1. Australia’s has no system for health workforce planning and, partly as a result, there are shortages of health professions in many parts of Australia. The result is poor access to care. This issue is relevant to the first of the terms of reference. 2. The Commonwealth regulates the number of medical school places, but has been pretty bad at doing that effectively over decades, but one can always live in hope that they might one day get their act together. 3. Apart from that, at present universities and vocational education providers (hereinafter, universities) make independent and autonomous decisions about how many students they will enrol and in what health professional programs. They often do this with no concerns about what the priority system needs are, and potentially, may not be aware of what they are. Universities are often motivated by the high average quality of students in health professional courses. 4. In my view there should be better mechanisms for coordinating the decisions of universities about enrolments, and the needs of health services and other sectors which employ health professionals. 5. Clinical placements are often the rate-limiting factor for universities in expanding intakes. Planning of intakes should be associated with agreement by health services on provision of adequate number of clinical placements. 6. One way of better linking university intake decisions with need would be to establish state-based compacts, or like term, between educational providers, health providers, the Commonwealth, and states. 7. Under the compacts, participating universities should have certainty that the necessary clinical placements would be provided. The compacts could ensure a better link between needs and supply of health professionals. Non-participating institutions would, of course, be free to do their own thing, but with no guarantee that clinical placements would be provided.