Special Commission of Inquiry into Healthcare Funding

Statement of Justine Harris

Name:	Justine Harris
Professional address:	1 Reserve Road, St Leonards, New South Wales
Occupation:	Chief Medical Workforce Advisor, NSW Ministry of Health

1. This statement sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**). The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. I am the Chief Medical Workforce Advisor, NSW Ministry of Health (**MoH**). I commenced in this role in January 2024.

3. I was previously the Director of Clinical Services at Sutherland Hospital from 2012 to 2019, and the District Director of Medical Workforce at Illawarra Shoalhaven Local Health District from 2019 to 2023. I am a Fellow of the Royal Australasian College of Medical Administrators. A copy of my curriculum vitae is exhibited (**MOH.0010.0672.0001**).

4. My current role involves provision of medical workforce advice to the branches of the MoH, and to external stakeholders. External stakeholders we work closely with include Executive Directors of Medical Services across NSW Health, the Health Education and Training Institute (**HETI**), the Rural Doctors Network (**RDN**), and medical colleges. My team provides assistance with strategic issues and the practical implementation of any projects on which we develop or are consulted, insofar as they relate to medical workforce issues. My team also collaborates on projects with HETI and the RDN, for example the NSW Rural Generalist Training Program. I am also a member of the State Training Councils. Other examples relevant to my role are set out below.

5. I report to the Director, Health Professional Workforce, in the MoH. This role is currently held by Adj/Professor Jacqueline Dominish.

6. This statement is provided in response to the Inquiry's Issues Paper 2/2024 Workforce Solutions Part 2 dated 16 September 2024. As my role concerns the medical practitioner

workforce in the NSW Health system, my discussion of workforce in this statement is limited to medical students and medical practitioners.

B. MEASURES TO ADDRESS MALDISTRIBUTION OF THE HEALTH WORKFORCE

7. I understand maldistribution of the medical workforce generally to mean the uneven distribution of medical practitioners between metropolitan health services and regional/rural/remote services classified 2 – 7 on the Modified Monash (**MM**) scale.

8. As of June 2024 there were 168 vacancies for post graduate year (**PGY**) 1 and 2 positions within NSW. Those vacancies are across the state, but disproportionately affect regional and rural areas.

9. There is, however, also maldistribution between regional hospitals and remote services and between different medical specialties. For example, in relation to trainees, there are more applicants for surgical trainee positions than places, but there is a shortage of applicants for available places for psychiatry and emergency medicine trainees. On top of these shortages in particular areas of specialist trainees, there is an overall maldistribution of the accredited trainee workforce between metropolitan and regional/rural services.

10. As to specialists, there is a shortage of specialists for available positions in the public health system, including psychiatrists, emergency physicians, radiologists, and anaesthetists, amongst other subspecialties. Recent Australian government modelling, released in August 2024, demonstrated that there is a national shortage of general practitioners (**GPs**) which is affecting both the private and public sectors.

11. There are many reasons for maldistribution including:

    a. Training opportunities – undergraduate and vocational training programs are mostly metropolitan based. During training, people establish connections to their metropolitan locality, making it more challenging to relocate for specialist positions in other localities. In addition, the limited exposure to general practice during their prevocational training may inhibit doctors making the choice to enter general practice. This ends up having a disproportionate impact on GPs in rural and regional areas due to the greater dependence upon GPs in the medical workforce of the public health services in these areas.

b. Type of work – there may be fewer opportunities in rural and regional areas to meet a doctor's desire for particular types of work, or a higher and better volume of work. For example, the doctor might wish to work in a particular subspeciality and/or to access private work, to supplement what might be available by way of work in the public system.

c. Volume of work – the on-call requirements in a rural and regional setting can often be more demanding compared with the requirements in a metropolitan setting. Coupled with a generational change towards better work/life balance, rural/regional work becomes less attractive to many doctors. In the regional setting it can also be difficult for a facility or Local Health District (**LHD**) to balance a reasonable on-call roster (for example, a minimum of five surgeons) with a sustainable and routine work income for such a volume of specialists. To commit to relocating to a regional or rural location, there needs to be adequate private work available to supplement incomes for many specialists.

d. Social and professional isolation – in a rural/regional setting there is a smaller community of peers or access to other specialists to provide support and advice for difficult cases, and the smaller cohort also makes it more challenging to schedule leave.

12. NSW Health has implemented some measures, and additionally is supporting the Commonwealth funded programs, and is considering others, to try to address maldistribution of the medical workforce between metropolitan and rural, remote and regional locations. Below, I discuss each of these in turn:

NSW Health Funded Programs:

a. Expansion of the Rural Doctor's Network (**RDN**) Rural Resident Medical Officer Cadetship (**RRMOC**) program,

b. Expansion of the NSW Rural Generalist Training program (**NSW RGTP**),

c. Single Employer Pathway (**SEP**),

d. Developing more rural/regional based training, and

e. Trial of an incentives package targeted towards medical practitioners to work in rural/remote and regional locations.

Commonwealth Programs:

f. Expansion of the John Flynn Prevocational Doctor Program (**JFPDP**), and

g. More Commonwealth supported places (**CSP**s).

i. Expansion of the Rural Doctors' Network Rural Resident Medical Officer Cadetship (RRMOC) program

13. The RDN, on behalf of the MoH, offers cadetships to medical students interested in undertaking a medical career in rural NSW.

14. Successful applicants receive up to $15,000 per year for the final two years of their medical degree. Successful indigenous applicants receive up to $30,000 spread across the course of their study. In return, they undertake two of the first three years of their hospital training in a rural NSW hospital (MM3-7).

15. Eligibility criteria for the RDN RRMOC are as follows:

a. Medical students studying at Australian universities in NSW. Applicants from NSW universities must be enrolled in second, third or fourth year medicine at certain universities.

b. Medical students studying interstate at an Australian university or in New Zealand and who completed Year 12 in NSW. Applicants from interstate or New Zealand universities must be enrolled in their third last year of a medical degree.

c. Applicants must be Australian or New Zealand citizens or permanent residents of Australia.

16. Eligibility criteria for the RDN RRMOC for Indigenous Medical Students are as follows:

a. Indigenous Australian medical students studying at an Australian university in NSW. Applicants must be studying medicine in first, second, third or fourth year at certain Australian universities, or certain years at a New Zealand university.

b. Indigenous Australian medical students studying interstate at an Australian university or in New Zealand and who completed Year 12 in NSW.

c. Applicants must be Australian or New Zealand citizens or permanent residents of Australia.

17. In their final year of study, cadets apply for an intern position through the Rural Preferential Recruitment (**RPR**) process or Aboriginal Medical Workforce pathway administered by HETI.

18. I understand that the RDN RRMOC program is currently over-subscribed. Applications versus positions is set out below:

Year	Available positions	Applications
2022	48	74
2023	48	88
2024	48	79

19. An evaluation by the RDN of the RRMOC program is currently taking place, and will be finalised in November 2024. I understand the career path of 107 former cadets who have completed their return of service is known, with 64% currently working in MM3-7 locations, which is an increase of 16% since 2014 when the retention rate at that time was world leading.

20. The program is funded by NSW Health. Expansion of the program, that is, offering more places, would increase the pool of trainees that go to rural areas but this would require identification of additional funding.

ii. Expansion of the NSW Rural Generalist Training Program

21. GP vocational training is funded by the Australian government and NSW Health has a limited role due to GP training being predominantly undertaken in the private sector.

22. Rural Generalist training can be undertaken under the Australian College of Rural and Remote Medicine (**ACRRM**) or the Royal Australian College of General Practice (**RACGP**). The training is for 4 years, and a minimum of one year of Advanced Skills Training (**AST**) is required. This training occurs in NSW Health facilities.

23. NSW Health has provided significant support to the NSW RGTP including funding and supporting Advanced Training positions for Rural Generalist trainees. NSW Health funds AST 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 AST. This will increase to 66 by 2026. A further 20 positions are funded for qualified GPs to undertake additional training under the GP Procedural

Training Program. These positions are undersubscribed, which matches the national trend for decreasing entry into general practice training.

iii. Single Employer Pathway

24. NSW piloted and is now implementing the SEP for rural GP trainees. This model provides an employment option for Rural Generalist trainees, by contracting them to a LHD and therefore providing the same employment entitlements as all other NSW Health doctors in training, whilst they work in general practice. This provides certainty around remuneration and leave entitlements. The program is voluntary for trainees, GP practices and LHDs. During 2024, 21 trainees opted to be employed on this pathway.

iv. More Regional/Rural Based Training

25. NSW Health has long standing training networks that were developed to support the rotation of trainees to regional and rural settings, while meeting their college training requirements. These networks have been successful in providing more metropolitan based trainees to fill accredited training positions in regional and rural NSW.

26. Aside from general practice, there is very limited vocational training that is based predominantly in rural and regional areas. More regional/rural based vocational training positions are needed to enable these junior doctors to remain in regional NSW for significant periods while undertaking training. This would be accompanied by rotations to metropolitan facilities or larger regional facilities to allow the trainees to meet all their training requirements.

27. Setting up these regional/rural based training positions would require the cooperation of the LHDs, accreditation by the medical colleges and potentially exploring different supervision models, such as allowing changing supervisors or hybrid on site and virtual supervision.

28. Some college training requirements mean that entirely regionally based training opportunities are limited. For example, the Royal Australasian College of Physicians (**RACP**) requires 12 months of the 36-month Basic Physician Training course to be undertaken in a principal teaching hospital. It also requires that 12 months must be spent in medical subspecialty terms, which may not be available in most regional facilities.

29. Further, some colleges require experience or training in subspeciality positions which are limited or not available in regional/rural areas. For example, the Australian and New

Zealand College of Anaesthetists requires that all anaesthetic trainees complete requirements for 12 specialised study units, including paediatric anaesthesia, cardiac surgery and neurosurgery training which are largely found in major metropolitan teaching hospitals. While paediatric anaesthesia is undertaken in regional facilities, the volumes of practice required by the college to be completed is unlikely to be met outside of larger facilities. Networking regional centres that meet the specialty requirements has been accomplished with Wagga Wagga and Albury Hospitals, but opportunities are limited.

30. Challenges in providing training in subspecialties where there is not sufficient volume of service regionally could be addressed by including rotations to metropolitan facilities for subspeciality training.

31. The Royal Australian and New Zealand College of Psychiatrists has identified opportunities for regionally based training opportunities across Australia. Northern NSW LHD has successfully appointed a Rural Director of Training who has increased the number of psychiatry trainees based in regional NSW. Other colleges have developed regional and rural strategies, such as the RACP and the Royal Australasian College of Surgeons (**RACS**), however they are still developing these programs.

32. Other constraints on regional training include provision of consistent supervision by appropriate senior medical staff. Where clinically appropriate, flexibility to permit mixed supervision models and consider virtual supervision and the ability for changing supervisors (to align to LHDs with a fly-in fly-out model) would assist meeting training supervision standards.

33. Finally, the NSW medical specialty (vocational) training networks in NSW were established to support the equitable distribution of the training workforce across metropolitan, regional and rural settings. These networks have been limited in growth and function due to funding constraints to support Directors of Training and Education Support Officer positions; additionally each network has variable functions due to the funding constraints in place when they were developed. Some networks are entirely education focussed while others have education, training and some workforce support functions. There is potential to expand the targeting of resources to new sites as they become accredited. Presently, the main barrier to this is funding of positions to ensure the facilities in each network can maintain accreditation, provide appropriate supervision and training resources, and the balance of their subspecialities as they expand or change.

v. Expanding the John Flynn Prevocational Doctor Program (JFPDP)

34. The JFPDP is a Commonwealth funded medical training program which supports PGY 1-5 medical trainees to undertake a rural primary care rotation, supervised by a GP.

35. The purpose of the program is to provide trainees with an opportunity to experience the work of a rural GP in a regional or rural practice (MM3-7 rating). The program also provides a supervision payment for the supervising GP.

36. The eligibility criteria for the JFPDP are set by the Commonwealth. The criteria are as follows:

    a. generally only rural hospital-based Australian Medical Graduates in PGY1-5 are eligible to apply, with priority given to PGY1 and 2s (those that spend the majority of each clinical year living and working at a rural home hospital with minimal rotation to metropolitan facilities). In NSW the only prevocational doctors (PGY 1-2) that are rurally based are limited to those in rural preferential pathways in MM2-7 locations.

    b. In the event that there are insufficient rural PGY1-5 doctors, subject to agreement by the Commonwealth Departmental delegate, the Commonwealth Department will consider extending access to a limited number of rural primary care rotation places to eligible metropolitan-based prevocational doctors. It is expected that no more than 10% of positions will be allocated to MM1 based supplying hospitals in each jurisdiction and will be considered on a case-by-case basis.

    c. If the number of Australian Medical Graduates (**AMG**s) are insufficient to fill JFPDP rotations, organisations can recruit rural-based foreign graduates of Australian medical schools (**FGAMS**). International medical graduates (**IMG**s) can only be recruited if there are insufficient FGAMS. However, in both circumstances, IMGs and FGAMS must have permanent residence or citizenship of Australia.

37. Due to these eligibility criteria, of about 2,200 Australian trained PGY 1 and 2 trainees in NSW each year, approximately 300 are rurally based and eligible to participate in the JFPDP under the existing criteria. The program was undersubscribed last year. It is likely the JFPDP will be undersubscribed this year as well.

38. In comparison, the previous Prevocational General Practice Placements Program (**PGPPP**), which ran from about 2004 to 2014, had placements available in MM1-7

facilities, and included metropolitan GP rotations, which meant that trainees at locations with no links to a rural network could still have access to a GP rotation.

39. NSW Health has made a submission to the Commonwealth seeking that the eligibility criteria for the JFPDP be expanded to allow metropolitan based trainees, FGAMS and IMGs to participate in the program.

40. All prevocational doctors are employed by hospitals and are exposed to hospital medicine to complete the requirements of training and gain general registration with these positions funded by the LHDs. Exposure to specialties during medical school and prevocational training does influence the career decisions of junior doctors. With the exposure to general practice during prevocational training being so limited, I consider there ought to be increased GP-focused training during medical school and prevocational training, to better inform the career decisions of young doctors.

41. I also consider that a GP leadership role based in LHDs that employ significant numbers of GPs would enhance the visibility of the profession, provide GP based education and training to healthcare professionals, act as a GP liaison with the GP community and support GPs working in LHDs.

vi. More Commonwealth Supported Places (CSPs)

42. Another measure that could assist with addressing maldistribution of the medical workforce is funding more CSPs in medical schools, particularly CSPs that are targeted to medical students from rural or indigenous backgrounds and based in rural and regional locations.

43. NSW Health's modelling in 2021 showed that we need an extra 165 – 212 doctors (across the whole medical workforce) each year, to 2040, to meet increasing demand on services. The extra doctors that are being recruited to fulfil this demand, currently, are drawn from increasing the numbers of IMGs. These doctors are filling roles across all levels of medical roles, i.e., intern to specialists.

44. NSW Health's view is that more CSPs are required in order for the medical workforce to grow, given we have significant vacancies across the whole of NSW which we expect to worsen in coming years. Given the high entry requirements for medical degrees, which are driven in part by supply and demand, I am confident there is an unmet demand for additional CSPs, that is, people who would like to undertake a medical degree but are unable to do so due to the number of CSPs currently available.

vii. Trial incentives package

45. NSW Health is in the process of developing a proposal for a potential trial for an incentives package to assist with the maldistribution of the medical workforce. This would comprise a package of financial and non-financial incentives for all levels of the medical workforce to work at MM3-7 locations, from staff specialist and Visiting Medical Officers (with a regional residency requirement); trainees in accredited training positions; and Career Medical Officer and Junior Medical Officer positions (that are in not in cadetships or bonded CSP places).

46. The payment may depend on the region they will be working in.

47. Subject to approval, funding would be available for a 2 year trial. NSW Health is currently in the process of seeking approval to further design the proposal, undertake consultation and then if approved by government, implement it.

48. We are also looking at additional payments potentially for senior medical officers relocating from overseas to assist with college assessment and Australian Health Practitioner Regulation Agency registration costs.

C. MEASURES TO ATTRACT MEDICAL GRADUATES TO PURSUE GENERAL PRACTICE, AND RURAL GENERALIST TRAINING PATHWAYS

49. Currently, if a trainee wishes to become a rural generalist, they must go through one of the two GP colleges.

50. Qualification through the RACGP requires a trainee first to undergo the usual GP training pathway. The trainee is then required to complete an additional year of AST, to gain additional skills for rural general practice.

51. Qualification through the ACRRM requires completion of 4 years of training in regional, rural and remote general practices, hospitals, Aboriginal and Torres Strait Islander health services and retrieval services. They must complete a minimum of 6 months of primary care, 3 months secondary care, 3 months of emergency care, 12 months of rural or remote practice and 12 months of AST in an appropriate discipline.

52. Fellows of both colleges are recognised as GPs and can practise in both rural and metropolitan areas.

53. I consider that there is a need to better promote the availability of the rural generalist training pathway. The pathway also has some complexity that could be improved which I outline below.

54. The colleges determine the curriculum, accredit training positions, facilitate training assessments and requirements to achieve fellowship. The colleges operate separately, so any NSW Health AST position needs to be accredited by each college separately, and some by a third specialty college. This could be streamlined with an agreement that positions are jointly accredited.

55. In terms of promoting the role, more exposure to the pathway and career at the medical student level is required. Most University medical schools offer predominantly hospital-based training programs, which means that students have limited exposure to work as a GP, and very little knowledge of the rural generalist training pathway. As stated above, in my view there ought to be increased GP-focused training in university and during the prevocational years.

56. As some Rural Generalists commence work in relatively small facilities, they do require additional support and access to additional training opportunities to transition to independent practice. NSW Health is also commencing work to develop a pathway for Rural Generalists to transition to independent practice post fellowship. Once a pathway is identified, further funding will be required to support the program.

57. The Rural Generalist positions are undersubscribed in NSW. I consider that more can be done to understand this and assist with trainees considering working as a rural generalist. NSW Health has commenced a research project, funded by the Commonwealth, to look at barriers for rural generalists, rural generalist trainees, and the LHDs and to obtain objective evidence about possible measures to improve outcomes in this area. We are starting with the subspecialty of GP obstetrics, as that is the most critical workforce. The overall estimated timeframe for completion of the project is 2 years.

D. MEASURES TO SUPPORT UNACCREDITED DOCTORS

58. There are a large number of doctors working in NSW, including in NSW Health, private facilities and undertaking locum roles, that are not in vocational training or not intending to complete a vocational training program. Within NSW Health this encompasses over 1300 full-time equivalent of staff working as Senior Resident Medical Officers, unaccredited trainees and Career Medical Officers, who fulfil critical roles in the delivery

of patient care. Some of these doctors are in these positions to gain necessary experience in areas to gain skills needed to apply for vocational training, and/or where demand exceeds the available accredited training places, for example in surgery. Others may be unsure of their specialty pathway and others are not interested in specialisation and are seeking an opportunity to provide their skills as employed medical officers in NSW Health facilities.

59. Data from the Medical Deans Australia and New Zealand database found that 19.7% of Australian medical students that graduated in 2009 are not in a registered medical specialty by 2023, this is 14 years after commencing internship. They are not a homogenous group, but they provide critical services and there is evidence that this group is growing.

60. Unlike prevocational or vocational training programs, these doctors have more limited access to structured training or education, no career pathways if they do not enter or complete vocational training and have limited or no access to Directors of Training, or similar roles, to support them in the workplace.

61. NSW Health has some programs to assist some of these doctors. For example, NSW Health offers:

    a. a surgical skills training network for unaccredited surgical trainees, and

    b. a hospital non-specialist program, which provides some funding for Directors of Training and Education Support Officers across LHDs.

62. Additionally, in November 2020, NSW Health published *Final Recommendations of the Review of Trainees in Unaccredited Positions* (**MOH.0010.0676.0001**). Ten recommendations flowed, which centre on:

    a. Establishment of Director of Unaccredited Training roles in LHDs and Specialty Networks,

    b. Trainees in unaccredited positions have an annual Professional Development Plan, receive formal performance feedback during and at the end of their term or 12 month period, and can provide feedback on their role,

c. Clarity of training opportunities and education available in job advertisements, face to face orientation when commencing a new role or rotation, training and development, and paid leave,

d. Two year employment contracts and oversight of rosters, and

e. NSW Health works with specialist medical colleges regarding entry requirements for college training programs to ensure they are reasonable and effective.

63. These programs only cover a small group of this cohort of doctors, and access and delivery is varied across NSW. Significant reform is needed to provide equitable support for all doctors in this cohort, provide more structured training and education, fund sufficient Directors of Training and Education Support Officers or other similar medical educators, provide career guidance, further develop a training pathway for a sustainable career for those doctors not seeking a college specialist training pathway and ensure statewide governance. This would encompass the existing Surgical Skills and hospital non-specialist programs. The MoH will collaborate with HETI to develop, implement and govern this program. The benefits of this approach would be retention of doctors in NSW Health, appropriate career guidance, encouragement of some doctors towards undersubscribed specialties such as general practice, appropriate governance, and support for the required non-specialty roles needed within NSW Health.

64. I understand that this is one of the objectives of the National Medical Workforce Strategy. The Commonwealth is working with all jurisdictions and consulting the Health Workforce Task Force on a framework for this cohort, which they have termed service registrars and career medical officers.

E. INTERNATIONAL MEDICAL GRADUATES (IMGs)

65. NSW Health is increasingly reliant on IMGs to support its medical workforce.

66. Many IMGs find the transition to working in the Australian healthcare system to be challenging. IMGs tend to require higher levels of support from the LHDs on entry into the Australian healthcare system and during their first 6 – 12 months in the workforce. Due to the levels of supervision and support required, LHDs are limited by the supervision levels, rostering and workload in regard to the number of IMGs that they can employ. The greater the number of IMGs in the workforce, the greater the workload for their supervisors and the facilities in which they are employed.

67. I consider that standardising the orientation process for IMGs, developing some standardised international medical graduate orientation modules and funding Directors of Training or medical educators to support and mentor IMGs would assist LHDs with this process and ensure IMGs have a successful supported transition into the workforce.

68. .Further, some IMGs in Australia struggle to find employment due to a lack of recent practice, large gaps in practice and a lack of knowledge of the Australian healthcare system.

69. In 2023, NSW Health piloted an IMG Clinical Readiness Program (**ICRP**) to assist this cohort. The ICRP is an unpaid, voluntary program for IMGs consisting of a one-week intensive central orientation training, a one-week on-site orientation training, and ten weeks of supervised clinical practice in a NSW hospital. The LHDs have the choice to opt in to the program. In 2023, 8 LHDs participated in the pilot program, including Northern NSW LHD, Hunter New England LHD, Northern Sydney LHD, Sydney LHD, Illawarra Shoalhaven LHD, Murrumbidgee LHD, Nepean Blue Mountains LHD and Southern NSW LHD.

70. During the ICRP, participants are referred to as Medical Support Officers and work under the supervision of a senior medical officer and assist in clinical tasks such as ward rounds, basic procedures and taking histories and performing clinical examinations under supervision. Exhibited is the role description for the Medical Support Officer role (**MOH.0010.0677.0001**). The MoH funds the Directors of Training for each LHD facility involved, the central recruitment of medical support officers (**MSOs**), the central orientation of the MSOs, and subsidises accommodation costs for MSOs that need to relocate to regional NSW. The LHD needs to provide a local orientation and ensure the IMGs are appropriately supervised. The MoH also coordinated some centralised education modules including sessions targeted to gaining employment including CVs, job applications and interview technique.

71. At the conclusion of the ICRP, participants receive a certificate of completion and a Professional Development Plan to assist with future job applications.

72. During the 2023 pilot program, we had 55 participants complete the ICRP, with 37 (66%) of the participants going on to find employment afterwards. Of those, 31 work for NSW Health, and the balance in other jurisdictions. The estimated cost of savings of the 31 IMGs employed, versus the cost of employing locums in the same role, is $3,686.551. This is against a $511,000 investment for the 2023 pilot.

73. The pilot program was oversubscribed, with approximately 300 people registering interest and 220 people completing applications. A copy of the NSW Health *International Medical Graduate Clinical Readiness Program, Pilot Evaluation Report, dated April 2024* is exhibited (**MOH.0010.0678.0001**). The MoH has funded a further two programs for 2024 and 2025, and the recommendations from the evaluation have been implemented in the 2024 program. Evaluation of the ICRP will be ongoing to further refine its success.

74. The ICRP is running again in 2024, with placements commencing in September 2024 in Northern NSW LHD, Hunter New England LHD, Northern Sydney LHD, Western Sydney LHD, South Western Sydney LHD and Sydney LHD.

75. While the position is unpaid, there is some support provided for accommodation in regional locations. For 2024, there was 455 registrations of interest with approximately 250 completed applications received for 43 positions.

76. Applicants to the ICRP must be residing in Australia, have passed the Australian Medical Council Part 1 exam, have recency of practice in the past three years (any country), and have not previously worked in Australia as a medical practitioner. Following the 2023 pilot, it was identified that those who had recency of practice performed better, and a criteria has been added requiring practice as a medical doctor within the past 3 years, to maximise success of the program.

77. The next ICRP runs in March 2025, and we are hoping to increase the number of rural and regional LHDs participating.

78. In the regional areas, the ICRP is funded from the Building and Sustaining the Rural Health Workforce initiative. The metropolitan positions are funded by NSW Health. At this stage, the MoH has sufficient funding to run this year's ICRP, and a further round in 2025. However, in order to keep the ICRP going, further funding will be required.

F. SPECIALIST HEALTH PRACTITIONERS AND SPECIALIST TRAINING

79. A further challenge to increasing positions in some specialist training networks is bottlenecks during the training pathway, which are experienced to the greatest extent in radiology and anaesthetics.

80. The bottleneck arises where expansion of training positions is constrained by the need to meet specific college requirements to complete training.

81. For example, in radiology, the college requires exposure to paediatric radiology to occur in facilities with a high volume of cases and Paediatric Radiology specialists. These are largely only available in specialty children's services such as The Children's Hospital at Westmead, Sydney Children's Hospital at Randwick, or John Hunter Children's Hospital.

82. In 2021, NSW Health undertook a review of the Radiology Training Networks to identify the challenges with the provision of radiology training in NSW. Challenges identified include:

    a. Challenges providing adequate access to high quality women's imaging subspecialty training, and

    b. Challenges providing adequate access to high quality paediatric radiology training.

83. As a solution, the MoH funded two additional Paediatric Radiologist Staff Specialist positions at The Children's Hospital at Westmead to increase supervision and provide additional training opportunities.

84. A trial implementation of reducing the length of rotations at The Children's Hospital at Westmead and introduction of an online component occurred, but was not continued after the trial period. This was due to the high burden of orientation of larger numbers of trainees to the positions and the subsequent impact on the delivery of services.

85. I understand HETI continues to assess the feasibility of utilising other sites within NSW and was successful in facilitating Blacktown Hospital to meet the requirements to manage their own trainees without the need to rotate to The Sydney Children's Hospitals Network.

86. In terms of specialist training in anaesthesia, this is largely based on a complex web of informal agreements between various LHDs, instead of formal network agreements or structures. These agreements are required to fulfil the training requirements of the Australian and New Zealand College of Anaesthetists (**ANZCA**), the College of Intensive Care Medicine (**CICM**) and the Australasian College for Emergency Medicine (**ACEM**). Additionally, these positions are used to provide trainee workforces in harder to fill areas in Intensive Care Units and emergency medicine.

87. However, similar to radiology, bottleneck anaesthetic training terms are the requirement for paediatrics, cardiothoracic and neurosurgery terms, which are available in limited places.

88. To understand the bottlenecks in NSW Anaesthesia training, and identify opportunities to increase scheme training positions, this would require mapping all the arrangements and available positions (funded and unfunded) across NSW Health.

89. In my view, the future opportunities could include development of more formal training networks for anaesthesia and intensive care medicine. This would be accompanied by centralised recruitment and coordinated recruitment and length of training contracts to simplify the training opportunities for doctors and reduce workload for LHDs.

90. Finally, a further opportunity may be possible in general surgical training by seeking support from RACS to reconsider rostering constraints in their accreditation standards and expand surgical operative experience by formally partnering with private hospitals, with appropriate funding mechanisms.

91. Overall, I consider the main opportunity is in detailed planning and mapping, to maximise training positions and opportunities. This would include service demand, training currently available, and workforce modelling.

92. Other opportunities could include a partially centralised medical workforce funding and allocation model for new workforce positions, that is determined based on workforce modelling and service development priorities of the state to meet community need. This would ensure growth in trainees and senior medical officers are targeted to specialties and regions where they are required. This would need to be accompanied by a model to ensure growth in the training support roles as the training positions expand, and supervision requirements increase.

93. In recognition of the changing demographics of the medical workforce and work/life balance, more flexible employment and training opportunities are required to be developed.

94. In relation to prevocational doctors, further centralised work to improve the training experience, ensuring work is meaningful including afterhours, and improved workplace culture will assist with retention to NSW Health. This could also include formal support, training and education for Junior Medical Officer Managers who are responsible for rostering, wellbeing, term allocations and recruitment of these doctors.

95. Aboriginal and Torres Strait Islander doctors make up 0.5% of the medical workforce and represent a total of 0.2% of specialists. Barriers to training and working in NSW health include cultural safety in the workplace, support to complete medical school, pathways

into vocational training programs and employment in specialist positions. Development of a model to support Aboriginal and Torres Strait Islander doctors, from medical school, internship to post fellowship with funding to support for training, mentoring, and targeted training and specialist positions, could also be an important opportunity.

DRadovanovic

Justine Harris

Witness: Danijela Radovanovic

2 October 2024

2 October 2024

Date

Date