GROUP OF EIGHT AUSTRALIA

Essential decisions for national success

Securing the Future of Australia's Medical Workforce

THE UNIVERSITY OF WESTERN AUSTRALIA

MONASH University

Australian National University

THE UNIVERSITY of ADELAIDE

THE UNIVERSITY OF MELBOURNE

UNSW SYDNEY

THE UNIVERSITY OF QUEENSLAND AUSTRALIA

THE UNIVERSITY OF SYDNEY

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Summary of Recommendations

Australia is facing long-term challenges to its medical workforce – and health workforce more broadly. These challenges have been exacerbated by the COVID-19 global pandemic. The Group of Eight (Go8), comprising Australia's leading research-intensive universities, educates 62 per cent of the nation's medical graduates.

On 1 April 2022, the Go8 convened a Medical Workforce Roundtable which included representatives from State/Territory and Commonwealth health departments; public and private health services; medical profession and student peak bodies; rural, regional and remote health bodies; and other health stakeholders. The objective was to identify policy levers critical to generating a medical workforce capable of meeting the needs of the Australian community now and into the future. This currently does not exist.

We have always acknowledged that addressing medical workforce issues is complex. That is not going to change despite our determination to deliver far better outcomes for the Australian people. This challenge should not stop us.

We also acknowledge the role of our universities as but one piece of a complex puzzle.

However, complexity must not be seen as a barrier to reform or an excuse not to reform.

As stated above, our starting point must be additional university places for medical students – and at scale – to underpin Australia's future medical workforce.

The objective was to identify policy levers critical to generating a medical workforce capable of meeting the needs of the Australian community now and into the future. This currently does not exist.

Go8 Recommendations for an incoming Government

- **Recommendation 1: An immediate increase in the number of Commonwealth Supported Places (CSPs) to secure Australia's 2030 medical workforce needs.** Bolster Australia's medical workforce to address projected 2030 medical workforce demands by increasing the number of commencing Commonwealth Supported Places (CSPs) for domestic medical students by a minimum of 1,000 over four years.
- **Recommendation 2: A sovereign capability charter for Australia's medical workforce.** The incoming Government should adopt a formal charter to build and maintain sovereign capability of our national medical workforce – working in partnership with State/Territory Governments and major healthcare stakeholders.
- **Recommendation 3: Priority funding for an evidence-based planning approach to our medical workforce.** Fast tracked approval of and dedicated funding for recommendations in the National Medical Workforce Strategy 2021–2031 to establish a joint medical workforce planning and advisory body and a National Medical Data Strategy.

The incoming Government should adopt a formal charter to build and maintain sovereign capability of our national medical workforce...

Recommendations for our Universities

- **Recommendation 1:** Reform entry pathways into and through medical schools to increase the number of medical graduates from rural and regional Australia, from Aboriginal and Torres Strait Islander communities and low SES backgrounds.
- **Recommendation 2:** Support an increased focus in medical school training on clinical placements in general practice; and primary, community based and aged care settings.
- **Recommendation 3:** Ensure an increased focus in medical school training on the burden of disease in the Australian community including the prevalence of mental health conditions and preparing graduates for new ways of working.
- **Recommendation 4:** Ensure an increased focus in medical school training on mentoring, career guidance and information in priority areas such as General Practice and in regional, rural and remote areas.

Ensure an increased focus in medical school training on the burden of disease in the Australian community including the prevalence of mental health conditions.

Summary of discussions

at the Go8 Medical Workforce Roundtable held on 1 April 2022

Reform to secure the future of Australia's medical workforce is urgent and long overdue. It does, after all, take 10–15-years to fully train a medical professional. We are already paying the high cost of inaction. If that continues Australia will be front and centre of a medical crisis.

The Australian medical workforce is complex – the reform process must pay attention to the broader issues related to the health workforce beyond medical practitioners. This context must be understood when focusing on the contribution of university medical schools to the medical workforce pipeline.

Key issues are:

- **Increasing the supply of domestic medical graduates.**
- **Factors related to the future geographic and discipline-based distribution of medical graduates that can be influenced by medical schools.**

Australia's pipeline of medical professionals is currently affected by sovereign capability issues both in the composition of the workforce, with approximately 30 per cent of medical professionals trained overseas and also with the current inflow of doctors into the system. **Australia currently recruits as many International Medical Graduates (IMGs) annually as there are domestic graduates from Australian medical schools. This is not sustainable. Nor should it ever be a preferred option of any Government.**

IMGs do play an essential role in Australia's medical workforce – particularly in rural, regional and remote areas – and they will

continue to do so. However, there is a shortage of healthcare workers worldwide, exposed by the COVID-19 pandemic, and Australia can no longer rely on international supply in an attempt to satisfy domestic demand.

In an increasingly competitive international marketplace for doctors, where the real threat of pandemics and geopolitical factors can inhibit international mobility, Australia needs certainty and a secure supply of domestically trained medical practitioners.

To increase our sovereign capacity – even without increasing the total number of doctors in Australia – requires **at least** an additional 1,000 domestic graduates per year.

This is not something there should be disagreement about.

Currently there is also mounting pressure (as was discussed on 1 April) across Australia's medical workforce, contributing to the rate of "burnout" among junior doctors.

It was also noted that acute shortages of doctors in regional and rural areas were key factors that reinforced the urgency of building a flexible and responsive medical workforce.

There is no disagreement that a patient-centred approach to health care and a design approach that "de-silos" health care and medical training at all levels should be a major consideration in any reform.

*To increase our sovereign capacity – even without increasing the total number of doctors in Australia – requires **at least** an additional 1,000 domestic graduates per year.*

Summary of discussions at the Go8 Medical Workforce Roundtable held on 1 April 2022

The Role of Universities in Developing the Medical Workforce

Universities are but one part, albeit a critical one of the medical workforce pipeline that extends from school education through to internships, pre-vocational and vocational training as medical graduates progress to specialty qualifications and into the public and private health sectors.

In 2020 Australia's 19 university medical schools produced 3,834 medical graduates – with 62 per cent of these from the Go8.

Our universities are also closely involved with the broader health system through training and research affiliations with hospitals and the public and private health system.

Many clinician researchers – with both medical and research training and undertaking research in clinical settings – have joint appointments or affiliations with universities and are key to driving Australia's national health and medical research effort.

The Go8 is deeply embedded in medical training for and in rural, regional and remote (RRR) areas, including through Rural Clinical Schools, University Departments of Rural Health and new collaborative regional training consortia.

In 2020 Australia's 19 university medical schools produced 3,834 medical graduates – with 62 per cent of these from the Go8.

The National Medical Workforce Strategy 2021–2031 (NMWS)

The NMWS[1] has cross-cutting themes of providing a medical workforce that:

- Is diverse and representative of the community – particularly the Aboriginal and Torres Strait Islander communities.
- Is adaptable to better and new models of care – the importance of which has been highlighted the COVID-19 pandemic.
- Supports the right people to have the right skills, where we need them most.

The strategy also acknowledges the multidisciplinary nature of health delivery, a factor emphasised as integral to quality healthcare by roundtable participants.

Key recommendations of the NMWS that relate to the role of medical schools in the medical workforce pipeline are the creation of a *joint medical workforce planning and advisory body*, and a *National Medical Data Strategy* to bring together jurisdictional and national health workforce data.

While the NMWS has widespread support, the Government is yet to allocate funding for the implementation of key recommendations. The specific measures relating to planning and data would provide the stronger evidence base for increasing the number of new medical Commonwealth Supported Places (CSPs).

The roundtable discussion broadly supported the implementation of the NMWS.

1 https://www.health.gov.au/initiatives-and-programs/national-medical-workforce-strategy-2021–2031

Summary of discussions at the Go8 Medical Workforce Roundtable held on 1 April 2022

Complexity and the consequences of delayed action

It is difficult to separate the complexity of medical workforce reform from the broader health workforce and the delivery of health services.

While there is a strong case to rebalance Australia's reliance on IMGs and boost the numbers of domestic graduates – which requires additional CSPs[2], the roundtable noted concerns regarding the availability of detailed workforce modelling data and whether the current system is geared to support 1,000 additional commencing CSPs through additional intern, junior doctor and vocational training positions.

Pre COVID there is evidence to suggest the provision of intern positions for graduating medical students was limited. This led to career uncertainty for medical graduates.

Currently there is no formal mechanism to dynamically match the national supply of medical graduates – through Commonwealth funded CSPs – with the demand for doctors driven by State/Territory and private health services. Nor is there currently reliable data on the demand for interns and junior doctors.

…the roundtable noted concerns regarding the availability of detailed workforce modelling data and whether the current system is geared to support 1,000 additional commencing CSPs through additional intern, junior doctor and vocational training positions.

2 The Roundtable did not consider a large-scale increase of full-fee paying domestic medical students

Previous efforts by Health Workforce Australia to undertake detailed modelling of Australia's health workforce and future demands did not lead to meaningful reform of the health workforce. That is unacceptable.

While there is a clear need for much improved data and research to underpin reform,[3] waiting for perfect data upon which to make decisions will only delay action – and we as a nation are out of time. That delay can be ill-afforded.

It is therefore essential to raise the political, media, and community profile of these issues in order to garner the support of Government(s) for reform. Increasing the domestic production of medical graduates effectively can be underwritten by Government as a part of broader national medical workforce reform.

There is no excuse for this not to occur. It is an investment in every Australian's health. It is **not** a cost.

Geographic Maldistribution of the Medical Workforce

The geographic maldistribution of Australia's medical workforce is a long-established issue and one of ongoing concern. While overall Australia has 3.8 doctors per 1,000 population – mid-ranking in the OECD – this rises to 4.3 doctors per 1,000 population in metropolitan areas, which is effectively a "trip hazard" to the equitable delivery of medical care in Australia.

As the demand for medical graduates increases, our medical workforce shortage disproportionately impacts regional, rural and remote (RRR) Australians as graduates are more likely to first fill metropolitan opportunities.

The roundtable acknowledged that there was an obvious need for better alignment between medical CSPs and prevocational and vocational

3 See for instance, *Improving knowledge and data about the medical workforce underpins healthy communities and doctors,* Grant M Russell, Matthew R McGrail, Belinda O'Sullivan and Anthony Scott, Med J Aust 2021; 214 (6)

Summary of discussions at the Go8 Medical Workforce Roundtable held on 1 April 2022

opportunities in RRR areas. This would require additional medical and health infrastructure in regional areas, including the staff necessary to supervise an increased level of training.

This must also be aligned with new and innovative ways of training doctors in RRR areas including consideration of a flipped model which prioritises high-quality distance enabled training – using videoconferencing and other technology – with face-to-face sessions in regional or metropolitan centres. This approach has been successfully implemented in the remote vocational training scheme within GP training.

A culture shift is also necessary to support RRR medical training and practice. For too long RRR practice has not been widely respected as a first choice for medical professionals.

Contributing to this cultural issue, is a lack of information and mentoring provided in metropolitan based undergraduate and postgraduate training to support any intention to practice in RRR areas. This exacerbates the disruption to the RRR medical workforce pipeline when RRR focused medical graduates are forced into metropolitan centres for pre-vocational or vocational training because of the availability of training places.

A culture shift is also necessary to support RRR medical training and practice. For too long RRR practice has not been widely respected as a first choice for medical professionals.

Aboriginal and Torres Strait Islander Medical Workforce

Only 2.3 per cent of students entering Australian universities identify as having Aboriginal or Torres Strait Islander (ATSI) background. By graduation this has dropped to 1.3 per cent[4] – well short of the parity benchmark of 3.4 per cent.

Medical practitioners from an ATSI background are more likely to work in ATSI health and in outer metropolitan or rural, regional and remote areas but they form only 0.5 per cent of the medical workforce.

There must be greater consideration of different models of training to support ATSI medical students – including options to undertake more of their studies in RRR settings and through Rural Clinical Schools. To reach parity in the medical workforce, the recruitment and graduation of ATSI medical students will need to be well above parity. A key part in delivering this outcome is to increase the number of ATSI academics in Australian medical schools to mentor and model careers in medicine.

Reforming Models of Health Care and the Balance of the Medical Workforce

A key element of reform is change to health care models – noting that there is no one size fits all approach in Australia. This is a highlighted in the NMWS – which supports a stronger emphasis on general practice, primary care, rural generalism, community-based care, and aged care.

Increasing the number of intern positions in each of these areas and developing them in high-quality training environments is essential to build a flexible and responsive medical workforce.

4 Department of Education, Skills and Employment; Selected Higher Education Statistics – 2020 Student data

Summary of discussions at the Go8 Medical Workforce Roundtable held on 1 April 2022

The role of technology, AI and data analytics is critical to prepare Australia's medical workforce for the future. Changing models of care such as telemedicine, 'hospital in the home' and other home-based care models will positively impact the way we can train medical students. These models require a multidisciplinary, team-based approach; one that includes nurses, allied health professionals, administrators and potentially a number of new roles.

To support this approach to healthcare, medical school and pre-vocational training should place a greater emphasis on general practice to re-establish the reputation of general practice as a career for the best and brightest.

Domestic General Practice Fellows currently comprise 25 per cent of the medical workforce, yet only 20 per cent of the growth in the medical workforce.

There is also a need to ensure medical training better reflects the burden of disease that practitioners will be facing in the health system. This includes a greater focus on specialties such as psychiatry to reflect the prevalence of mental health conditions in the community and significant Commonwealth and State/Territory initiatives to address mental health.

Broadening the Base of Consultation on Medical Workforce Issues

The Go8, as the major stakeholder in the medical workforce space, given the high percentage it educates, was determined to bring together experts from our universities, professions, public and private health, Government departments, students and advocacy groups to elevate discussion on the medical workforce and demand for additional graduates beyond the usual university discourse.

For success it needs every group mentioned above. It needs a strong team effort advocating together for this urgent change. There is never a better time than now.

However, important additional perspectives must be added into ongoing discussions, including those of International Medical Graduates, and the full range of medical specialties – particularly those working in disciplines which reflect a high burden of disease in Australia.

1 Detailed Recommendations for an incoming Government

Recommendation 1: An immediate increase in the number of Commonwealth Supported Places (CSPs) to secure Australia's 2030 medical workforce needs

The current pressure on Australia's medical workforce is predicted to increase over the next decade as our population grows and ages. By 2031, projections indicate that the Australian population will have grown by as much as 21 per cent over 2021 levels with the population of those aged 65 and over increasing by 1.25 million or 29 per cent. These are not insignificant figures.

It is also projected that there will be a shortfall in GPs of over 9,000 by 2030 with significant shortfalls also occurring across a number of specialty disciplines, in particular psychiatry.[5,6] For the National Medical Workforce Strategy 2021–2031 to effectively address these issues within its timeframe, there must be an immediate increase in the number of Commonwealth supported domestic medical graduates.

- **Increase in medical Commonwealth Supported Places to support an additional 1,000 medical graduates per year.** The increase in CSPs would be a staged implementation over four years and would include a process for addressing both geographic and discipline priorities of Australia's future medical workforce.

5 General Practitioner workforce report 2019, Deloitte Access Economics https://www2.deloitte.com/au/en/pages/economics/articles/general-practitioner-workforce-report-2019.html

6 National Medical Workforce Strategy Scoping Framework 2019

Recommendation 2: A sovereign capability charter for Australia's medical workforce

The imperatives for reform of the Australian medical workforce are clear and have been articulated in the National Medical Workforce Strategy 2021–2031. They cannot be ignored by the incoming Government

In particular, Australia has significant issues with the current and future structure of the medical workforce. We have a heavy reliance on International Medical Graduates – for both existing and future workforce – and an obvious maldistribution of the workforce both geographically and across medical disciplines.

Without reform these issues will only become more acute over the next decade and beyond. Australia cannot afford to wait to begin to address these issues. It has already waited too long.

The Go8 recommends that the incoming Government adopt a sovereign capability charter for Australia's medical workforce that commits to in-principle and up-front support to implement the necessary reforms that would secure the future of Australia's medical workforce, in partnership with all major stakeholders in Australia's health system, including State/Territory Governments.

This charter would have a number of key elements.

Without reform these issues will only become more acute over the next decade and beyond. Australia cannot afford to wait to begin to address these issues. It has already waited too long.

- **A commitment to implement the National Medical Workforce Strategy 2021–2031.** The NMWS has been developed by leading experts in the healthcare sector. The recommendations must be adopted, funded and implemented as a matter of priority.
- **A commitment to increase the number of domestic medical graduates.** Current statistics and future projections clearly indicate that Australia's medical workforce will need to increase in size and with its focus on domestic graduates to safeguard against future supply-shocks of international medical graduates, exacerbated by the COVID-19 pandemic.
- **Development of a formal mechanism to match the supply of Commonwealth Government supported medical graduates with medical workforce demand in States and Territories.** Critical to increasing the supply of domestic medical graduates is ensuring that there is a matching of supply with demand. There is currently no such existing mechanism. This matching mechanism must take into account the supply of intern positions, junior doctor positions and vocational training opportunities in identified priority areas to guarantee jobs and career pathways for graduating medical students.

This could lead to a broadening of the 2006 COAG agreement to guarantee intern positions for all Commonwealth supported medical graduates.

Current statistics and future projections clearly indicate that Australia's medical workforce will need to increase in size and with its focus on domestic graduates to safeguard against future supply-shocks of international medical graduates, exacerbated by the COVID-19 pandemic.

Recommendation 3: Priority funding for an evidence-based medical workforce planning approach

Establishing a rigorous evidence-based medical workforce planning approach that incorporates data at both the State/Territory and Commonwealth levels is key to delivering future medical workforce planning that has the confidence of the sector.

To that end, it is recommended that approval and funding be fast tracked for two key actions identified in the National Medical Workforce Strategy 2021–2031:

- Establish a joint planning and advisory body to oversee implementation and evaluation of the Strategy. This will include making recommendations to responsible Ministers. (NMWS Action 1.1)
- Develop a National Medical Workforce Data Strategy (Data Strategy) that informs local, regional, state and territory, and national medical workforce planning. (NMWS Action 3.1)

In addition, it is critical to ensure long-term funding for established time-series surveys of the medical workforce, in particular:

- Medical Deans of Australia and New Zealand (MDANZ) Medical Schools Outcomes Database.[7]
- Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey of Australian doctors conducted by the Melbourne Institute.[8]

7 https://medicaldeans.org.au/priorities/medical-schools-outcomes-database/

8 https://melbourneinstitute.unimelb.edu.au/mabel#mabel

2 Detailed Recommendations for Universities

Recommendation 1: Reform entry pathways into medical schools to increase the number of students from regional and rural, Aboriginal and Torres Strait Islander and low SES backgrounds

Australia's domestically trained medical workforce should be representative of the communities it serves. Whilst our universities do have explicit and supported pathways to increase the number of medical graduates from rural and regional Australia, Aboriginal and Torres Strait Islander communities and low SES backgrounds, further targeted reform is required.

Recommendation 2: Ensure an increased focus in medical school training on clinical placements in general practice; and primary, community based and aged care settings

Much of Australia's current and future health care demand should be delivered outside of (or in combination with) hospitals and so medical school training should reflect an increased level of clinical placements in these settings. This includes primary, community based and aged care settings, as well as general practice more broadly.

Recommendation 3: Ensure an increased focus in medical school training on the burden of disease in the Australian community including the increasing prevalence of mental health conditions and preparing graduates for new ways of working

Medical school training should be targeted to the diseases and conditions most likely to require treatment in the Australian community, that is, reflect the burden of disease. Medical School training should also prepare graduates for working in digitally enabled models of health care delivery.

Recommendation 4: Ensure an increased focus in medical school training on mentoring, career guidance and information in priority areas such as General Practice and in regional, rural and remote areas

To support priorities such as General Practice and practicing in regional, rural and remote areas the medical workforce pipeline needs to both create and support the interest in pursuing careers in these areas. This is particularly the case in metropolitan training settings. For their part, medical schools should have a focus in their training on providing mentoring, career guidance and information in priority areas such as General Practice and in regional, rural and remote areas. We also recognise the importance of a strong clinician researcher pathway as a means to attract the best and brightest to priority areas.

Appendix 1: Key facts from Australia's Medical Workforce

- Australia's medical profession comprises 23 specialties, and 82 specialist titles regulated by the Medical Board of Australia (MBA) – including General Practice.[9]
- In 2020 there were 105,000 medical practitioners employed in Australia in registered professions. Of those reporting a primary specialty 45 per cent were General Practitioners, 14 per cent Physicians, 8 per cent Surgeons, 7 per cent Anaesthetists, and 6 per cent Psychiatrists. There are 32,000 medical practitioners who report their job area as being a General Practitioner.[10]
- According to the latest OECD data, Australia has 3.8 medical practitioners per 1,000 population which places Australia 13th in the OECD[11] and by the World Bank, World Development Indicators this places Australia 35th in the world by this measure.[12]
- The National Skills Commission (NSC) in its 2021 Skills Priority List listed 12 medical occupations in either national or regional shortage and all 32 specific medical occupations with the second highest rating of moderate future national demand.[13] The NSC Labour Market Information Portal (LMIP) models that by 2025 there will be a need for over 14,000 additional medical practitioners over 2020 numbers, with a 15 per cent increase in the number of General Practitioners and Resident Medical Officers needed.[14]

9 https://www.medicalboard.gov.au/registration/types/specialist-registration/medical-specialties-and-specialty-fields.aspx

10 National Health Workforce Dataset, Accessed 3/3/2022

11 https://data.oecd.org/healthres/doctors.htm

12 https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

13 https://www.nationalskillscommission.gov.au/2021-skills-priority-list which uses the Australian and New Zealand Standard Classification of Occupations (ANZCO) classification of medical practitioner occupations

14 https://lmip.gov.au/default.aspx?LMIP/EmploymentProjections

Appendix 1: Key facts from Australia's Medical Workforce

- Of the 105,000 medical practitioners in the Australian workforce, 30 per cent completed their initial qualifications outside of Australia and New Zealand. This figure has remained consistent over the last five years.[15]
- **In international terms, Australia is 6th in the OECD for percentage of medical workforce trained overseas and 21st in the OECD for the number of domestically trained doctors per capita.**[16]
- In terms of the geographic distribution of Australia's medical workforce, around seven million people, or 29 per cent of Australia's population, live in rural and remote areas,[17] while approximately 79 per cent of Australia's medical practitioners are located in metropolitan areas.
- Since 2013, the annual rate of increase of employed doctors outside of the cities was 3.9 per cent, the FTE was 3.4 per cent and the population was 0.7 per cent.[18]

15 National Health Workforce Dataset, accessed 18 March 2022

16 Calculated from OECD Health Workforce and Population Statistics

17 Australian Institute of Health and Welfare (AIHW), 'Australia's Health 2018', *Australia's Health Series 16*, catalogue number AUS 221, AIHW, Australian Government, 2018, accessed 25 September 2020

18 Australian Department of Health, *NHWDS Medical practitioners*, *2014 to 2019* [data set], hwd.health.gov.au, 2020, accessed 22 September 2020

Appendix 2: Profile of the Go8

The Group of Eight (Go8) is the peak body for Australia's eight leading research-intensive universities. It comprises The University of Queensland, UNSW Sydney, The University of Sydney, The Australian National University, The University of Melbourne, Monash University, The University of Adelaide, and The University of Western Australia.

- The Go8 members are in the top tier internationally with seven ranked in the top 100 universities in the world and seven in the top 100 globally for Clinical and Health.[19,20]
- Collectively, the Go8 members educate over 425,000 students and over one in three international students that study at Australian universities do so at a Go8 member.
- Go8 members produced over 110,000 graduates in 2020 including 62 per cent of the national total in medicine.
- In research the Go8 spends $6.5 billion annually on R&D including $3 billion on research in the fields of Health and Biological Sciences.
- The Go8 has nearly 23,000 researchers and over 30,000 higher degree by research students. In 2020 the Go8 graduated 4,400 PhDs, representing 50 per cent of the national total.

19 2021 Academic Ranking of World Universities

20 2022 Times Higher Education Rankings 2022 for Clinical and Health

Appendix 2: Profile of the Go8

- Go8 research is conducted at a standard that sees over 99 per cent of the research rated as world class or above by the Australian Government's official university research audit Excellence in Research for Australia (ERA). ERA also rated seven Go8 members at the maximum rating of 5 (well above world standard) for research in Medical and Health Sciences.
- Go8 members are the heavy lifters in the delivery of rural/regional medical training. Each has a sizable Rural Clinical School and Go8 members are involved in the majority of the Rural Training Hubs.
- Go8 members run four of the five nodes of the Murray Darling Medical Schools Network[21] and conduct clinical placements and training in over 500 regional and rural locations across Australia.
- All Go8 members offer programs that provide significant regional or rural based training for medical students and there is evidence that these Go8 programs lead to a higher likelihood of graduates practising in regional, rural or remote areas.[22,23,24]

21 https://www.health.gov.au/initiatives-and-programs/murray-darling-medical-schools-network

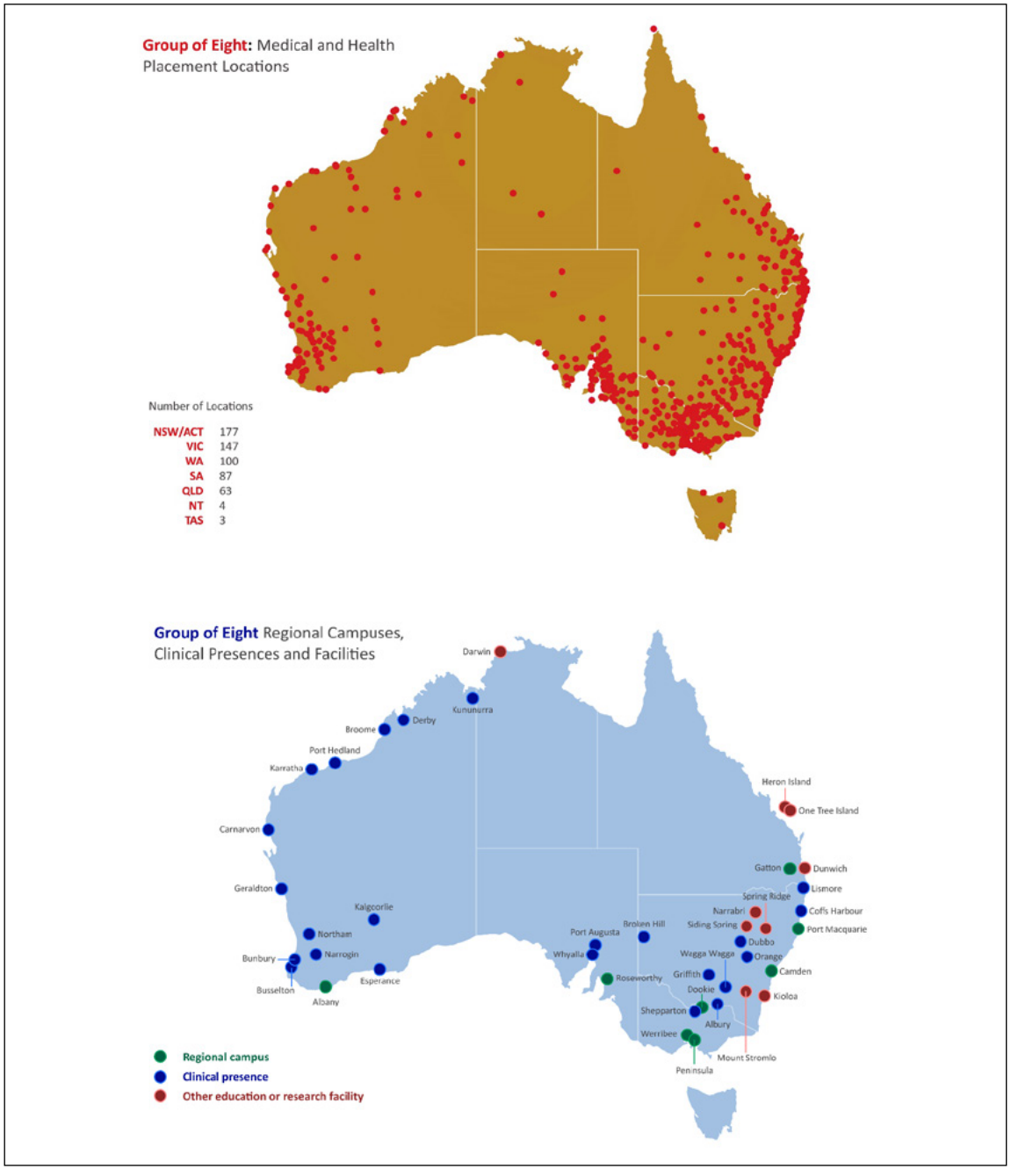
22 Kwan, S Kondalsamy-Chennakesavan, G Ranmuthugala and M Toombs, 'The rural pipeline to longer-term rural practice: General practitioners and specialists', *PLoS ONE*, 2017, 12(7), doi:e0180394, accessed 22 April 2021

23 O'Sullivan B, McGrail M, Russell D, Walker J, Chambers H, Major L, Langham R. (2018) Duration and setting of rural immersion during the medical degree relates to rural work outcome, Med Educ. 2018 Aug;52(8):803-815. doi: 10.1111/medu.13578. Epub 2018 Apr 19

24 Playford DE, Nicholson A, Riley GJ, Puddey IB. Longitudinal rural clerkships: increased likelihood of more remote rural medical practice following graduation. BMC Med Educ. 2015 Mar 21;15:55. doi: 10.1186/s12909-015-0332-3

Appendix 3: Go8 Regional, Rural & Remote Medical Education

The two maps below show, respectively, the collective Go8 medical and health placement sites and the distribution of Go8 regional facilities.



Appendix 4: List of Participants

at the Go8 Medical Workforce Roundtable on 1 April 2022

Monica Barolits-McCabe	Chief Executive Officer	Australian Indigenous Doctors' Association (AIDA)
Dr Megan Belot	President	Rural Doctors Association of Australia (RDAA)
Assoc. Prof. Marco Briceno	Chief Medical Advisor, NT Health	Director of Medical Services, East Arnhem Regional Health Service, Medical Director, NT Rural Generalist Pathway
Dr Matthew Brown	Deputy Chief Executive	Group of Eight
Prof. Shane Bullock	Head of School, Monash Rural Health	Monash University
Prof. Sir Edward Byrne AC	Group Chief Medical Officer	Ramsay Health Care
Prof. Stuart Carney	Dean, Medical School	University of Queensland
Dr Sarah Chalmers	President	Australian College of Rural & Remote Medicine
Prof. Andrew Coats AO	College Dean	Royal Australasian College of Physicians
Helen Craig	Chief Executive Officer	Medical Deans Australia and New Zealand
Sally Cross	Policy Manager	Australian Medical Association (AMA)
Jasmine Davis	President	Australian Medical Students Association (AMSA)
Julie Faoro	Chief Executive Officer	Postgraduate Medical Council of Victoria (PMCV)
Deborah Frew	Director, Workforce Strategy and Culture	NSW Health
Prof. Margaret Gardner AC	Chair, Group of Eight	Vice-Chancellor and President, Monash University
Dr Ian Graham	Interim Chief Medical Officer	Latrobe Regional Hospital

Prof. Russell Gruen	Dean, College of Health and Medicine	Australian National University
Prof. Jane Gunn	Dean, Faculty of Medicine, Dentistry and Health Sciences	University of Melbourne
Mika Hayward	Director of Health Partnerships and Major Projects	University of Queensland
Dr Robert Herkes	Chief Medical Officer	Ramsay Health Care
Guy Jeffery	Vice President External	Australian Medical Students Association (AMSA)
Prof. Alison Jones	Acting Chief Medical Officer	Department of Health, Western Australia
Prof. Cheryl Jones	Head of School and Dean, Sydney Medical School	Professor of Paediatrics, Faculty of Medicine and Health, University of Sydney
Prof. Christine Kilpatrick AO	Chief Executive	Royal Melbourne Hospital
Assoc. Prof. Vinay Lakra	Director, Council of Presidents of Medical Colleges	President, Royal Australian & New Zealand College of Psychiatrists
Dr Sally Langley	President	Royal Australasian College of Surgeons
Prof. Michelle Leech	Deputy Dean (Medicine), Faculty of Medicine, Nursing and Health Sciences	Monash University
Prof. Danny Liew	Dean of Medicine, Head of the Adelaide Medical School	University of Adelaide
Katherine Logan	ONRHC Senior Policy Advisor	Australian Government Department of Health
Adjunct Clinical Prof. Don Mackie	Executive Director Medical Services	Cairns and Hinterland Hospital and Health Service
Prof. Jennifer May AM	Co-Chair	Medical Workforce Reform Advisory Committee (MWRAC)

Appendix 4: List of Participants at the Go8 Medical Workforce Roundtable on 1 April 2022

Prof. Geoff McColl	Chair of Go8 Deans of Medical Facilities	Executive Dean of the Faculty of Medicine, University of Queensland
Dr Brendan McQuillan	Dean and Head, Medical School	University of Western Australia
Phil Minns	Deputy Secretary, People, Culture and Governance	NSW Health
Prof. Christina Mitchell AO	Academic Vice-President and Dean, Faculty of Medicine, Nursing and Health Sciences	Monash University
Greg Mullins	Head of Policy	Research Australia
Prof. Richard Murray	President	Medical Deans Australia and New Zealand
Ben Neal	Partner & Workforce Transformation Leader	PwC Australia
Angela Nolan	Chief Executive Officer	St Vincent's Hospital Melbourne
Prof. Kathryn North AC	President	Association of Australian Medical Research Institutes (AAMRI)
Dr Gabrielle O'Kane	Chief Executive Officer	National Rural Health Alliance
Dr Antonio Penna	Executive Director, Office for Health and Medical Research	NSW Health
Assoc. Prof. Luis Prado	Chief Medical Officer & Executive Director Academic and Medical Services	Epworth HealthCare
Dr Karen Price	President	Royal Australian College of General Practitioners (RACGP)
Prof. John Prins	Head, Melbourne Medical School	University of Melbourne
Peta Rutherford	Chief Executive Officer	Rural Doctors Association of Australia (RDAA)
Prof. Ingrid Scheffer AO	President	Australian Academy of Health and Medical Sciences (AAHMS)

Dr Tanya Schramm	President	Australian Indigenous Doctors' Association (AIDA)
Dr Alex Stephens	Director of Research	Northern NSW Local Health District
Adjunct Prof. Ruth Stewart	National Rural Health Commissioner	Australian Government Department of Health
Andrew Stripp	Chief Executive	Monash Health
Dr Ashwin Swaminathan	Acting Executive Director of Medical Services	Canberra Health Services
Dr Peter Thomas	Executive Director	Association of Australian Medical Research Institutes (AAMRI)
Vicki Thomson	Chief Executive	Group of Eight
Georgina van de Water	Chief Transition Officer	Royal Australian College of General Practitioners (RACGP)
Prof. Gary Velan	Senior Vice Dean – Education	UNSW Medicine & Health
Dr Christine Walker	Board Member	Consumers Health Forum of Australia
Assoc. Prof. Susan Wearne	Senior Medical Adviser, Health Workforce Division, Department of Health, Canberra	Clinical Associate Professor, Australian National University, Chair, National Medical Workforce Steering Committee
Tobi Wilson	Chief Executive	South Eastern Sydney Local Health District

GROUP OF EIGHT AUSTRALIA

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THE UNIVERSITY OF WESTERN AUSTRALIA

MONASH University

Australian National University

THE UNIVERSITY of ADELAIDE

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