GO8 MEDICAL WORKFORCE ROUNDTABLE:
SECURING THE FUTURE OF AUSTRALIA'S MEDICAL WORKFORCE

PROGRAM

Friday, 1 April 2022
10:00am – 12:00noon (AEDT)

HYBRID EVENT:

Monash University Conference Centre Boardroom
Level 11, 30 Collins St
Melbourne

Join Zoom Meeting
Meeting ID: 998 2350 7470
Passcode: 010354

GROUP OF EIGHT AUSTRALIA

CONTENTS

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PROGRAM

09:45	***Virtual Room Open***
09:45–10:00	Virtual room open for attendees to test/connect before forum
10:00–10:30	**WELCOME AND OVERVIEW (30 MINS)** ■ **Vicki Thomson** Go8 Chief Executive and Roundtable Facilitator – Welcome ■ **Professor Margaret Gardner AC** Go8 Chair, President and Vice-Chancellor, Monash University – Outline of Roundtable objectives and outcome ■ **Professor Jennifer May AM** Co-Chair, Medical Workforce Reform Advisory Committee (MWRAC) – Outline of the National Medical Workforce Strategy ■ **Professor Richard Murray** President, Medical Deans Australia and New Zealand (MDANZ) ■ **Professor Geoff McColl** Chair Go8 Deans of Medical Faculties Group, Executive Dean of the Faculty of Medicine, University of Queensland
10:30–11:15	**SESSION 1: WORKFORCE NEEDS – MEDICAL WORKFORCE CHALLENGES AND THE CONSEQUENCES OF INACTION (45 MINS)** **Facilitator: Vicki Thomson, Go8 Chief Executive** ■ Is there currently a medical workforce crisis and where in Australia is this most acute? Are workforce shortages both structural and pandemic related? ■ What is at stake for the health of the nation if we do not act? **Summary of insights on the medical workforce problems – including timeframes, solutions, consequences of inaction and what keeps sector leaders up at night:** **45 minute facilitated discussion amongst all participants.**

FRIDAY 01 APRIL 2022

11:15–11:55	**SESSION 2: SHARED NATIONAL SOLUTIONS (40 MINS)** **Facilitator: Vicki Thomson, Go8 Chief Executive** ■ How can universities strengthen the medical workforce pipeline? ■ How do we undertake immediate action – e.g. increasing the number of domestic medical graduates – in parallel with work on addressing the geographic maldistribution of the medical workforce in rural, regional, remote and outer metropolitan areas, and in parallel with the National Medical Workforce Strategy more broadly. ■ What options should we put to government as an outcome of this Roundtable? **40 minute facilitated discussion amongst all participants.**
11:55–12:00	**ROUNDTABLE WRAP (5 MINS)** **Summary of outcomes and next steps** ■ **Vicki Thomson** Go8 Chief Executive and Roundtable Facilitator
12:00	***Roundtable Close***

DISCUSSION PAPER

CONTENTS

CONTEXT AND RATIONALE

The COVID-19 pandemic has highlighted two major structural challenges of Australia's medical workforce: geographic maldistribution of the medical workforce leaving regional, rural and some outer metropolitan areas without satisfactory access to medical care; and the inadequate size of Australia's medical workforce with its dependence on International Medical Graduates (IMGs) for 30 per cent of medical practitioners.

Given the decadal time frame for training a medical practitioner, any changes implemented now will not have a significant impact until the 2030's. Therefore, to ensure better access to healthcare for all Australians, it is critical that these two challenges be addressed concurrently as a matter of urgency.

Both issues have been highlighted in the recently released *National Medical Workforce Strategy 2021–2031 (NMWS)*.[1]

The Group of Eight (Go8) Medical Workforce Roundtable is focused on seeking solutions to these challenges through increasing national supply of **domestically trained medical practitioners** to meet Australia's future needs. In order to meet future demand, which will only increase as our population ages, we recommend accelerating the implementation of the NMWS recommendations.

The focus of discussion will necessarily be limited to the central role of universities and medical schools in the medical workforce pipeline and implications for the medical training system.

As such, it will not include detailed examination of migration policy and settings, although relevant to the issue of IMGs.

CHALLENGE 1: AUSTRALIA'S MEDICAL WORKFORCE

The composition of Australia's medical workforce by qualification, role, employer, jurisdiction, funding and geographical distribution is incredibly complex.

Australia's medical profession comprises 23 specialties, and 82 specialist titles regulated by the Medical Board of Australia (MBA) – including General Practice.[2] The MBA is also currently reviewing an application for the inclusion of Rural Generalist Medicine as a specialist field.

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.[3]

According to the latest OECD data, Australia has 3.8 medical practitioners per 1,000 population which places Australia only 13th in the OECD[4] and by the World Bank, World Development Indicators this places Australia 35th in the world by this measure.[5]

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

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

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

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

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

CONTEXT AND RATIONALE *continued*

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.[6] 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.[7]

> *Different parts of Australia rely on IMGs more heavily than others, particularly those in rural and remote areas, and specific urban locations. IMGs are, at present, critical to ensuring the delivery of medical care in many parts of Australia.* (Reducing the reliance on international medical graduates, pages 40–41).

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.[9]

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.*

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 – indicating a structural dependence of the Australia's medical workforce on International Medical Graduates (IMGs).[8]

The NMWS highlights the issue, including its impact on rural and remote areas:

> *The benefits of self-sufficiency, and the challenge of our continued reliance on IMGs became increasingly apparent during COVID-19.* (Understanding national self-sufficiency, page 30)

Annually, the inflow of IMGs into Australia is approximately 3,000 (2,993 in 2019) – noting that Australian medical schools graduated 3,834 new doctors in 2020 with 817 of these being international students[10]. **That is, roughly 40 per cent of new additions to Australia's medical workforce are IMGs – significantly higher than the 30 per cent of the entire medical workforce that are IMGs.**

While IMGs will continue to play a critical role in Australia's medical workforce – in the interest of boosting sovereign capability in the national medical workforce and meeting future demand, Australia needs to consider the balance between IMGs and domestically trained medical practitioners.

6 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.

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

8 National Health Workforce Dataset, Accessed 18/3/2022

9 Calculated from OECD Health Workforce and Population Statistics

10 DESE Award Course Completions Pivot Table: https://www.dese.gov.au/higher-education-statistics/student-data/selected-higher-education-statistics-2020-student-data-0

As global competition for medical practitioners increases, in order to increase sovereign capacity in Australia's medical workforce it will be necessary to increase the domestic pipeline of medical graduates.

Further, as Australia's population ages and we deal with unexpected medical crises as seen with COVID-19, future demand on our medical workforce is likely to increase.

Australia's population is growing older, faster than expected and life expectancy will continue to increase, putting increased pressure on our health system.

The 2021 Intergenerational Report (IGR) which focusses on key economic and demographic trends highlights a key challenge as being the continued demographic ageing of the population.[11]

> *In 2060–61, 23 per cent of the population is projected to be over 65, a rise of around 7 percentage points from 2020. Right now we already are in the middle of the biggest demographic transition of the last century.*[12]

According to the IGR, spending on health, per person, is projected to more than double in the next 40 years. Baby boomers are reaching retirement age, we are living longer which is welcome, but the impacts on the economy and health system will be profound.

CHALLENGE 2: THE GEOGRAPHIC MALDISTRIBUTION OF AUSTRALIA'S MEDICAL WORKFORCE

The geographic maldistribution of Australia's medical workforce is a longstanding and complex issue and has been well documented in the NMWS (pages 37–38).

> *Appropriate distribution of the medical workforce is critical for providing an appropriate level of health services for all communities.*
>
> *Around seven million people, or 29% of Australia's population, live in rural and remote areas.*[13]
>
> *Since 2013, the annual rate of increase of employed doctors outside of the cities (MM 2 to MM 7) was 3.9%, the FTE was 3.4% and the population was 0.7%.*[14]

The factors contributing to this are well known, and include remuneration and recognition barriers, lifestyle requirements, and less sophisticated clinical infrastructure to support clinical practice and other career interests such as research, teaching and new technology.

Since 2013, the annual rate of increase of employed doctors outside of the cities (MM 2 to MM 7) was 3.9%, the FTE was 3.4% and the population was 0.7%.

11 https://treasury.gov.au/publication/2021-intergenerational-report

12 https://joshfrydenberg.com.au/latest-news/intergenerational-report-release/

13 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.

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

CONTEXT AND RATIONALE *continued*

The pursuit of specialist training also means many medical practitioners are required to move from regional to metropolitan centres.

There has however been some recent progress made in fostering the intention of medical students to practice in regional, rural or remote areas. 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.[15,16,17]

THE ROLE OF UNIVERSITIES

Universities are only 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.

The Department of Education, Skills and Employment (DESE) reports that Australia currently has 19 universities producing medical graduates with approximately 62 per cent of annual medical completions taking place in the Go8.[18]

Government support for medical training – Commonwealth Supported Places (CSPs) – through the Commonwealth Grant Scheme (CGS) caps the number of places, with medicine the only discipline in which such a cap is currently imposed. In practice, universities can negotiate with Government to also offer non-government subsidised medical places to international students and full fee-paying domestic students. Universities with an accredited medical program and not in receipt of medical CSPs may accept full fee-paying students without restriction.

Despite being in the highest band of Government subsidy for university teaching under the CGS ($38,644 per student place in combined Government contribution and student fees with an additional medical student loading applied), medicine is one of the most expensive courses to teach. This is the case even though most medical courses are substantially subsidised by pro-bono teaching from medical professionals whose main employment is in the broader medical system.[19]

Australian universities have a significant footprint in rural and regional medical education supported by the Government Rural Health Multidisciplinary Training program comprising 19 Rural Clinical Schools, 19 University Departments of Rural Health and 26 Regional Training Hubs. (See Appendix for detail)

In addition to this, universities are also required to reserve 28.5 per cent of their medical CSPs for students as part of the Bonded Medical Program.[20]

15 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.

16 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.

17 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.

18 2020 Student Data from the Higher Education Statistics collection. The respective medical schools of Macquarie University and Curtin University also reported completions in 2021.

19 See, for instance, Oates R. Kim, Goulston Kerry J. (2012) The hidden cost of medical student education: an exploratory study. Australian Health Review 37, 185–188.

20 https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-st-bmp

Go8 members are heavy lifters in the rural/regional training space with each having a sizable Rural Clinical School, involved in the majority of the Rural Training Hubs and with many students undertaking either end-to-end regional medical training or significant rotations through regional training precincts. 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.

These rural and regional medical training initiatives are increasing demand amongst medical students to practice in regional areas, however progress is being impeded by the fixed cap on medical CSPs. Any recent additions of new medical schools and expansions to existing medical schools have been the result of clawing back CSPs from world class medical schools (predominantly in the Go8).

Exacerbating this issue, was the clawback of 2 per cent of CSPs announced as part of the 2018–19 Federal Budget. This clawback has only been partly implemented (sufficient to support the creation of the new Orange medical school) due in large part to concerns expressed by the broad medical education sector that this measure is only tinkering at the margins of necessary reform, providing no capacity for substantial strategic medical education initiatives. In addition, it erodes the capacity of medical schools to pursue their existing regional medical education programs.[22]

To increase the number and effectiveness of regional medical education programs – particularly in the context of Australia's lower than OECD average number of domestically trained medical practitioners per capita –the obvious solution is to increase the pool of medical CSPs.

Despite being in the highest band of Government subsidy for university teaching under the CGS ($38,644 per student place in combined Government contribution and student fees with an additional medical student loading applied), medicine is one of the most expensive courses to teach.

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

22 https://go8.edu.au/go8-submission-go8-response-to-the-discussion-paper-on-the-redistribution-pool-of-medical-places

OBJECTIVES AND OUTCOMES

Motivating the objectives and outcomes for this Summit are five essential observations:

- Australia's medical workforce has been significantly challenged by the demands of COVID-19.
- Australia is below the OECD average in the number of domestically trained medical practitioners per capita and above the OECD average in percentage of the medical workforce trained overseas.
- Australia has an unequal geographic distribution of its medical workforce which impacts rural, regional and some outer metropolitan communities.
- The supply of domestically educated medical graduates comes from universities – supported (in part) by Government funding. The current level of capping on Commonwealth Supported Places is constraining the nation's ability to address these medical workforce issues.
- Solutions to the medical workforce challenges must come through teamwork – a strong collaboration between universities, professional bodies, and the public and private health sectors, facilitated where necessary by Government. These solutions will not be a "tweak" of business-as-usual practices and funding.

The ***objective*** of this Summit is to provide the opportunity for universities, professional bodies, the public and private health sectors, and government stakeholders to discuss and develop policy solutions to enable universities to deliver the domestically trained workforce necessary to meet the nation's future challenges.

Policy options should be aimed at increasing the overall medical workforce to meet future demand but also allow the flexibility to deliver the workforce required for specific geographic areas across the range of medical services and specialties.

Consideration should also be given to the cost of inaction as an enhanced medical workforce is a "must have" for Australia's health and economic future.

Given time constraints it is proposed that discussion focus be on the core medical education at *universities* and indicating where action needs to be taken in other areas to integrate these actions into the broader medical workforce pipeline.

The *outcome* of this Summit will be a fast-tracked development of an options paper from the group to government outlining solutions to the medical workforce challenges facing Australia.

PRIORITY AREAS FOR DISCUSSION

TOPIC 1: AUSTRALIA'S CURRENT AND FUTURE MEDICAL WORKFORCE CHALLENGES

Australia's medical workforce provides services across a range of specialties to geographically and culturally diverse communities.

Any reform to the education of Australia's medical workforce must consider the diversity of local health area needs and be flexible enough to address them in an effective, coordinated way.

Key Questions

1. What are the local pressure points for Australia's medical workforce and what has been the impact of the COVID-19 pandemic?
2. What is the scale of the increase in/pivot of the medical workforce required by Australia in the:
   - **a.** Short-term: 0–2 years
   - **b.** Medium-term: 3–5 years
   - **c.** Long-term with a focus on emerging medical services and demographic shifts: 5+ years?
3. What is the mix of medical disciplines needed from the future medical workforce?
4. What balance should be struck between upskilling or reskilling existing medical practitioners and producing new medical graduates?

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PRIORITY AREAS FOR DISCUSSION
continued

TOPIC 2: THE ROLE OF UNIVERSITIES IN AUSTRALIA'S MEDICAL WORKFORCE PIPELINE

Australian universities provide qualifications in foundational medical education and provide additional qualifications that expand the roles that a medical professional may undertake in the medical workforce. This may include medical research qualifications – such as PhDs – or qualifications in associated disciplines such as, for example, public health or health economics.

Key pathways include:

- **Undergraduate medical programs**: typically taking six years.
- **Postgraduate medical programs**: typically taking four years.
- **Upskilling**: To upskill an already accredited medical practitioner there are a number of options including microcredentials, graduate certificates, graduate diplomas, and masters and PhD degrees – taking anywhere from a few weeks to four years. It should be noted that this education may also be undertaken concurrently with or even before foundational medical education.

Identifying the mix of these pathways to meet medical workforce demands is a key challenge. However, other challenges include:

- Increasing the exposure of medical students to training in rural, regional and outer metropolitan areas and in-demand medical disciplines.
- Resolving the blockages in the broader medical workforce pipeline that prevent existing demand created for rural and regional practice created by medical education being translated to correct the geographic maldistribution of Australia's medical workforce.
- Ensuring universities can support all required medical pathways and transition into the next phase of the medical workforce pipeline. Medical education is expensive and funding levels under the Job Ready Graduates package (noting a slight rise in funding for medicine) places pressure on delivering education in a wider variety of disciplines and locations as well as an increasing demand for funding for internship arrangements.

Key Questions

1. What is the scale of the uplift required in the medical workforce pipeline to match demand – particularly in rural, regional and remote areas? Can this be done at the same time as increasing Australia's sovereign capacity in medical training?
2. What broader medical workforce pipeline changes need to be implemented (e.g., in internship positions and specialty training) to maximise the impact of existing and future-enhanced university medical training?
3. What additional activities can medical schools and universities undertake in the short term to address immediate pressures on the medical workforce?

APPENDICES

Profile of the Go8

The Group of Eight (Go8) represents Australia's eight consistently leading research-intensive universities. It is the main policy development and advocacy unit of its members. It also plays a leading role in wider policy development and national and international areas such as national security.

The Go8 universities are: 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.[23,24]

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.

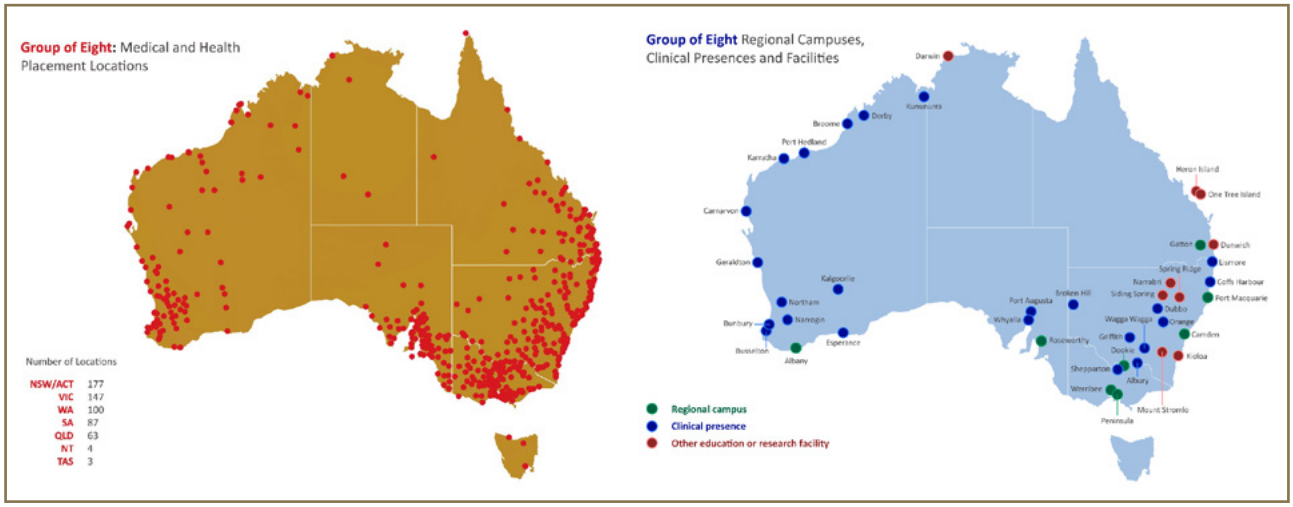
In research, the Go8 spends $6.5 billion on R&D including $3 billion on research in the fields of Health and Biological Sciences.

To prosecute this research agenda, 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.

This research is conducted at a standard that sees over 99 per cent of Go8 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 Regional, Rural and Remote Medical Education

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



23 2021 Academic Ranking of World Universities

24 2022 Times Higher Education Rankings 2022 for Clinical and Health

GROUP OF EIGHT AUSTRALIA

MEMBERS

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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