

RESPONSE TO THE GENERAL PRACTICE ATTRACTION STRATEGY – DISCUSSION FRAMEWORK

November 2023

INTRODUCTION

Thank you for the opportunity to comment on the GP attraction strategy – discussion framework.

General Practitioners (GPs) are a vital part of our health care workforce. They play a major role, both individually and as part of multidisciplinary teams, in providing frontline care to people in our communities. GPs develop ongoing relationships with patients to provide holistic, continuous care across the different life stages that takes into account the broader context in which people live. This type of care is the cornerstone of Australia's health system.

As highlighted in the discussion framework, GPs – along with certain other specialities and health workforce more generally – are an area of workforce need in Australia.

The university role in health and medical workforce development

Universities Australia (UA) is the peak national body representing Australia's 39 comprehensive universities. These universities educate and train virtually all of Australia's new-entry domestic medical and health professional workforce¹. Without universities, there would be a significant shortfall – greater than there already is – of these vital professionals. Universities also provide ongoing education, upskilling and reskilling opportunities for existing health professionals - both domestic and international - as well as undertaking health research. We therefore have a strong interest in health professions education, workforce policy and related regulation.

Twenty-one universities currently provide medical education leading to provisional registration as a junior doctor. In 2022, 3805 medical students graduated from medical schools in Australia², ready to enter the workforce as interns.

Context of this response

The education provided to medical students by universities and medical schools has an impact on overall health workforce volume, skills and distribution (to specialty and setting). However, medical schools are not the only factor influencing medical students' experiences and career choices. Almost as much medical education occurs post medical school as it does within the university. Even during university, much medical education and training is dependent on experiences provided by and within health services where students undertake clinical placements. As outlined in the discussion framework, a range of other factors also impact medical students' career choices. Our response therefore centres on the discussion paper's focus areas (FAs) most relevant to universities (FAs 1, 4, 7 and 9) particularly sections about university/medical school education. Responses to the discussion papers' questions are implicit throughout.

Similarly, as the peak body for all universities, our response is from a whole of sector perspective which considers the broader university context and the potential contribution of other health disciplines, where relevant. We refer the Department of Health and Aged Care (DOHAC) to the Medical Deans Australia and New Zealand (MDANZ) submission for responses specific to medical education.

¹ This includes domestic and international students who have studied health professional entry qualifications in Australian universities.

² Medical Schools Outcomes Data (MSOD) National Data Report 2023: <https://medicaldeans.org.au/medical-schools-outcomes-database-reports/>

RESPONSE TO RELEVANT FOCUS AREAS

FA1: Early exposure

Existing efforts

UA acknowledges the programs and approaches listed in the “existing efforts” section, many of which involve universities. These approaches have generally contributed to general practitioner/rural practitioner workforce growth and are broadly supported.

We also recommend development of a program that provides post medical school, pre-specialist junior doctors with extended exposure (three to four months minimum) to general practice. Extended exposure to quality general practice/primary care experiences in the pre-vocational years enable junior doctors to experience the connection to patients and the community that general practice provides. It can be instrumental in junior doctors choosing general practice as a speciality.

We recommend that any such program be developed in close consultation with universities/MDANZ as well as with the Royal Australian College of General Practitioners, (RACGP), the Australian College of Rural and Remote Medicine (ACRRM) the Australian Medical Council (AMC) and medical students. The program could include extending the universities’ current Regional Training Hub (RTH) role to include support for medical graduates interested in a prevocational general practice experience.

Gaps and opportunities to consider

UA broadly supports points four to nine presented in the framework under “Gaps and opportunities” and provides feedback below on points one to three:

Re point 1: promoting general practice careers/pathways to young people from under-represented communities: Universities already participate with schools, industry providers and others in activities such as careers expos to promote study programs and pathways within their communities. This includes activities targeted towards under-represented groups. A major focus of the current Universities Accord is widening participation through student diversification. The final report of the Universities Accord is still awaited (due at the end of 2023). However, it is highly likely that under the Accord, universities will further increase their efforts to drive enrolment growth across a broader range of students.

Re point 2: “Lowering entry scores for medicine or creating pathways through health science into general practice”: Lowering entry scores for medicine is not supported for the following reasons:

- Entry requirements to university courses are set by the university³. This includes entry scores for all degrees. Entry scores are one of multiple factors considered by a university regarding student entry to a course. It is up to each university to determine the overall suitability of a student to undertake and complete a program of study. Determinations are based on a comprehensive assessment of a student’s overall capability, capacity, motivation and other factors.
- Many medical students already believe that general practice does not have a high status within the medical profession⁴. Lowering entry scores for medicine (potentially with a view to offering a specific general practice stream through medical school – see comments re point 3) is likely to further widen the gap between general practice and other medical specialities.

We seek further clarification about what is meant by “pathways through Health Science into General Practice”. If this refers to study pathways into medicine from other health disciplines, then these already exist. For example, in 2022, about two-thirds of medical students entered university with a prior post-school qualification ranging from certificate to postgraduate degree level. This figure has remained stable over the last five years. In 2022, nearly half of the medical students with prior degrees had gained their previous degree in a health-related field⁵.

³ Although some professional accreditation bodies stipulate certain requirements, for example around English language requirements.

⁴ D Pols; H Kamps et al. BMC Medical Education Feb. 2023 [Medical students perceptions of general practice: a cross-sectional survey](#)

⁵ Medical Schools Outcomes Data (MSOD) National Data Report 2023: <https://medicaldeans.org.au/medical-schools-outcomes-database-reports/>

Re point 3: Link CSP funding to GP outcomes: We seek further clarification about what this means. It is currently unclear if it means payment of CSPs to universities dependent on their graduating medical students who select general practice as a speciality. If so, this is not supported. Properly supported, universities are willing to work in partnership with relevant stakeholders to enhance medical students' general practice and primary care experiences while at university. However Medical students undergo at least two – often more - years of general medical training post-medical school. During this time, the university/medical school has little to no jurisdiction over medical graduates. Universities are not in a position to influence career choices of interns/junior doctor at this stage of their training.

Alternatively, linking CSP funding to GP outcomes could mean development of a GP stream within medical schools for which there are specific CSPs allocated. UA refers DOHAC to MDANZ's submission for views on specific general practice streams within and beyond medical school.

Point 9: Develop opportunities for First Nations students to undertake primary care placements. We support increasing access to primary care placements for First Nations students - and for health professional students more broadly. This includes placements in both Aboriginal Community Controlled Health Organisations (ACCHOs) as well as in mainstream primary care services. Our ideas about expanding placements in ACCHOs have been provided to DOHAC in our submission to the National Aboriginal and Torres Strait Islander Health Workforce Strategy⁶. Further ideas about primary care placements are provided in our response to FA4.

FA 4: Supervision, accreditation and placement experience

For specific feedback on “Existing efforts” and Gaps and opportunities to consider” see MDANZ's response.

General comment re placement quality and supervision: Publicly accessible data on the exposure of medical students to general practice/primary care is lacking. However, anecdotal reports suggest that this is low and of variable quality. As outlined in the discussion paper, universities' capacity to oversee experiences of medical students within general practice are limited.

As the discussion paper also highlights, while overall medical graduate numbers are increasing, Australia is experiencing a relative decline in general practitioners. Factors contributing to this include:

- lower proportions of junior doctors choosing general practice as a specialty post-university; and
- the increasing care needs of consumers presenting to general practice. (The increasingly chronic and complex nature of presentations requires more GP time/more frequent visits.)

This relative decline exacerbates the challenge of increasing the capacity for quality medical student placements in general practice.

Previous work has highlighted some of the barriers to general practice participation in teaching/supervision⁷. These include:

- adequate space/infrastructure;
- lack of practitioners' confidence in their teaching ability;
- lack of time to teach,
- inadequate remuneration for teaching; and
- other aspects associated with the small business environment of general practice.

Various policies have been implemented over the last decade to support capacity building in general practice including in teaching⁸. However, Practice Incentive Payments (PIP) data suggest that less than 25% of general practices claim the teaching PIP⁹. This suggests that about 75 percent of general practices currently do not take students/registrar. This is a significant amount of untapped capacity. Unlocking some of this capacity, including by better understanding - and addressing - the barriers and enablers to general

⁶ Available on UA's website

⁷ A Dallas, W Gin et al. Medical students value-adding to general practice – a qualitative study. Australian Journal of General Practice Mar. 2022 [Medical students value-adding to general practice](#).

⁸ e.g. an increase in the teaching PIP; general practice infrastructure payments; the Workforce Incentive Program (WIP) to build multidisciplinary capacity; support for nursing/allied health students to undertake clinical experiences in primary care; My Medicare.

⁹ Based on 2015 and 2016 financial year PIP data - averaged over quarters - the latest publicly available data.

practice supervision, would support more medical students to undertake meaningful clinical learning experiences in general practice.

UA has long advocated for partnership approaches between universities and health services to develop customised placement strategies. Partnership approaches bestow multiple benefits on health services, patients and students¹⁰. This includes building supervision capacity and promoting quality learning experiences for students linked to clear learning objectives. Previous policy support for such approaches in other practice settings has been fruitful¹¹ and a similar approach could be developed for general practice.

We would welcome the opportunity to be part of a broader, multistakeholder primary care clinical education and placement working group to determine a collaborative approach to expanding and supporting placement capacity/supervision in general practice. The multistakeholder group would include representatives from higher/tertiary education, the professions, accreditation bodies, primary care networks, ACCHOs and general practice. It would advise on quality general practice/primary care placement models - for medical and other health professional students – and how these could contribute to interprofessional education/collaborative practice (IPE/IPCP - see also response to FA 9 also).

FA 7: Culture and Prestige Perceptions

Existing efforts

We acknowledge the Government's support to universities to deliver the following programs:

- the Rural Health Multidisciplinary Training (RHMT) Program; and
- Medical Student Networks as part of the broader National Rural Health Student Network.

These have been shown to make a significant contribution to workforce development and distribution in rural/regional Australia. We support their continuation and further expansion.

Gaps and opportunities to consider

Re points 1 and 2: Decisions about academic staff appointments are made by each individual university. However, the small business nature of general practice can make it difficult for GPs to accept academic appointments, especially where these lead to loss of income and/or decreased patient care due to inability to backfill GP time. We therefore support mechanisms that enable GPs to move more easily between clinical and academic work. This includes GPs taking up academic teaching and research positions (point 1), and potentially, more senior university roles (point 2) as appropriate to each university's own staffing decisions.

Previous programs and agencies¹², have supported GP and other primary health care professionals' involvement in academia to good effect¹³. Programs such as the Primary Health Care Research Evaluation and Development (PHCRED) strategy led to gains in primary care teaching and research, particularly the latter¹⁴. The Australian Primary Healthcare Research Institute (AHCRI – a plank of PHCRED) undertook priority-driven research which improved the quality and effectiveness of primary health care (PHC)¹⁵. Both PHCRED and AHCRI raised the profile of primary care, of which general practice is the foundation. Importantly, it offered general practitioners and others in primary care the opportunity to combine clinical and academic work. This promoted the presence of GPs/primary care within universities and enabled GPs to pursue portfolio careers that combined clinical practice, teaching and research. We recommend revisiting a PHCRED style program to further support this aim.

Re Point 3: Introduce anti-denigration policies into universities: Universities already have broad policies/procedures and codes of conduct in place to support campuses to be safe, fair and anti-discriminatory environments. These exist within every university. UA's member universities have also

¹⁰ TRACS to the Future, National Evaluation of Teaching and Research Aged Care Service (TRACS) 2015: https://digital.library.adelaide.edu.au/dspace/bitstream/2440/123068/1/Barnett_National_Final_P2015.pdf

¹¹ Ibid

¹² Such as the Primary Health Care Research, Evaluation and Development (PHCRED) program and the Australian Primary Health Care Research Institute (AHCRI)

¹³ L Brown and E McIntyre, 2012: The contribution of Primary Health Care Research, Evaluation and Development-supported research to primary health care policy and practice: <https://www.publish.csiro.au/py/pdf/PY12058>

¹⁴ Ibid

¹⁵ [ANU Australian Primary Health Care Research Institute \(AHCRI\) 2003 - 2015](#)

endorsed UA's Indigenous Strategy. The updated strategy (released in early 2022) strengthened universities' commitments to creating culturally safe campuses free from racism. We understand the suggestion in the discussion framework to be an anti-denigration policy specifically targeted towards medical studies. Our view is that this is already covered in universities' broader policies. A specific anti-denigration policy for medical faculties is not supported.

FA9: Teamwork and collegiality

For specific feedback on "Existing efforts" and Gaps and opportunities to consider" see MDANZ's response.

General comment re teamwork and collegiality: The discussion paper suggests that general practice registrars experience challenges in moving from hospital-based post-graduate medical years to general practice registrar roles. The challenges include:

- lack of confidence in clinical decision-making across a broad range of illnesses, especially in settings where diagnostic resources may be scarcer (than in hospitals); and
- new social expectations and difficulties - although these are not elucidated.

It is not uncommon for beginning practitioners in all disciplines to lack confidence in their abilities. A key goal of quality clinical training and experience is to embed not only skills but also confidence in future new-entry practitioners. Ways to support this have been outlined earlier in this submission, including:

- increasing quality clinical general practice placements; and
- offering an optional extended prevocational general practice period for post-medical school interns

A major difference for GP registrars compared to hospital doctors is that GPs – and therefore GP trainees¹⁶ - tend to practice alone, not as part of a team (although the increasingly private practice nature of allied health provision means that many allied health professionals experience this too.)

GPs have traditionally practiced autonomously. However, the bulk of presentations to general practice are now chronic and complex conditions. These require – and respond better to – multidisciplinary team-based care. There is clearly a need for more GPs overall. However, building more multidisciplinary capacity in general practice not only supports patient outcomes, it also provides a more supportive team environment for GPs, medical students and trainees – and other primary care practitioners.

Understanding how to work as a multidisciplinary/multi-professional team starts at university through interprofessional education (IPE) and exposure to Interprofessional collaborative practice (IPCP). IPE teaches students how to draw on each discipline's areas of expertise. It is reinforced as students' understanding of their own discipline deepens. All university-based new entry health professional programs of study include professional accreditation standards for IPE. Students' IPCP and IPE experiences are dependent to an extent on the degree to which they are modelled in health services. As highlighted in the discussion paper, you can't be what you can't see.

The Workforce Incentive Program (WIP) already provides incentives to general practices who employ nurses, Aboriginal and Torres Strait Islander health workers/practitioners and allied health professionals. We strongly encourage further promotion and uptake of the WIP. This will both:

- promote team working for GPs/trainees; and
- build greater supervision/placement capacity and interprofessional learning opportunities for a range of health professional students in primary care, including medical students.

We also encourage greater opportunities for cross-disciplinary supervision in general practice/primary care. This will necessarily involve discussion with multiple stakeholders including the professions, accrediting bodies, education providers and government. As outlined in our response to FA4, we recommend a primary care clinical education and placement group is formed to look at placements and interprofessional learning opportunities/team-work in general practice/primary care. The current scope of practice review also offers

¹⁶ Registrars are able to practise without direct supervision of every clinical encounter from their first general practice term. However, the supervisor is expected to be onsite and available during practice hours for most of the first term of training.

opportunity to review full and expanded roles for health professionals and how these can provide effective patient care and supportive workplaces.

In relation to social challenges in general practice: Aspects of this are already addressed through relevant education and training at medical school. In practice, it can also be supported through multidisciplinary team care where primary care teams include relevant allied health professionals. Although out of the scope of universities, we also recommend further consideration of policy to support social prescribing in primary care. Social prescribing is a new and emerging field in Australia. However, it has been successful in countries such as the UK in better integrating health and social care services.

Further comments

Health workforce development occurs within a complex adaptive system in which levers for change are held by many different parties. Transformation requires a concerted, long-term effort and commitment by all involved. We welcome the current work looking at various health workforce aspects, including the contribution of health professions education to workforce¹⁷. We continue to recommend a multi-stakeholder, whole-of-health workforce and education approach to achieve the necessary policy and operational alignment. We welcome further opportunities to contribute to this important work.

¹⁷ Including, development of the National Nursing and Midwifery workforce strategies; Scope of practice review, implementation of the Medical Workforce Strategy: Increased medical CSPs; Universities Accord.