New South Wales

Special Commission of Inquiry into Healthcare Funding

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NSW Government

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Dear Mr Mullane,

NSW Government Special Commission of Inquiry into Health Funding

Thank you for the opportunity to provide comment into the Special Commission of Inquiry to enquire into the funding of health services provided in NSW.

Medical Deans Australia and New Zealand (MDANZ) is the peak body representing the 22 Australian university medical schools and the two in New Zealand whose responsibility is to educate, support and foster a future medical workforce attuned to, skilled in, and well-prepared to meet the healthcare needs of our communities.

Medical schools have a strong commitment to their graduates subsequently pursuing a career in the locations and specialties where they are most needed, in particular that means a medical career in remote, rural and regional locations, Aboriginal and Torres Strait Islander communities, general practice and other generalist specialties, and in areas of medical workforce shortage and rapid population growth.

As the nature of medical education is strongly focused around immersive, work-based learning – with students' placements in clinical settings being a vital aspect of health professional training – the vast majority of those involved in the education and training of our medical students also have substantial experience in the delivery of hospital and community-based clinical care, postgraduate training (both prevocational and during specialty training) and, through the work of our Rural Clinical Schools and Rural Training Hubs, partnering to support rural placements and rural training pathways and the progression of our graduates into rural careers.

MDANZ has developed a powerful linked data set which examines the future practice intentions and outcomes of our graduates across the Australian Medical Schools – the Medical Schools Outcomes Database (MSOD)[1]. We will reference this data within our comments.

Australia and NSW needs an increase in the supply of local medical graduates to deliver the doctors we need

Across Australia, there are substantial health and medical workforce shortages and a number of this Inquiry's Terms of Reference (TOR) refer to this issue. Whilst these shortages are being felt most acutely in the rural and remote regions, they are impacting far more widely. Geographically, we are seeing shortages in outer-metropolitan areas and population growth corridors. In addition, there are shortages in a number of medical specialties – general practice and psychiatry being two of the disciplines most under pressure. It goes without saying that a sufficient and appropriately qualified

[1] Medical Deans' Medical Schools Outcomes Database (MSOD) https://medicaldeans.org.au/medical-schools-outcomes-database-reports/

and distributed health workforce is the fundamental underpinning to the delivery of quality and accessible healthcare services.

In each jurisdiction, including NSW, there is a growth in hospital beds with a commensurate demand for interns and junior doctors to staff this increase. As there has been no attendant increase in the number of medical student Commonwealth Supported Places (CSPs) – the last being in 2006 – it means the growing intern vacancy rates[2] are having to be filled by international medical graduates of Australian medical schools and, increasingly, overseas-trained doctors (also referred to as International Medical Graduates or IMGs) and graduates of offshore Australian medical programs.

In NSW[2], for the 2023 clinical year there were 1,120 NSW Ministry of Health funded intern positions (an increase of 46 from 2022), of which 1,088 were filled by 1,090 medical graduates (two positions being job shared) leaving 32 vacancies at the end of the Late Vacancy Management process at the end of March 2023.

Of those accepting NSW intern positions, 799 were domestic students of NSW-based medical schools, 141 were those schools' international students, 121 were graduates of interstate universities (116 domestic and 5 international), and 29 were offshore graduates.

This growth and demand on state hospital services has correlated with the aging of the Australian population and the decline of a strong primary health sector nationally, and shows no signs of slowing. To relieve the ever-burgeoning pressures on our hospital system, there must be a stronger focus on building the capacity of our primary care system.

It is worth noting that data reveals that, each year, **Australia recruits around the same number of overseas trained doctors as we graduate domestic medical students.** The most recent Department of Health and Aged Care published data[3] that includes the origin of the doctor's primary medical qualification shows that in 2018 there were 6,513 first time medical practitioner registrants, in the year where there were 3,025 Australian trained domestic medical graduates and 450 international graduates – meaning that over 3,000 of our new doctors were IMGs[4]. This is not an appropriate balance. Australia has huge potential within our own population to attract and train the doctors our communities need.

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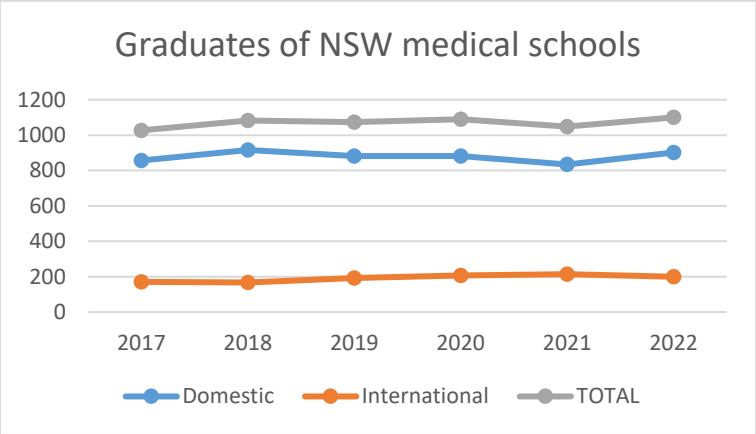
[2] NSW Health Education and Training Institute (HETI) Annual Report: Medical Interns Recruitment to NSW Prevocational Training Positions for the 2023 Clinical Year https://www.heti.nsw.gov.au/__data/assets/pdf_file/0011/576767/Annual-Report-on-Medical-Intern-Recruitment-for-the-2023-Clinical-Year.pdf

[3] National Health Workforce Data Factsheet 2018 https://hwd.health.gov.au/resources/publications/factsheet-mdcl-2018-full.pdf

[4] The contribution overseas trained doctors make to Australia is significant and must be genuinely valued and supported. Without them many of our rural towns would have no doctor at all and Australia, and NSW as the most common destination for those migrating to Australia, benefits greatly from the increased diversity, perspectives and experience they bring to our workforce, health system and society. However, our current health workforce development policies are overly reliant on an ability to recruit sufficient numbers, exposed in the last few years as highly vulnerable and ethically questionable in the face of global shocks such as COVID-19. We continue to try to recruit doctors from countries in dire need. Our review of the AHPRA Medical Register data for 2022* shows that a third of Australia's medical workforce was trained overseas. Of these over 7,500 were trained in India, over 2,500 in Sri Lanka, and over 2,300 in South Africa, all of whom have recognised and substantial health workforce shortages themselves.

* Note: this data is accessible via Medical Deans' Data Dashboard:
https://app.powerbi.com/view?r=eyJrIjoiMjdiNTU2NWMtMmJjYy00MTBiLTg5NTgtNzg1OTE4ZjU4NGJhIiwidCI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9).

The number of medical graduates from NSW medical schools has remained fairly stable over the last few years, with 1,100 graduating at the end of 2022.



Over the last 3 years, the prevocational training (intern) places has increased from 1,041 in 2021 to 1,120 for 2023. During the same period, the vacancy rates reported by HETI rose from 6 vacancies to 32.

Increased self-sufficiency in medical graduate supply can influence health care reform

MDANZ data shows that domestic medical graduates are more likely to express interest in rural practice and also in GP training compared with international graduates of Australian medical schools:

- Preference for location of future practice to be outside a capital city
  - 39.7% of domestic students
  - 30.2% of international students
- Preference for future GP career
  - 19.7% of domestic students
    - General Practice #2 ranked, with 13.2%
    - Rural Generalist #8 ranked, with 6.5%
  - 13.2% of international students
    - General Practice #3 ranked, with 12.4%
    - Rural Generalist #12 ranked, with 0.8%

Our review of the available data also suggests that many IMG may only temporarily fill areas of need before relocating to areas of minimal doctor shortages.

The AHPRA medical registration[5] indicates that there is substantial and ongoing movement of Australia's IMG workforce from regional locations into metropolitan practise, with 2021 data showing three quarters (76.5%) are working in major cities (MM1[6]) and a further 10.7% in areas within 20km road distance of a town with a population greater than 50,000 (MM2).

[5] Accessible via Medical Deans' Data Dashboard, available at https://app.powerbi.com/view?r=eyJrIjoiMjdiNTU2NWMtMmJjYy00MTBiLTg5NTgtNzg1OTE4ZjU4NGJhIiwidCI6IjIjY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9

[6] Using the Modified Monash Model https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

How can NSW contribute to building the size and shape of our medical workforce to meet community need?

Acknowledging the complexities involved in Australia's Federal and State-based model of healthcare, there are common aims that unite all governments – a key one being the need to strengthen our primary care system. This is crucial to relieving the pressures on the hospital system.

Medical students are expressing a strong interest in GP training and rural generalism at graduation, but factors including lack of early post graduate community experience and high-quality supervision are impediments. State governments have a key role to play in these areas.

High-quality and highly-valued training opportunities for early postgraduate doctors outside the hospital – including GP training terms, community-based internships, hybrid junior doctor terms – can be created and accredited but there are obstacles. The first is the difficulty of releasing junior doctors from hospitals in the context of workforce shortages. The second, and possibly most important, is the significant imbalance in the support and funding for training and supervision in the community compared with the hospital. Since the removal of the PGPPP there have been no consolidated funds to support the training of junior doctors in the primary care setting.

While we acknowledge the funding of primary care is the responsibility of the Federal government, there are many areas where the NSW government could contribute to and directly benefit from a stronger primary care system.

1. **Support the move to greater self-sufficiency in our health workforce**

   NSW health should use the data from HETI regarding the intern vacancy rates and from their health services on their overall medical workforce shortages, reliance on the IMG workforce and locums, and the impacts of this on the immediate and future provision of health care to advocate more strongly for a more self- sufficient medical workforce in the next decade.

2. **Contribute to the development of a stronger primary care system, that is attractive to medical graduates and early career doctors (and other healthcare professionals)**

   NSW Health services could encourage and enable some of their employed non-GP specialists and registrars to provide clinical care and student/junior doctor supervision and training in GP settings, to increase the instances of care provided outside of hospitals and share some of the load to grow community-based training opportunities. This investment would in turn benefit NSW Health by enabling primary care's capacity to share the patient case load.

   NSW government could explore opportunities and funding models for shared roles for GP and non-GP specialists to work in both the hospital and community-based sectors. There is some interesting work underway in the Riverland in South Australia[7] that is integrating hospital and general practice training.

3. **Support a move to more medical education and training to be undertaken in community-based settings**

   NSW could lead in innovation and partner with the commonwealth to establish best practice examples of hybrid models of intern and junior doctors training that blends community and hospital settings. There are examples where rural health services have worked with primary care providers to create intern and junior doctor training models that blend time in general

[7] Riverland Academy of Clinical Excellence – Rural Generalist / General Training Pathway https://www.samet.org.au/wp-content/uploads/2023/04/Information-Pack-2024-PGY2-Rural-General-June-2023.pdf

practice with hospital-based experiences. Young hospital doctors that are able to experience community-provided care are more experienced with connected care, high value care, and the principle of 'choosing wisely' about health services.

There are a number of innovative models where small investments in local GP supervision of training have resulted in a substantial increase in the primary care workforce and has fostered strong primary care training and placement experience (for example, in metropolitan ACT). Similarly, there are already examples of hybrid junior doctor training terms that are receiving very positive responses from both the health services and the learners and supervisors involved (for example, in Bega Southern NSW[8] and at Portland in Victoria[9])

NSW Health could identify one or more local health districts where champions in a lead GP practice or network and the hospital would be willing to pilot some hybrid models as a precursor to establishing a sustained approach.

4. Increase, and preference, medical education and training placements and early-career roles in rural and regional areas

Data[10] shows the strong impact rurally based postgraduation training has on subsequent longer-term decisions to work in rural locations, for GP and non-GP specialists, and highlights the importance of strengthening and expanding rural training pathways after medical school.

We acknowledge the work of NSW Health in growing the number of rural intern places and their work to promote and preference these places and urge these efforts to be sustained and amplified.

This could be strongly supported by building on and leveraging the substantial and successful investment by successive Federal governments in universities' Rural Clinical Schools (and University Departments of Rural Health) and open them up to partnerships with health services and medical colleges responsible for postgraduate training. They could form the basis of a state-wide network across the regions to support better career planning and progression for our early career doctors and enable innovative supervision models and broader support for doctors in training.

There is the opportunity to learn from the UK experience in this area where they established Deaneries (now called Local Education and Training Boards)[11] and Foundation Schools[12] – groups of locally-based institutions involved in medical education. These have played an important role in coordinating training positions across the pipeline and across local areas, improving supervisor education and training and, crucially, supporting those early-career doctors who are experiencing difficulty.

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[8] Building Careers in General Practice and Rural Generalism, Anderson, K. June 2023 https://medicaldeans.org.au/md/2023/06/Article-Innovation-at-Bega.pdf

[9] A case study of a novel longitudinal rural internship program - Abstract; Beattie J et al, Rural and Remote Health Journal, August 2023 RRH: Rural and Remote Health article: 8327 - A case study of a novel longitudinal rural internship program

[10] Rural medical workforce pathways: exploring the importance of postgraduation rural training time; McGrail M et al, BMC Human Resources for Health Vol 21, April 2023 https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-023-00819-3

[11] UK NHS Training Regions https://specialtytraining.hee.nhs.uk/portals/1/Content/Resource%20Bank/Inter-Deanery%20Transfer/UK%20Training%20Region%20Websites.pdf

[12] UK Foundation Programme https://foundationprogramme.nhs.uk/

5. Support graduates' transition into clinical practice

The transition from medical school to internship is a critically important time for medical students – and also a time of high stress and anxiety levels for many. It is vital for medical schools and health services to work closely together on the many complex aspects involved.

One key area is the fundamental readiness for practice of our graduates – not just of the skills, knowledge and competencies, but also of their understanding and readiness to step into the clinical environment, their role as part of the healthcare team, and the culture and systems of their hospital employers.

The Assistant in Medicine (AiM) experience developed during the COVID-198 pandemic by NSW Health in close collaboration with the medical schools provided clear feedback of the value of having a more closely integrated role for students in the final stages of their medical program. The NSW Health evaluation[13] showed that AiMS help take the clinical load off Junior Medical Officers and help reduce the amount of un-rostered overtime which directly impacts clinicians' burnout and also additional costs to the system. The report revealed the positive response from those students who partook in this role, with feedback they felt better prepared and more confidence for their step into clinical practice as an intern.

We strongly recommend establishing a sustained model for final-phase students to have a clearly defined and recognised role as part of the healthcare team.

6. Re-think the Hospital/Community Junior doctor scope of practice

The rapid emergence of AI and digital healthcare solutions is an opportune time to review the scope and activity of the intern role. Many interns and junior doctors are not operating at the top of their scope largely due to ever increasing bureaucracy and paperwork. Data from the Medical Training Survey[14] reveals the alarming figure of 1 in 5 junior doctors expressing intentions to leave the medical profession. The use of medical locum rates is at an all-time high nationally and contributing to blow out of hospital costs and the distortion of the health workforce with doctors and other health professionals choosing to locum rather than accept permanent roles. More importantly locums and increased use of agency staff can create fragmentation of care and affect clinical communication.

Community terms are less hampered with this and provide an opportunity for extended scope of practice. It is also hypothesized that burn out rates may be reduced by providing some relief from the hierarchical hospital settings.

The new National Framework for Prevocational Medical Training coming into effect in 2024, and its move away from traditional clinical rotations, provides an opportunity to have a stronger focus on the knowledge, skills, and experiences being sought rather than the setting of the training. For example, data shows that more than half of the presentations to general practice are for mental health issues, which would provide a valuable and rich training experience. Currently, the majority of exposure to mental health care for students and interns is the public hospital acute medical health unit. Recognising the abilty for junior doctors to learn specialty skills in a generalist clinical setting will enable a pivot to more training to be in community and primary care settings.

[13] NSW Health Assistant in Medicine Evaluation Report, May 2021
https://www.health.nsw.gov.au/workforce/medical/Pages/aim-evaluation-report.aspx
[14] Medical Board of Australia, Medical Training Survey https://medicaltrainingsurvey.gov.au/

We recognise that a key barriers to more medical graduates learning outside of the traditional training environment of major metropolitan public hospitals is the reliance of large hospitals on the labour of junior doctors and specialist trainees to meet their service demands, without reference to the needs of the community for a specialist workforce. A better deployment of medical workforce requires adaptation of current models of care, including consideration of expanded roles for non-medical clinicians.

7. Increase opportunities for portfolio careers involving teaching and research; support education and innovation through strengthening of clinical academic pathways; address the issues and impact of clinician burnout

At graduation more than 80% of Australian medical graduates express a strong desire to teach in their future career and more than 70% express an interest in research[15]. However we know there is pressure on the clinician-academic workforce due to the difficult balance between service delivery and teaching, research and leadership roles.

It is vital that we more strongly support the development of the clinician-academics. NSW health could create some embedded and well delineated clinical academic pathways in both hospital and community settings, demonstrating to junior doctors the importance of these roles and providing clear paths to a well-rounded portfolio medical career. These would not only drive health care quality but higher retention of medical staff in the system.

NSW Health should fund dedicated medical education and training roles, to relieve the pressure on those juggling high patient caseloads and the demands of supervision.

There is also the scope to offer senior clinicians an agreed lower patient caseload to increase their time for clinical supervision. This is an opportunity to retain those who are otherwise considering early retirement or suffering from burnout.

Echoing our earlier comments about the importance of a strong primary care system to state-funded services, we strongly recommend NSW government explore options for closer collaboration and mutual support between hospital and community-based supervisors and researchers.

We need a healthcare system that enables and encourages multidiciplinary team-based care

Whilst our comments have focused on the medical workforce, we strongly support moves that will help drive a more multidisciplinary approach to health service delivery. Reforms are needed that enable health practitioners to work to their full scope of practice and to support extended scope of practice where appropriate. Not only does this support high quality care and, often, a more patient-centred approach, it better leverages the skills highly-trained health professionals, helps sustain them through their career, and can deliver more appropriately-costed health services.

We would welcome further discussion and opportunities to contribute to reforms resulting from this Inquiry.

Your sincerely

Michelle Leech AM
President
Medical Deans Australia and New Zealand

[15] Medical Schools Outcomes Database, National Data Report 2023, pg 31, tables 28 and 29
https://medicaldeans.org.au/md/2023/08/MSOD-National-Data-Report-2023-July.pdf