|---|---|
| Macquarie University | 0 | 0 | 53 | 4 | 57 |
| Notre Dame Sydney | 14 | 62 | 47 | 8 | 131 |
| University of Sydney | 59 | 135 | 0 | 55 | 249 |
| University of New South Wales | 64 | 151 | 1 | 78 | 294 |
| University of Newcastle/University of New England | 43 | 108 | 0 | 16 | 167 |
| Western Sydney University | 26 | 69 | 4 | 28 | 127 |
| University of Wollongong | 29 | 40 | 0 | 9 | 78 |

*NB: Charles Sturt/Western Sydney Joint Medical Program did not have any students completing in 2023. First cohort graduate in 2025*

50. The Australian Medical Council Standards for Assessment and Accreditation of Primary Medical Programs (**Standards**), a copy of which is exhibited to this statement (**MOH.0010.0057.0001**), address the requirements for delivery of high-quality medical education that must be met by universities delivering medical programs. The graduate outcome statements in the Standards set out, at a high level, the knowledge, skills and

[2] Medical Deans Australia and New Zealand Data Dashboard at https://medicaldeans.org.au/. Accessed 5 June 2024.

behaviours required of medical students at the time of graduation from the medical program and provide the basis for medical program curricula and systems of assessment. Further, the Standards require that the university medical program outcomes are consistent with the Australian Medical Council graduate outcome statements. They also require the program outcomes to be consistent with a safe transition to supervised practice in internship in Australia and Aotearoa New Zealand, and with the needs of the communities that the medical education provider serves.

51. Universities are responsible for developing curriculum and systems of assessment that meet the Australian Medical Council standards and for selection of students.

## F. MEDICAL INTERNSHIPS

52. Australian and New Zealand medical graduates who have completed a program of study accredited by the Australian Medical Council and approved by the Medical Board of Australia as providing a qualification for the purposes of general registration in the medical profession, must satisfactorily complete an accredited period of supervised clinical training in Australia (known as a medical internship or postgraduate year one or PGY1) to become eligible for general registration. Medical interns are granted provisional registration by the Medical Board of Australia.

53. The Medical Board of Australia registration standard: *Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of postgraduate year one training* (**the General Registration Standard**), a copy of which is exhibited to this statement (**MOH.0010.0058.0001**), sets out the requirements that interns must meet to be eligible for general registration. Requirements to be granted general registration include:

    a. evidence of satisfactory completion of at least 47 weeks full-time equivalent (**FTE**) experience as a PGY1 doctor in supervised clinical practice, completed in accredited terms (rotations) in hospital, general practice or community-based health services,

    b. must include a minimum of four terms (of at least 10 weeks each term) in different specialties, and

    c. must include direct clinical care of patients in each of the types of patient care: undifferentiated illness patient care; chronic illness patient care; acute and critical illness patient care; and peri-procedural patient care.

54. The above standard is effective from 1 January 2024. The previous registration standard required medical interns to complete mandatory rotations in emergency medical care, medicine, and surgery. This is not a requirement of the new general registration standard.

55. The current General Registration Standard supports interns training in a wider range of settings, especially rural and regional locations. This is relevant when rural and regional sites can support good training but could not meet the previous requirements for training in mandatory rotations in emergency medicine, surgery and medicine.

56. HETI as the approved postgraduate medical council accredits intern terms in NSW. Training sites must meet accreditation requirements to employ interns and postgraduate year 2 (**PGY2**) doctors. Interns must work in HETI accredited intern positions to meet Medical Board of Australia requirements for general registration.

57. Internship is a paid position, not a clinical placement. Interns are an important workforce in delivering clinical services.

**(i) COAG guarantee**

58. At the July 2006 Council of Australian Governments (**COAG**) meeting, States and Territories agreed to guarantee intern training for CSP medical students.

59. The COAG guarantee has guided the recruitment of medical graduates to intern positions in all States and Territories.

60. Each State and Territory guarantees intern positions for CSP medical graduates from their own state/territory university medical school. NSW has extended the guarantee to all domestic graduates (Commonwealth Supported and domestic full fee paying) of NSW universities.

61. Each State and Territory has a priority list that guides the filling of intern positions based on the priority category of the applicant. A copy of the NSW Health Priority list is exhibited to this statement (**MOH.0010.0059.0001**).

**(ii) NSW intern positions**

62. Intern positions are funded by Local Health Districts (**LHDs**). LHDs have responsibility for determining the number of intern positions they require and that they can support. An LHD's workforce requirements to deliver clinical services is a key factor in determining

the number of intern and other medical training positions at a facility. Other factors that determine the number of intern positions at a facility are the ability to provide appropriate supervision to interns and the ability to support the intern to complete the Medical Board of Australia requirements for general registration.

63. The MOH Building and Sustaining the Rural Health Workforce initiative is funding an additional 45 intern and 45 PGY2 positions over four years in rural and regional locations.

64. In 2023 the MOH invited rural and regional LHDs to apply for the first tranche of positions funded under the Building and Sustaining the Rural Health Workforce initiative. The first round allocated funding for 15 new intern positions commencing in 2024 and 15 new PGY2 positions to commence in 2025 at the following locations:

| Local Health District | Facility | Positions |
|---|---|---|
| Far West | Broken Hill | 1 x intern<br>1 x PGY 2 |
| Hunter New England | Armidale<br>Manning Base<br>Tamworth<br>Maitland | 1 x PGY 2<br>1 x intern; 1 x PGY 2<br>2 x intern; 1 x PGY 2<br>1 x intern; 1 x PGY 2 |
| Illawarra Shoalhaven | Shoalhaven | 1 x intern; 1 x PGY 2 |
| Murrumbidgee | Wagga Wagga | 2 x intern; 1 x PGY 2 |
| Mid North Coast | Coffs Harbour<br>Kempsey<br>Port Macquarie | 2 x intern; 2 x PGY 2<br>1 x intern; 1 x PGY 2<br>1 x intern; 1 x PGY 2 |
| Northern NSW | Lismore<br>Tweed Heads- RPR sites | 1 x intern; 1 x PGY 2<br>1 x PGY 2 |
| Western NSW | Orange<br>Cowra<br>Mudgee | 2 x intern<br>1 x PGY 2<br>1 x PGY 2 |

65. The MOH is identifying the next round of positions funded from the Building and Sustaining the Rural Health Workforce initiative.

66. NSW has more intern positions than any other state or territory. For the 2024 clinical year there were 1,153.5 intern positions that were available to be filled through the NSW recruitment process. This was an increase of 33.5 positions from the 2023 clinical year. In addition, there are an additional 8 positions in Southern NSW LHD that are filled by ACT Health. The location of the positions by LHDs and facility is included in the table exhibited to this statement (**MOH.0010.0060.0001**).

67. Over the last 10 years, there has been an 18 per cent increase in intern positions in NSW. That is, an increase from 980 to 1153.5 from 2015 to 2024 respectively. The growth in rural and regional intern positions during this time is set out in the table below:

| LHD | 2015 | 2024 | % change 2015 - 2024 |
|---|---|---|---|
| Central Coast | 61 | 72 | 18% |
| Far West | 3 | 4 | 33% |
| Hunter New England<br>NB: Tamworth Hospital- 22 % growth; Manning Base -50% growth | 125 | 134 | 7% |
| Illawarra Shoalhaven | 65 | 76 | 17% |
| Mid North Coast | 35 | 49 | 40% |
| Murrumbidgee | 23 | 32 | 39% |
| Northern NSW | 35 | 46 | 31% |
| Western NSW | 32 | 50 | 56% |
| Southern NSW (filled by ACT) | 5 | 8 | 60% |

68. Intern and PGY2 (prevocational) training in NSW is managed through 15 prevocational training networks. The prevocational training networks link rural, regional and metropolitan training sites across the different LHDs. A copy of the NSW Prevocational Training Networks is exhibited to this statement (**MOH.0010.0263.0001**).

69. Prevocational trainees rotate within and across the different training sites within the prevocational training network.

**(iv) National coordination of intern recruitment**

70. Each state and territory undertakes its own intern recruitment. Applicants for intern positions apply separately to each state and territory where they would like to undertake internships. Applicants therefore may receive offers from more than one state and territory.

71. Since 2013 there have been nationally agreed dates for intern recruitment and national data collection, audit of applications, and a late vacancy management process for medical intern recruitment.

72. The national audit of multiple acceptances is a well-established process. After each round of offers an audit is undertaken to identify applicants holding multiple offers in different states/territories. Applicants holding multiple offers are asked to confirm which offer they are actually accepting. The audit of acceptances is an important process to ensure that all positions are filled in a timely way, so that no hospital is left with unexpected vacancies at the beginning of the clinical year and so that applicants have maximum opportunities to receive intern offers.

73. Recruitment to 2025 intern positions is underway in all state and territories. Applications opened on 6 May 2024 and closed on 6 June 2024. Offers will start to be made from 15 July 2024 and the intern recruitment process closes on 18 October 2024. Any vacant positions after 18 October 2024 will be filled through the nationally managed Late Vacancy Process. Through the Late Vacancy Process only applicants who are not holding an intern position offer at the close of intern recruitment are eligible to receive an offer to a vacant intern position.

74. At the time of application to intern positions applicants are in their final year of study. Sometimes applicants who accept an intern position are not able to start an internship because they do not complete their medical studies and do not graduate in that year. This failure to complete is one reason for vacancies occurring after the close of intern recruitment.

**(v) Recruitment to NSW intern positions**

75. HETI coordinates the recruitment of medical graduates from Australian Medical Council accredited Australian and New Zealand universities to LHD intern positions.

76. There are four recruitment pathways: Aboriginal Medical Workforce Pathway; Rural Preferential Recruitment Pathway; Direct Regional Allocation; and the Optimised Allocation Pathway.

77. Thirty-six Aboriginal applicants applied for a position through the **Aboriginal Medical Workforce pathway** and 30 accepted a NSW intern position for the 2024 clinical year. This was an increase from 19 recruited for the 2023 clinical year. This pathway facilitates the recruitment allocation of Aboriginal and/or Torres Strait Islander medical graduates to prevocational training positions in NSW. Positions are allocated through the Aboriginal Medical Workforce (AMW) pathway before any other pathway.

78. The **Optimised Allocation Pathway** is the main pathway through which eligible medical graduates from any priority category can be allocated to internship positions in NSW. Applicants rank each of the 15 prevocational training networks and positions are allocated according to the preferences and priority category of the applicant.

79. For the 2024 clinical year 1641 medical graduates applied for 1153.5 intern positions in NSW. Of those who applied 57 per cent (930) were domestic medical graduates of a NSW university and guaranteed an intern position, 22 per cent (364) were domestic applicants of an interstate university, and 11 per cent (184) were international full fee paying medical graduates of a NSW university.

80. A total of 1059 intern positions were filled by 1061 medical graduates (four are completing their internship part time). The number and proportion of medical graduates who accepted a NSW Intern position was as follows:

    a. 777 domestic applicants from NSW universities (84% of those who applied),

    b. 148 interstate domestic applicants (41% of those who applied), and

    c. 133 international full fee paying applicants from NSW universities (72% of those who applied).

81. **The Rural Preferential Recruitment Pathway** supports medical graduates completing their internship and second postgraduate year in a rural location. The following hospitals recruited to positions via the Rural Preferential Recruitment Pathway: Albury, Broken Hill, Coffs Harbour, Dubbo, Lismore, Manning Base, Maitland, Orange, Port Macquarie, Tamworth, Tweed Heads and Wagga Wagga.

82. There were 196 intern positions available to be filled through the Rural Preferential Recruitment process. At the end of the intern recruitment process, 125 Rural Preferential Recruitment Pathway intern positions had been filled, a decrease from 150 positions filled in the 2023 clinical year.

83. At the close of the nationally managed Late Vacancy Management Process there were 94.5 intern position vacancies in NSW, including 66 in rural and regional NSW hospitals.

84. The national audit of applicants identified that nationally there were more intern positions than applicants for the 2024 clinical year.

85. After medical graduates have received an offer of an NSW intern position through the HETI coordinated process, the LHDs are responsible for completing the onboarding process. Doctors recruited to an intern position are employed by the LHD and receive a two-year employment contract.

**(vi) John Flynn Prevocational Doctor Program**

86. The John Flynn Prevocational Doctor Program is an Australian Government initiative that provides hospital-based prevocational doctors in postgraduate years 1-5 the opportunity to undertake primary care/general practice rotations in Modified Monash Model locations 2-7.

87. In the 2023 clinical year, 61 NSW prevocational doctors completed a primary care/general rotation through the John Flynn Prevocational Doctor Program. For the 2024 clinical year, 94 prevocational doctors are allocated to undertake a John Flynn funded primary care/general practice rotation.

88. The John Flynn Prevocational Doctor Program rotations are managed through the prevocational training networks and are included in the overall number of available NSW intern positions.

## G. MEDICAL SPECIALITY TRAINING

89. To be eligible for specialist registration in Australia, doctors must complete an Australian Medical Council accredited medical college training program.

90. Medical college specialist medical programs range from three to five year full-time training.

91. To be eligible for a Medicare benefit to be paid for services provided by a medical practitioner, the medical practitioner must meet a number of criteria under section 19AA of the *Health Insurance Act* (Cth) (**Act**) including that they must be a specialist, consultant physician or specialist general practitioner or registered in an approved placement under section 3GA of the Act. If a medical practitioner meets these criteria they are issued a Medicare provider number.

92. The majority of medical specialist training, with the exception of general practice training, occurs in state and territory public health facilities. A small number of medical specialist training positions are in private settings.

**(i) Medical colleges**

93. There are sixteen Australian Medical Council accredited colleges that deliver training programs that lead to specialist qualifications in a recognised medical specialty:

a. Australasian College of Dermatologists (**ACD**) - provides training in dermatology,

b. Australasian College for Emergency Medicine (**ACEM**) - provides training in emergency medicine (adult and paediatric),

c. Australasian College of Anaesthetists (**ANZCA**) - provides training in anaesthetics and pain medicine. Each specialty has its own training program and accreditation standards,

d. Australian College of Rural and Remote Medicine (**ACRRM**) - provides training in general practice,

e. Australian College of Sports and Exercise Physicians (**ACSEP**) - provides training sport and exercise medicine,

f. College of Intensive Care Medicine of Australia and New Zealand (**CICM**) - provides training in intensive care medicine (adult and paediatric),

g. Royal Australian College of General Practitioners (**RACGP**) - provides training in general practice,

h. Royal Australasian College of Dental Surgeons (**RACDS**) - provides training in oral and maxillofacial surgery,

i. Royal Australasian College of Medical Administrators (**RACMA**) - provides training in medical administration,

j. Royal Australasian College of Obstetricians and Gynaecologists (**RANZCOG**) - provides training in obstetrics and gynaecology and five subspecialties,

k. Royal Australasian College of Physicians (**RACP**) - provides training in 33 specialties in adult medicine and paediatrics, each with its own training program and accreditation standards,

l. Royal Australasian College of Radiologists (**RANZCR**) - provides training in radiation oncology and diagnostic radiology, each with its own training program and accreditation standards,

m. Royal Australasian College of Surgeons (**RACS**) - provides training in nine surgical subspecialties, each with its own training program and accreditation standards,

n. Royal Australian and New Zealand College of Ophthalmologists (**RANZCO**) - provides training in ophthalmology,

o. Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) - provides training in psychiatry,

p. Royal College of Pathologists of Australia (**RCPA**) - provides training in eight pathology disciplines, each with its own training program.

94. The medical colleges are also accredited to assess specialist international medical graduates seeking registration in Australia.

95. Medical colleges are independent private member organisations, constituted as companies limited by guarantee, subject to their constitutions and applicable corporations law. They are registered charities regulated by the Australian Charities and Not-for-profits Commission.

96. Most medical colleges are bi-national delivering training programs in both Australia and New Zealand.

97. Medical colleges exercise other functions under their constitutions for example: support fellows, provide advice to government, and support other professional organisations.

98. The medical colleges vary in size and their governance structures and functions differ.

99. Australian Medical Council Standards for Assessment and Accreditation of Specialist Medical Programs outline minimum high-level requirements for the accreditation of specialist training sites by medical colleges. The governance structures usually include decision making committees, advisory groups and staff. The Australian Medical Council Accreditation Standards do not mandate a particular governance model. They support diversity where the structures can be demonstrated to function effectively.

**(ii) Accreditation of training sites**

100. Medical college accreditation is an important process to ensure that a hospital can provide a suitable training experience for a medical specialist trainee and can meet college requirements for specialist training.

101. Medical colleges accredit training sites and/or positions. Medical college trainees must complete training in an accredited training site/position to meet college training requirements and complete the specialist training program.

102. Each college has its own accreditation standards and processes and each undertakes separate accreditation visits of hospitals. The accreditation process usually involves:

    a. a training site submitting documentation for accreditation or re-accreditation to the relevant college,

    b. a college accreditation team comprising college Fellows and trainees undertaking a site visit, and

    c. the college Accreditation Committee considering the Accreditation teams' accreditation report to determine the accreditation status of the training site.

103. Medical training sites must meet the college accreditation standards to be granted accreditation. If a training site does not fully comply with all accreditation standards it may be granted accreditation with conditions. If it does not meet accreditation standards, it will not be granted accreditation or may have accreditation withdrawn if it is an existing accredited training site.

104. The withdrawal of training accreditation does not mean the services are no longer operational and available to patients. It means that the training site is not currently able to train doctors leading to specialist qualifications. However, accreditation decisions, including withdrawal of accreditation, can have a significant impact on the availability of medical workforce at sites/locations, which in turn, can have a impact on patients through a reduced service.

105. Medical College trainees must complete training at an accredited training site for training to be recognised as meeting college requirements for specialist qualifications. If accreditation is withdrawn any medical college trainees at the training site need to find a training position at another accredited training site to continue their specialist training. They can continue to work at the site that has lost accreditation, but the time spent at the site is not counted towards meeting the requirements for specialist training.

106. Training sites that lose accreditation and so lose their college trainees must fill the vacant position(s) with other workforce, including unaccredited (non-college) trainees.

**(iii) Actions to improve the college accreditation process**

107. Over the last few years, employers and jurisdictions have raised concerns about the medical college processes concerning accreditation of training sites, particularly where accreditation has been withdrawn. Concerns included inconsistency of decisions, due process not followed, lack of transparency for accreditation decisions, real and/or perceived conflict of interests, timeframes for implementing accreditation decisions, and a perceived lack of evidence around direct benefit on training outcome.

108. In July 2023, Health Ministers met with representatives of the Australian Medical Council and several medical colleges to discuss current challenges with specialist recognition, specialist numbers and accreditation for training sites, as well as the requirement for the Australian Medical Council and Colleges to collaborate with all jurisdictions to improve these processes.

109. On 1 September 2023 the Ministerial Policy Direction 2023-1: *Medical college accreditation of training sites* was issued, a copy of which is exhibited to this statement (**MOH.0010.0063.0001**). The Ministerial policy direction was issued to Ahpra and the Medical Board of Australia and clarifies Ministerial Council expectations of the Australian Medical Council and medical colleges regarding accreditation of training sites. The Ministerial policy direction directed Ahpra and the Medical Board of Australia to note these expectations when exercising their functions for the purposes of the National Law.

110. The Ministerial Policy Direction requires that:

a. The Australian Medical Council work with jurisdictions and medical colleges to implement the National Health Practitioner Ombudsman recommendations,

b. The Australian Medical Council work with jurisdictions and medical colleges to develop a Communication Protocol,

c. The Australian Medical Council reviews existing arrangements to ensure greater consistency of accreditation policies and processes and that the scope of medical college accreditation of training sites, standards and decisions is clarified to matters relevant to the delivery of high quality education and training of medical specialist trainees,

d. The Australian Medical Council works with medical colleges on training site accreditation arrangements to reduce the impact on patient services caused by withdrawal of training site accreditation and reduced workforce.

111. The Communication Protocol was developed in September 2023 by the Australian Medical Council in consultation with jurisdictions and medical colleges, and a copy is exhibited to this statement (**MOH.0011.0006.0001**).

112. The Communication Protocol sets out the roles and responsibilities of medical colleges, accredited organisations and health departments for the accreditation of specialist medical training sites/posts in Australian public hospitals and health facilities.

113. In November 2023, Health Ministers considered the Ombudsman Report and all Health Ministers supported the recommendations. A copy of the HMM Communique dated 10 November 2023 is exhibit to this statement (**MOH.0010.0302.0001**).

114. The Ombudsman Report notes that the accreditation of specialist medical training sites by colleges is not supported by a legislative framework. Instead, training site accreditation standards and associated assessment processes have developed organically over time. The Ombudsman Report also notes that a range of concerns continue to be raised across the health sector in relation to colleges' roles in accrediting specialist medical training sites. The Ombudsman Report also noted the conflict of interest in practising specialist medical practitioners setting standards for their profession (page 25).

115. The Ombudsman Report made 23 recommendations in five priority areas to improve college accreditation of training site processes. The Ombudsman Report recommended that if insufficient progress has been made, Health Ministers should consider progressing with legislative reform to formally recognise the colleges' function in accrediting specialist medical training sites, and that consideration of legislative reform should also include whether relevant specialist medical training site accreditation decisions should be subject to review by the responsible tribunal (recommendation 23).

116. The Ombudsman Report reflects the concerns that NSW has had with the training site accreditation processes conducted by the medical colleges. The 23 recommendations provide a clear pathway to improve the training site accreditation processes and NSW Health supports the work underway to implement the recommendations.

117. I understand the Australian Medical Council is working with the medical colleges to implement the recommendations.

**(iv) Selection into college training programs and recruitment to health service positions**

118. The *Australian Medical Council Standards for Assessment and Accreditation of Specialist Medical Programs 2023*, a copy of which is exhibited to this statement (**MOH.0010.0062.0001**), requires that colleges have clear, documented selection policies and principles that are merit based (Standard 7). The Standards are supported by explanatory notes. Standard 7 states the Australian Medical Council does not endorse any one selection process and that the medical college as the professional body for the speciality should take a leadership role in the development of selection criteria into training. Further, as trainees are both postgraduate students in specialist medical training programs and employees of health services, this may lead to tension between selection into a specialist medical program and employment.

119. The Health Workforce Taskforce is undertaking a project to look at opportunities for coordination and streamlining junior medical officer recruitment across the different stakeholders involved in recruitment of specialist and non-specialist (unaccredited) trainees.

120. The Health Workforce Taskforce will collate information on junior medical officer recruitment processes across states and territories and medical colleges; assess how recruitment supports distribution of the junior medical officer workforce and efficient entry into specialist training; assess the intersection between college recruitment into training programs and employer recruitment into accredited training positions.

121. Selection into medical college training programs and recruitment to health service positions varies between medical colleges. The various approaches are:

    a. Colleges select trainees into the program and then allocate them to positions in health services. The employer is not involved in the selection or recruitment process. An example is RACS.

    b. Colleges have a selection process to select doctors into the training program and then the doctors apply to health services for a position. An example is ACEM.

c. A combined college and employer process with recruitment to an accredited health service position and selection into the college training program. An example is RACP Basic Physician Training.

122. Where colleges select trainees and allocate them to positions in health services, the NSW Health Policy Directive *Recruitment and Selection of Staff to the NSW Health Service* (PD2023_024), a copy of which is exhibited to this statement (**MOH.0010.0064.0001**), applies. The policy states when junior medical officers in some vocational training programs are recommended to facilities / positions by the relevant medical specialty college, the final decision to appoint the recommended trainee remains with the employer and that the college trainee must provide the required documentation.

123. The majority of NSW health service positions, both accredited and unaccredited, are recruited during the annual junior medical officer recruitment campaign. Interns are not recruited through this annual medical officer recruitment campaign but are recruited separately through the HETI coordinated intern process as outlined at paragraphs 75 - 85. Any vacant positions that occur during the year are filled through ad hoc recruitment.

124. All health services are competing for the same limited pool of applicants to fill positions. Where there are more positions than suitable applicants, some locations and/or specialities find it more difficult to fill all their positions.

**(v) Number and distribution of specialist training positions**

125. LHDs are responsible for determining junior medical officer workforce requirements and funding positions. Factors that health services consider when establishing junior medical officer positions include the type and level of clinical service provided and the workforce (medical and other) required to deliver the services and the funding available to establish the positions.

126. The Australian Government funds specialty training positions, outside the traditional metropolitan teaching hospitals, in private settings and rural and regional areas, including in rural and regional public hospitals, through the Specialist Training Program. There are 920 Specialist Training Program positions available nationally each year that support establishing non-GP specialist training positions in private settings and rural and regional locations. The Department of Health and Aged Care has funding agreements with the following 13 medical colleges to manage the Specialist Training Program: ACD, ACEM, ACSEP, ANZCA, CICM, RACMA, RACP, RACS, RANZCOG, RANZCO, RANZCP, RANZCR, and RCPA.

127. The following funding is provided under the Specialist Training Program: $105,000 per full-time equivalent position; an additional $25,000 Rural Support Loading allowance for training positions in regional, rural and remote areas; a Private Infrastructure and Clinical Supervision allowance of $30,000 for training positions in a private sector setting.[3]

128. Health services establish positions usually based on local clinical service and roster needs, rather than future specialist workforce requirements, and then seek accreditation of these positions. This can result in a mismatch between specialist training positions and future specialist workforce requirements. Better and safer rostering practices require more doctors to fill rosters across the 24/7 operating cycle of a hospital and this increases the demand for both accredited and unaccredited trainee doctors. This can result in more accredited trainees than the number required to deliver the future specialist workforce required in some specialties.

129. Health services prefer having accredited positions as they are more desirable than unaccredited positions and so more likely to be filled. The relevant college accreditation requirements will determine if a position is able to be accredited. The health service needs to consider if they have the appropriate number of college Fellows who can supervise trainees, and if the health service is able to provide the range of settings, experiences, and clinics that support achievement of college training requirements. For example, General Surgeons Australia (**GSA**) *Hospital Accreditation and Trainee feedback regulations for the General Surgical Education and Training Program* (**GSA Regulations**), a copy of which is exhibited (**MOH.0010.0065.0001**) states that for all new post applications, the hospital must provide at least one Consultant supervised outpatient clinic, with new and follow-up patients, per week (8.1.2 (d)).

130. Networking of positions and rotations between health services can support trainees to meet college training requirements. This approach has supported an increase in rural and regional training positions, with metropolitan based trainees rotating to rural and regional training sites. There is a focus on establishing more rotations where the trainee is based mainly in rural/regional location and undertakes a metropolitan rotation to obtain specific training experience that cannot be met in the rural /regional location.

131. A lack of a specific experience/subspecialty positions at a training site, network or a statewide level can create bottlenecks in training. As a result, this can reduce the overall

[3] Specialist Training Program information accessed at: https://www.health.gov.au/our-work/specialist-training-program#who-delivers-the-training; 7 July 2024.

number of positions that can be accredited, or the number of trainees selected. For example, a lack of access to enough paediatric rotations for radiology and anaesthetic trainees, or access to child and adolescent and liaison psychiatry rotations for Stage 1 psychiatry trainees, may limit the number of trainees selected.

132. College or Specialty Association requirements related to accreditation standards determine the number of positions that can be accredited at each site, resulting in a need to have both accredited and unaccredited positions to fulfil service needs. For example, most hospitals in NSW providing general surgical services require the support of surgical registrars 24/7, either on site or on call to manage emergencies and support inpatient care. The GSA Regulations state that accredited surgical trainees cannot work for more than 2 weeks of nights (or on call nights) in a 6-month term. To maintain a 24/7 general surgical roster and comply with the GSA Regulations would require 13 accredited trainees. However, a unit with that number of accredited trainees would not meet the required surgical exposure, therefore hospitals will usually have fewer accredited trainees and more unaccredited trainees to balance the provision of surgical training and service needs for patients.

133. Some sites/positions may receive accreditation that allows a trainee to complete all their training at one location, but at other sites their level of accreditation may only allow trainees to undertake a component of their training there.

134. Training in a rural location is an important workforce strategy to support increasing the rural medical workforce. Rural hospitals may struggle to meet the college accreditation requirements, including supervision requirements and the caseload or casemix numbers.

135. Training positions are funded by LHDs and Specialty Health Networks (**SHN**s). The MOH does not manage or distribute intern, accredited training positions and unaccredited positions centrally.

136. The MOH uses published college data on the number of registered college trainees in a college training program when undertaking medical specialty workforce modelling. The number of accredited medical specialty trainees in NSW by specialty training in NSW in 2018 and 2022 is shown in the table below. I note some training programs consist of basic/advanced training components, and others are a combined training program. Where there are separate basic/advanced components the training numbers have been combined.

| Medical specialty trainees - NSW 2018 and 2022 | | |
|---|---|---|
| | 2018 | 2022 |
| Addiction Medicine | 25 | 30 |
| Adult Medicine | 1577 | 1700 |
| Anaesthesia | 408 | 482 |
| Anaesthesia -Pain Medicine | 19 | 22 |
| Dermatology | 34 | 33 |
| Emergency Medicine | 660 | 675 |
| General Practice | 1851 | 1860 |
| Intensive Care | 132 | 216 |
| Medical Administration | 21 | 36 |
| Obstetrics and gynaecology | 183 | 175 |
| Occupational & environmental medicine | 26 | 18 |
| Ophthalmology | 65 | 42 |
| Oral & maxillofacial surgery | 4 | 8 |
| Paediatrics | 515 | 675 |
| Palliative medicine | 9 | 17 |
| Pathology | 103 | 98 |
| Pathology & RACP (jointly) | 97 | 109 |
| Psychiatry | 429 | 553 |
| Public health medicine | 30 | 30 |
| Radiation Oncology | 48 | 55 |
| Radiodiagnosis | 159 | 145 |
| Rehabilitation medicine | 89 | 93 |
| Sexual Health medicine | 9 | 20 |
| Sport & exercise medicine | 14 | 12 |
| Surgery | 354 | 369 |

Source: Medical Education and Training 6th edition Chapter 4
Royal Australasian College of Surgeons Activities Report 2022

137. Award classifications are not different for doctors working in accredited and unaccredited positions. The MOH cannot obtain information on the number and distribution of accredited and unaccredited positions in NSW Health facilities from the payroll system based on junior medical officer award classifications.

138. The recruitment system does not provide a full picture of the number and distribution of specialty training positions for the following reasons:

    a. Due to specialty trainees receiving length of training contracts not all positions are advertised and filled on an annual basis,

    b. Some sites may recruit trainees for a training network, or to rotate to another facility, and therefore the site recruiting the position does not necessarily reflect the location of the position that will be filled by trainees recruited to the advertised position.

139. The MOH is able to provide information on the number and distribution of intern positions as these are recruited on an annual basis and HETI coordinates the intern recruitment process and confirms the number of intern positions in each LHD/SHN.

140. A process has been established for coding of medical specialty positions as set out in *Medical Speciality Coding in StaffLink* Information Bulletin (IB2016_019) a copy of which is exhibited to this statement (**MOH.0010.0066.0001**). LHDs and SHNs are required to code positions as either accredited or not accredited and in which speciality and subspecialty. However, the coding of positions does not impact on payment of salary to the doctors, and there are no penalties or incentives for LHDs/SHNs to maintain accurate coding of positions. As such, while there is information against positions, this information is not as accurately maintained in centrally reportable systems as is intended by the process.

141. The MOH has not actively monitored the quality of the coding of specialty positions. A high level review by the MOH identified about 10% of positions were not appropriately coded, while data for some specialties is similar to trainee positions reported by colleges, others such as reported by the RACS are materially different.

**(vi) Medical Specialty Training Networks**

142. Medical Specialty Training Networks have been established for basic physician (adult) training, paediatrics, psychiatry, emergency medicine and radiology. The training networks link rural, regional and metropolitan hospitals, and trainees recruited to the training networks rotate across and within the different facilities within the network. The training networks support trainees to meet their college requirements as often they cannot be met at one training location.

143. The NSW Basic Physician Training Program commenced in 2005. The Basic Physician Training Program was the first specialty network training program to be established in NSW Health and in Australia. Network training programs are now established in other states and territories in Australia.

144. The development of the Basic Physician Training Program was in response to concerns raised at the time by employers, trainees and colleges about the system of delivery of specialist training.

145. The aim of establishing the Basic Physician Training Program was to ensure that the delivery of basic physician training is of the highest quality, sustainable, transparent; and in accordance with RACP training requirements and clinical service needs.

146. To support the Basic Physician Training Program, funding was provided centrally to establish Network Director of Training positions and Education Support Officer positions. The Network Directors and Education Support Officers are based in LHDs and SHNs, and are employed by the LHD.

147. The number of Basic Physician Training networks has grown from eight to eleven since first established in 2005, however the funding has not increased to support this growth in networks.

148. Each training network has its own governance structures. HETI provides oversight and management at a state level for the training networks.

149. For Basic Physician Training there is a state Clinical Chair and a state Physician Training Council. Each network has a Network Governance Committee. A copy of the NSW Basic Physician Training Network Training Operating Framework is exhibited to this statement (**MOH.0010.0067.0001**).

150. Other network training programs managed by HETI are:

    a. Psychiatry Network Training Program – implemented in 2006 and training is coordinated through five training networks,

    b. Paediatric Physician Training Networks Program – started in 2008 and consists of three networks,

    c. Emergency Training Networks – implemented from 2011 with training coordinated through five training networks, and

    d. Radiology Training Networks – the three radiology training networks commenced in 2016.

151. Not all specialty training programs are supported through HETI managed training networks. Ophthalmology training is coordinated through the Prince of Wales Hospital Training Network and the Sydney Eye Hospital Training Network.

152. RACS determines surgical trainee rotations across the NSW Health facilities. Obstetrics and gynaecology training is managed through RANZCOG Integrated Training Programs. Other programs are managed through informal networks, and for some there are no networks and trainees are recruited directly by a health service.

153. General Practice training is funded and governed by the Australian Government. General practice trainees train in private general practice settings and not within NSW Health facilities. The exception to this is rural generalist training. Rural Generalist training can be undertaken under the ACRRM or the RACGP. The training is 4 years and a minimum of one year of Advanced Skills Training is required. The Advanced Skills Training positions are funded by the MOH in NSW Health facilities where the training occurs. Rural Generalist trainees complete the general practice training component in private general practice settings funded by the Australian Government.

154. The NSW Health Rural Generalist Training Program funds Advanced Skills Training positions across the state in 6 specialties: emergency medicine, obstetrics, anaesthetics, palliative care, mental health, and paediatrics. In 2024 a total of 58 positions are funded for Advanced Skills Training, this will increase to 66 in 2026.

155. The NSW Health General Practice Procedural Training Program, with 20 funded positions, supports qualified General Practitioners to complete Advanced Skills training. In addition, a further 20 positions are funded by qualified General Practitioners to undertake additional training.

## H. INTERNATIONAL MEDICAL GRADUATES

156. International Medical Graduates are an important workforce supplementing the locally trained medical workforce.

157. The Medical Board of Australia determines the registration requirements for overseas trained medical practitioners. There are 3 pathways to registration in Australia:

    a. Competent Authority Pathway: available for overseas-trained non-specialist doctors. Doctors on this pathway need to satisfactorily complete a 12-month period of supervised practice to be eligible for general registration. They are not required to complete any exams to be eligible for general registration,

    b. Standard Pathway: for overseas trained non-specialists who are not eligible for the competent authority pathway or specialist pathway. Doctors on this pathway need to

pass the Australian Medical Council part 1 and 2 exams and satisfactorily complete a 12 month period of supervised practice to be eligible for general registration, and

c. Specialist Pathway: available for overseas trained specialists. Australian Medical Council accredited medical colleges are responsible for the assessment of overseas trained specialists and determining their comparability to an Australian trained specialist. The medical college can find the overseas specialist as substantially comparable, partially comparable or not comparable.

158. The Medical Board of Australia determines supervision requirements for doctors on the competent authority and standard pathways. The relevant medical college that has assessed a specialist international medical graduate determines supervision requirements for specialist international medical graduates.

159. A key challenge is that international medical graduates are recruited to fill positions in areas of workforce shortage, and because of the workforce shortage these sites may not be able to provide the required level of supervision.

160. The Kruk Report has recommended consideration of innovative supervision solutions, including a review of the current Ahpra supervised practice framework, expansion of remote supervision models and online cultural competency and Australian health system training (Recommendation 15).

161. There are international medical graduates on the standard pathway who find it difficult to gain employment in Australia. Reasons may include a lack of experience and familiarity of the Australian health care system and lack of recency of practice.

162. The MOH International Medical Graduate Clinical Readiness Program pilot was developed to provide International Medical Graduates (**IMGs**) who are struggling to gain employment with an opportunity to complete a voluntary clinical placement in a NSW public hospital. Participants worked as Medical Support Officers across multidisciplinary teams to help them learn about the Australian healthcare system, improve communication with patients and within multidisciplinary teams, and build effective relationships within the health system.

163. The IMG Clinical Readiness Program ran as a pilot program from 10 July to 29 September 2023. The program centrally recruited 56 IMGs to complete a voluntary placement in a NSW public hospital, working within multidisciplinary teams to improve

their clinical experience, understanding of communications and system processes in NSW.

164. The program was run in 8 pilot sites in the following LHDs: Illawarra Shoalhaven, Hunter New England, Murrumbidgee, Northern Sydney, Nepean Blue Mountains, Sydney and Southern NSW. An evaluation of the program is underway.

## I. CHALLENGES

165. Training networks support high quality training across different training sites. There are challenges to establishing training networks for additional specialties, or increasing support for existing training networks as trainee numbers increase in the existing trainee networks, as there is no identified funding source to support any expansion.

166. It is difficult for the MOH to have a significant role in determining the distribution of specialist training positions across NSW Health as the training positions are not discretely funded by the MOH and so no mechanism to redistribute medical training positions across local health districts and there is a lack of accurate specialist training position data at a central level to inform distribution decisions as discussed in paragraphs 140 and 141 above.

167. Preparing for medical college accreditation of training sites and monitoring responses to accreditation recommendations and conditions is an important but resource intensive process for health services. The different college standards and requirements add to the complexity and challenge of ensuring appropriate and correct responses to accreditation requirements. The implementation of the National Health Practitioner Ombudsman recommendations should result in improved processes and decrease variation across the medical colleges.

168. IMGs are an important workforce supplementing the local workforce. IMGs require support and orientation to the Australian health care system in addition to the standard orientation that domestically trained medical practitioners receive when starting in a new workplace. This increased level of support can be challenging to provide, particularly as IMG numbers increase, and workforce shortages mean there are fewer supervisors available to provide the required supervision and support.

Dr Linda MacPherson

12 July 2024

Date

Witness: COLLIN MACPHERSON

12 JULY 2024

Date