



Response to the

Australian Universities Accord
Discussion Paper

April 2023

Introduction

Thank you for the invitation for Medical Deans Australia and New Zealand (Medical Deans) to provide feedback to the Discussion Paper released by the Australian Universities Accord Panel (the Panel).

Medical Deans is the peak body representing the 22 Australian and 2 New Zealand university medical schools, whose responsibility is to educate, support and foster a future medical workforce attuned to, skilled in, and well-prepared for the healthcare needs of our communities. Our university members also have a strong commitment to and role to play in our graduates subsequently seeking to progress 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, in general practice and other generalist specialties, and in areas of rapid population growth.

As highlighted in Table 1 of the Discussion Paper, the health disciplines are a substantial proportion of student enrolments (19.2%). The paper also recognises the increasing demand for skilled labour in the personal and health care sectors and references the impact that the COVID-19 had on the health workforce and health professional education.

Our response is structured around six key areas:

1. Investing in domestic-trained students
2. Widening participation
3. Universities as anchor institutions in the regions
4. Students' learning and experiences
5. Partnerships with postgraduate stakeholders
6. Teaching, training & research

Our responses are grounded in the context of medical education, medical schools and healthcare, but have relevance to higher education more broadly.

We make 23 detailed recommendations, and would welcome discussion with the Panel to further articulate the key opportunities, challenges and potential for step-changes that will see our higher education sector remain strong, vibrant and a core contributor to Australia's society, economy and labour market.

Summary of recommendations

Medical Deans recommends the Accord Panel:

Section 1. Investing in domestic-trained students

1. Recognises and supports the need for a substantial increase to the number of medical school places, to invest in developing the doctors Australia needs.
2. Supports moves to develop a joint position between universities and WIL partners on the individual and shared roles, responsibilities, and funding needs to enable teaching, training and research to be embedded into the work environment; including specific needs of regional, rural and remote environments.
3. For students studying medicine, recommends the HELP loan limit is increased to more realistically match tuition fees for domestic full fee paying students.

Section 2: Widening participation

4. Sets targets for First Nations enrolments to be above population parity, in order to more quickly address the current disparity in employment and professions' representation.
5. Incentivises and recognises a university's contributions to increasing First Nations participation in a medical program/higher education, in addition to their individual enrolments.
6. Reviews the AQF and how it might be applied in the context of more flexible and varied options to enable wider participation in the higher education sector.
7. Ensures additional funding is allocated for the levels of student support needed to ensure those from disadvantaged backgrounds have the services and resources needed to support their entry into and progression through university.
8. Makes education and training locally accessible to remote and regional students (see below).

Section 3. Universities as anchor institutions in the regions

9. Recommends building upon regional university campuses to enable universities to act as anchor institutions to encourage and enable greater connections and partnerships in the community, with graduate employers and with specialty medical colleges.
10. Develops incentives and mechanisms for universities to contribute to postgraduate training, support and career progression.

Section 4. Students' learning and experiences

11. Support Medical education providers to ensure that curricula and placements have a sufficient focus on generalist skills and the provision of care for people with long-term conditions, and their role as part of a multidisciplinary team.

12. Require the Regulator/s to progressively reflect in their accreditation standards an increased emphasis on generalist skills, multidisciplinary care, and the provision of care across traditional boundaries and in community and home-based settings.
13. Identifies as a priority funding reforms to enable a substantial growth of WIL in community-based (healthcare) settings.
14. Establish strengthened arrangements to ensure students can be connected into workplaces settings where they will experience digital (health) and AI innovations, recognising the placement training costs in these areas. This needs to improve students' access to work-based systems – such as Electronic Medical Records' systems.

Section 5. Partnerships with post-graduate employers and stakeholders

15. Develop a set of shared principles between the higher education sector and the jurisdictions on the common aims of collaboratively recruiting, educating, developing and supporting Australia's future workforce.
16. Support the development of a pre-intern role for medical students, with shared responsibility between universities and health services, and sufficient flexibility to allow for adaptation to local needs and contexts whilst retaining consistency at a national level.
17. In conjunction with the jurisdictions, explore how to enable a more flexible approach to WIL, internship and students' needs, including the feasibility of enabling more than one intern intake each year.
18. Explore the higher education sector's role in educating and supporting the workplace based supervisors of our students and graduates.

Section 6. Research

19. Develops targets for the proportion of educators within a program, including ensuring sufficient management-level support for the roles.
20. Recommends the development of new university employment structures for educators and researchers that redresses the current high levels of job insecurity, underpayment, and lack of career progression.
21. Recommends the development of an Australian Clinician Researcher Training Pathway.
22. Recommends the establishment of new funding for research into educational best practice.
23. Sets national targets for the proportion of research funding provided to research into translational and systems-level research, and specifically including workforce development research.

1. Investing in domestic-trained students

In this section, we respond to the following questions in the Discussion Paper.

- Q2: How can the diverse missions of Australian higher education providers be supported, taking into account their different operating contexts and communities they serve (for example regional universities)?*
- Q3: What should the long-term target/s be for Australia's higher education attainment be by 2030 and 2040, and how should these be set and adjusted over time?*
- Q9: How should Australia ensure enough students are studying courses that align with the changing needs of the economy and society?*
- Q48: What principles should underpin the setting of student contributions and Higher Education Loan Program arrangements?*

In the context of medical education and health, there are substantial benefits to be gained from a stronger connection between higher education and the planning and delivery of the health workforce. The impact of the COVID-19 pandemic exposed many industries where Australia is experiencing labour shortages and has been over reliant on an overseas trained workforce. This has been the case in health, where each year Australia brings in around the same number of overseas trained doctors as we graduate domestic medical students and yet are still failing to address the shortages.

The contribution overseas trained doctors (or International Medical Graduates, IMGs) 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 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 Australia's 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 2021 shows that a third of Australia's medical workforce was trained overseas.¹ Of these over 11,000 were trained in India, over 2,200 in South Africa, and over 2,100 in Sri Lanka, all of whom have recognised and substantial health workforce shortages.

Whilst the primary focus of this recruitment is to fill doctor shortages in regional areas, national health workforce data from 2021² shows that three quarters (76%) of IMGs are working in major cities (MM1³) and a further 11% in areas within 20km road distance of a town with a population greater than 50,000 (MM2). In effect, the policy of overseas recruitment for the regions is ultimately contributing doctors to metropolitan areas.

¹ AHPRA medical registration data for 2021 shows that of the 121,806 doctors registered to practice in Australia and working here (i.e., excluding the 0.8% working overseas and the 3% who didn't state their location of practice) 34% received their primary medical qualification overseas.

² National Health Workforce Data Set, available at <https://hwd.health.gov.au/>

³ Using the Modified Monash Model <https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm>

The most recent Department of Health and Aged Care published data⁴ 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 were IMGs. This is not an appropriate balance. Australia has huge potential within our own population to attract and train the doctors our communities need.

However, in order to realise the benefits to our communities, health system, and the economy from this better alignment of higher education policy with health workforce planning – that is, ensuring we are delivering the doctors we need; with the right skills, working in the right location, and in the right specialties – *in parallel* to this investment in domestic medical places, we must implement other changes, namely:

i) Our approach to recruitment and admissions

The target/s referenced in the Discussion Paper's Q3 and throughout must appropriately support widening participation at university by those groups currently under-represented, and not simply increase the levels of participation by the groups traditionally favoured.

We discuss this further in section 3.

ii) Our approach to students' learning

In medicine, and health more widely, connecting more closely to industries' needs means supporting students' learning in, for, and with the settings in which we want them to establish their career. Work integrated learning (WIL) has always been a bedrock of medical and health professional education and training, however a number of areas need to be re-considered, refreshed and renewed, including:

- the role and contribution of employers to the education and support of our students, and their future workforce
- the settings for education and training, with a greater focus community-based placements
- the knowledge, skills and behaviours needed for a future career in medicine

The central 'wicked problem' for WIL is how to balance the teaching and support of students with the pressures of their other work responsibilities; in the medical context, this is of course the pressures on doctors dealing with high demand for patient care and the complexity and intensity of the clinical environment. It is a significant challenge for health services to be able to guarantee protected time for supervisors, along with the other elements necessary to support their role such as ensuring they have up-to-date skills and knowledge on adult education principles and techniques.

To support this much-needed investment in developing our home-grown medical workforce, we need to better embed teaching, training and research into the business and clinical models of health services. This will require clearer funding, responsibilities, and accountability

⁴ National Health Workforce Data Factsheet 2018 <https://hwd.health.gov.au/resources/publications/factsheet-mdcl-2018-full.pdf>

between universities and health services. As noted in the Discussion Paper (page 17), there are often specific challenges involved with WIL in regional, rural and remote areas, and these need to be better understood and better addressed.

iii) Our partnerships with future employers

Medical graduates are unusual in that domestic graduates are guaranteed a job (an internship) when they complete their degree. This is through funding arrangements between the Commonwealth and the jurisdictions via the National Health Reform Agreements.

In addition to the role employers play in our students' learning, they have huge influence on graduates' next steps in terms of choosing the location and focus of their future career. As more and more of government policy for higher education becomes focused on ensuring graduates are both job-ready and delivering the workforce Australia needs, the role of universities in supporting the career progression of students must become stronger.

We discuss this further in section 5.

Enabling a stronger focus on these three areas will support higher education providers in being able to focus on their mission (referenced in Q2); for example those medical schools with a focus on developing doctors *from and for their local area*; schools who aim to deliver graduates more likely to progress a career in *general practice*; schools with a mission to deliver *rural doctors*; as well as all schools' shared goals of also supporting clinician-researchers, clinician-educators, and clinician-leaders (discussed further in section 6).

One other barrier currently in place that specifically impacts domestic full fee paying medical students and that should be resolved is the **current value of the HELP loan limit**. For domestic students, this limit can be reached during their program. The impact of this is also felt by those international students who receive citizenship during their medical program and therefore move to a domestic full fee paying place. There is a high likelihood that these medical graduates will be in a position to repay their tuition fees. Increasing this limit for students studying medicine would remove this unnecessary impediment without a materially increased risk to government and without changing the principles underlying the program arrangements.

We recommend the Accord Panel:

1. Recognises and supports the need for a substantial increase to the number of medical school places, to invest in developing the doctors Australia needs.
2. Supports moves to develop a joint position between universities and WIL partners on the individual and shared roles, responsibilities, and funding needs to enable teaching, training and research to be embedded into the workplace environment; including specific needs of regional, rural and remote environments.
3. For students studying medicine, recommends the HELP loan limit is increased to more realistically match tuition fees for domestic full fee paying students.

Section 2: Widening participation

In this section, we respond to the following questions in the Discussion Paper.

- Q4: Looking from now to 2030 and 2040, what major challenges and opportunities should Australian higher education be focused on meeting?*
- Q5: How do the current structures of institutions, regulation and funding in higher education help or hinder Australia's ability to meet these challenges? What needs to change?*
- Q22: What role do tertiary entrance and admissions systems play in matching learners to pathways and supporting a sustained increase in participation and tertiary success?*
- Q28: What is needed to increase the numbers of people from under-represented groups applying to and prepared for higher education, both from school and from other pathways?*
- Q29: What changes in provider practices and offerings are necessary to ensure all potential students can succeed in their chosen area of study?*
- Q30: How can governments, institutions and employers assist students, widen opportunities and remove barriers to higher education?*
- Q31: How can the costs of participation, including living expense, be most effectively alleviated?*
- Q38: What governance or higher education reforms are needed to allow the higher education sector to meet contemporary demands?*
- Q40: What changes are needed to ensure all students are physically and culturally safe while studying?*

Widening participation in higher education must be a core focus for this Accord. The concept of participation at university reflecting society is still a long way off and there remain substantial practical, financial and cultural barriers in the way. We need to more effectively level the playing field if we are to achieve a materially broader representation of Australia's population enrolled in and progressing through university courses.

Specifically, more support is needed for students from low SES areas; more flexibility needed for students in different situations; and different approaches needed for universities to be a viable and desired option for those who still cannot see themselves reflected in the images and tales of university life.

In a number of areas, medical schools have made substantial inroads to increasing the participation of students from previously under-represented groups. In early 2021, Medical Deans released a Guidance document on **medical program applicants and students with a disability** – '[Inclusive Medical Education](#)'. Sustained work is continuing at schools to progress their individual approaches to the suggested seven-stage framework for an inclusive culture and set of systems and processes to support students with a disability – whether visible or invisible – starting with the concept of promoting inclusiveness and encouraging early discussions on reasonable adjustments.

In medicine, **Aboriginal and Torres Strait Islander students** comprise just over 3.5% of commencing domestic students, and just over 2.8% of domestic enrolments. The vast majority of medical schools in Australia have set themselves specific targets for Indigenous enrolments that

exceed population parity – this is especially important in health education, due to the extremely low numbers of Indigenous doctors and health professionals.

Figure 1: Aboriginal and Torres Strait Islander commencements, enrolments, and graduates in 2022 – numbers

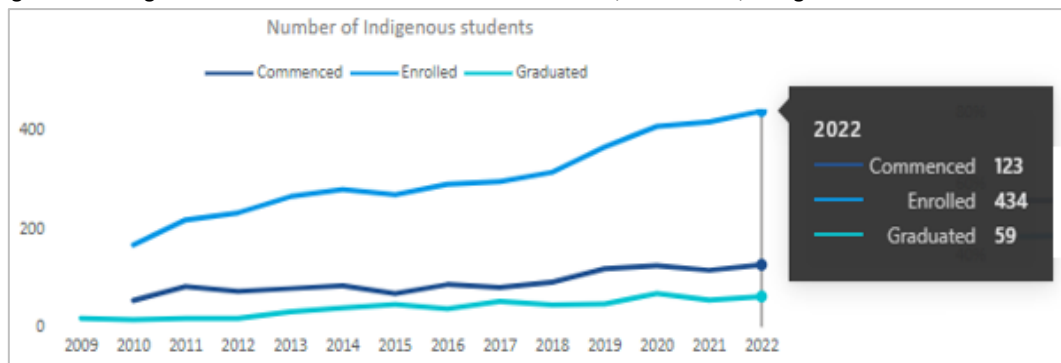
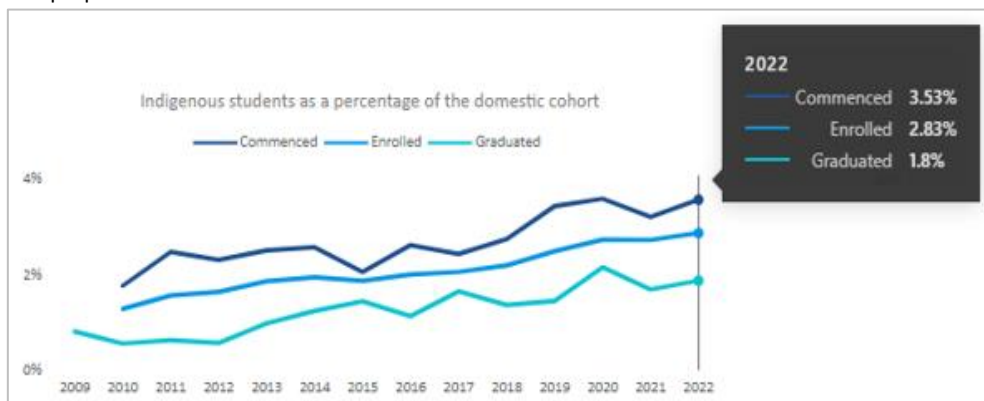


Figure 2: Aboriginal and Torres Strait Islander commencements, enrolments, and graduates in 2022 – as a proportion of the domestic student cohort



The growth in numbers has been delivered by the longstanding and committed work of medical schools to engage and partner with communities, Indigenous elders, their own First Nations alumni, Indigenous peak bodies, secondary schools and other organisations to promote medicine and university study as an option to Aboriginal and Torres Strait Islander students, and to support potential applicants in considering, applying to, commencing, and progressing through a medical program.

Whilst this work is ongoing and we expect will continue to help grow the numbers of students, one of the issues we and First Nations students face is the inadvertent consequence of competition – competition for medical school places and competition for First Nations applicants. We have multiple universities competing for a small pool of applicants, and we need to be asking about the impact this approach might be having on them – are First Nations students going to the university that is best for them? This is important, with the non-completion rates for First Nations students remaining higher than for non-Indigenous Australians.

For programs such as medicine that are not available at every university, we recommend that the Accord explore balancing the competitive nature of arrangements in this instance, and consider setting collaborative, national-level targets – above parity – and incentivise and support universities to also **collectively contribute to** the growing pool of students enrolled in a medical school no matter

which school the applicant ends up choosing. This would provide a balance to the current model which in effect is that universities compete for the small pool of potential applicants, and which does not always help the applicant to be able to compare across the programs to see which might be the most suitable for them. We have had *very preliminary* discussions with the Australian Indigenous Doctors Association, who support this idea being explored. Care must be taken that this is not read as allowing universities to not grow their own enrolments of First Nations students – this must remain a priority for each individual university, it should just not be the only approach taken.

In 2022, 34% of commencing domestic medical students were from a **rural background**⁵ (note: this excludes data from WSU for whom the data was not available for that year). It is also important to note that this has been shown to have a strong correlation with those choosing a future practice in rural areas – a key community and health system need, and thus important for universities to actively support and contribute to. One of the major barriers to those living in rural and regional locations is the need to uproot and move. This is a key reason for the drive for more regionally based campuses, however the costs involved with these campuses are significant, as are the increased calls on the educator workforce which is already struggling to meet demand.

If we are to realise the benefits of a more regionally-based higher education sector – and its value to opening up admissions to tertiary education, contributing to the social and economic fabric of rural communities, and connecting with regionally based industries and employers – we need to ensure it is properly supported.

The need to reach out and ‘recruit’ from broader sections of society

Medical school places are highly sought after, with many more applications than there are places. To substantially widen participation, the higher education sector needs to change its thinking from ‘selection’ to ‘active recruitment’ if we are to reach and attract those applicants from historically underrepresented groups. Merely changing selection criteria will have little impact unless the pool of applicants substantially changes.

Factors that need to be considered include:

- Attracting applicants who have demonstrated *academic potential* and an ability to achieve (possibly to a different level or in a different way) despite being in constrained or difficult environments or circumstances, otherwise we will continue to privilege those from higher SES groups, private schools, and those able to access costly tutoring services.
- Local, place-based models of recruitment that have been shown to be effective particularly when seeking to attract applicants who are older, have families, or ties to the local area.
- Different pathways into and through university, including differential fee structures.
- Support for a broader array of bridging and preparatory programs that address matters such as foundational knowledge, study skills, communication and writing skills.

⁵ Medical Deans’ data dashboard – Medical Schools Outcomes Database

<https://app.powerbi.com/view?r=eyJrIjoiMzEyNjRmYjAtOGFIMS00MWQzLWl0Y2UtYmVIMTgyOTM4NDQ3IiwidCI6IjY2Y4YjAxLWJhZTQtNDQ2ZC1hZWVhLTdkYTljMDFIZDBmOSJ9&pageName=ReportSection5e5459dc898591506e79>

- Flexible programs that enable a balance between study and other commitments; fundamental for those who cannot afford to cease working in order to study – an important factor highlighted in the Discussion Paper (Q31).
- How to better value prior and ongoing learning, particularly for those in similar or associated professions. For example, options for someone already working in a health profession to study medicine whilst continuing in their role part-time – there are many shared skills and behaviours that they could continue to develop from their current role. This is currently being explored in the UK through their health apprenticeships scheme.

Universities also need to give more consideration to how students can exit a program with **recognised competencies of their learning thus far** rather than being labelled a ‘failed’ student. We need to embrace (and use the language of) more flexible approaches with clearer ways to move between programs of study, however this doesn’t fit well with medical programs which have protected CSPs.

The impact of the Australian Qualifications Framework being **applied too rigidly is that it reduces the ability to flex and develop people in the directions that are needed**. More flexibility is required to enable a more responsive approach on what the different levels of learning mean, and enable some of the options that we have outlined above.

However underpinning all this must be the recognition that broadening participation requires a more flexible and person-centred approach – and that this will **inherently be more complex and costly**. It is vital that sufficient funding and support is provided to ensure that effective, relevant and sufficient help and support is available. The impact on the individual of not progressing through a course – in terms of incurred student debt, their confidence and health, and potential opportunities not otherwise taken up – could be significant.

We recommend the Accord Panel:

4. Sets targets for First Nations enrolments to be above population parity, in order to more quickly address the current disparity in employment and professions’ representation.
5. Incentivises and recognises universities’ contributions to increasing First Nations participation in a medical program/higher education, in addition to their individual enrolments.
6. Reviews the AQF and how it might be applied in the context of more flexible and varied options to enable wider participation in the higher education sector.
7. Ensures additional funding is allocated for the levels of student support needed to ensure those from disadvantaged backgrounds have the services and resources needed to support their entry into and progression through university.
8. Makes education and training locally accessible to remote and regional students (see below).

Section 3. Universities as anchor institutions in the regions

In this section, we respond to the following questions in the Discussion Paper.

Q2: How can the diverse missions of Australian higher education providers be supported, taking into account their different operating contexts and communities they serve (for example regional universities)?

Q:9 How should Australia ensure enough students are studying courses that align with the changing needs of the economy and society?

This section also addresses a number of the Questions relating to Section 2: Widening Participation

The Discussion Paper highlights the valued role of universities “*as anchor tenants of innovation precincts*” and we contend there is substantial potential for universities to play a stronger role as **anchor institutions in the regions**.

In the context of medicine and health, through the Rural Health Multidisciplinary Training Program (RHMT) the Australian government has supported the establishment and growth of regionally-based campuses – Rural Clinical Schools and their multidisciplinary counterparts, University Departments of Rural Health. As well as successfully delivering on their aims of supporting regionally-based education and training and supporting the provision of health services to local communities, an independent evaluation of the program⁶ reflected the impact that these investments have on local communities:

- *“For every dollar spent under the RHMT, another dollar is generated in the local economy*
- *Academic and professional staff contribute to the social fabric of the communities where they reside*
- *The RCS and UDRH Network has delivered multifaceted social and economic benefits to rural communities, health and community services, rural health professionals, supervisors and students, in addition to those benefits directly related to teaching and research”*

As well as supporting increased participation in higher education by rural students, leveraging the regional investment in and by universities would enable them to act as anchor institutions to stimulate and create more connections and partnerships between universities, the graduate employers and the medical colleges responsible for specialty training – **Regional Training Collaboratives**.

Aligned with the comments in the Discussion Paper on the need for stronger and more extensive university-industry partnerships, multiple reviews of health education and training and health workforce development have echoed the need for a more collaborative approach to and alignment across the stages of training; from the 2013 Mason Review of Australian Government Health Workforce Programs⁷ to the Australian Government’s 2021-2031 National Medical Workforce

⁶ <https://www.health.gov.au/resources/publications/evaluation-of-the-rural-health-multidisciplinary-training-rhmt-program?language=en>

⁷ Review of Australian Government Health Workforce Programs, Jennifer Mason, 2013: https://medicaldeans.org.au/md/2018/07/2013-April_Mason-Review.pdf

Strategy⁸ with its core theme to “*Work together*” and call for a “*whole-of-training pathway view from medical schools to Fellowship*”.

To support the communities’ need for medical graduates to progress their careers to areas of workforce shortages – that is, in rural and regional areas and in general practice – government policy is supporting the drive to increase to postgraduate training in these areas. Universities could and should play a significant role in this, providing academic leadership and support, regional infrastructure, and the basis of a national network across the regions to support better career planning and progression for their graduates.

There is the opportunity to learn from the UK experience in this area where they established **Deaneries** (in England these are now called Local Education Training Boards)⁹ and Foundation Schools¹⁰ – 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.

We recommend the Accord Panel:

9. Recommends building upon regional university campuses to enable universities to act as anchor institutions to encourage and enable greater connections and partnerships in the community, with graduate employers and specialty medical colleges.
10. Develops incentives and mechanisms for universities to contribute to postgraduate training, support and career progression.

⁸ Australian Government National Medical Workforce Strategy 2021-2031: <https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031>

⁹ UK Training Regions <https://specialtytraining.hee.nhs.uk/portals/1/Content/Resource%20Bank/Inter-Deanery%20Transfer/UK%20Training%20Region%20Websites.pdf>

¹⁰ <https://foundationprogramme.nhs.uk/contact-us/foundation-schools/>

Section 4: Students' learning and experiences

In this section, we respond to the following questions in the Discussion Paper.

- Q5: How do the current structure of institutions, regulation and funding in higher education help or hinder Australia's ability to meet these challenges? What needs to change?*
- Q8: What reforms are needed to promote a quality learning environment and to ensure graduates are entering the labour market with the skills and knowledge they need?*
- Q10: What role should higher education play in helping to develop high quality general learning capabilities across all age groups and industries?*
- Q19: What would a more effective and collaborative national governance approach to tertiary education look like?*

In a paper released September 2021, [*Training Tomorrow's Doctors: all pulling in the right direction*](#), Medical Deans laid out our vision for a medical education and training continuum that leads to an adaptable and supported workforce with the required capabilities, and in the right numbers, right places, and right specialties to serve the needs of our communities.

The paper highlighted key areas that must change in the way we educate and training our medical students and graduates, and ensure they are well-prepared for their future role:

- Generalist skills at the forefront of being a doctor.
- Teamwork and their role in the healthcare team.
- Working across traditional healthcare boundaries and in many settings.
- Skills and experiences in adapting to ongoing disruption and innovation.
- Students (and graduates) learning in and for our communities, in an education and training system that actively supports paths to careers in the regions and specialties where they are most needed.

Central to this is the need to move away from a medical education and training model that is dominated by the hospital sector, to one that **values the learning available in community-based** healthcare settings – which is where the majority of healthcare is provided, and where technology is rapidly accelerating access. In essence, our current model is substantially impeding our ability to prepare our future doctors for their role.

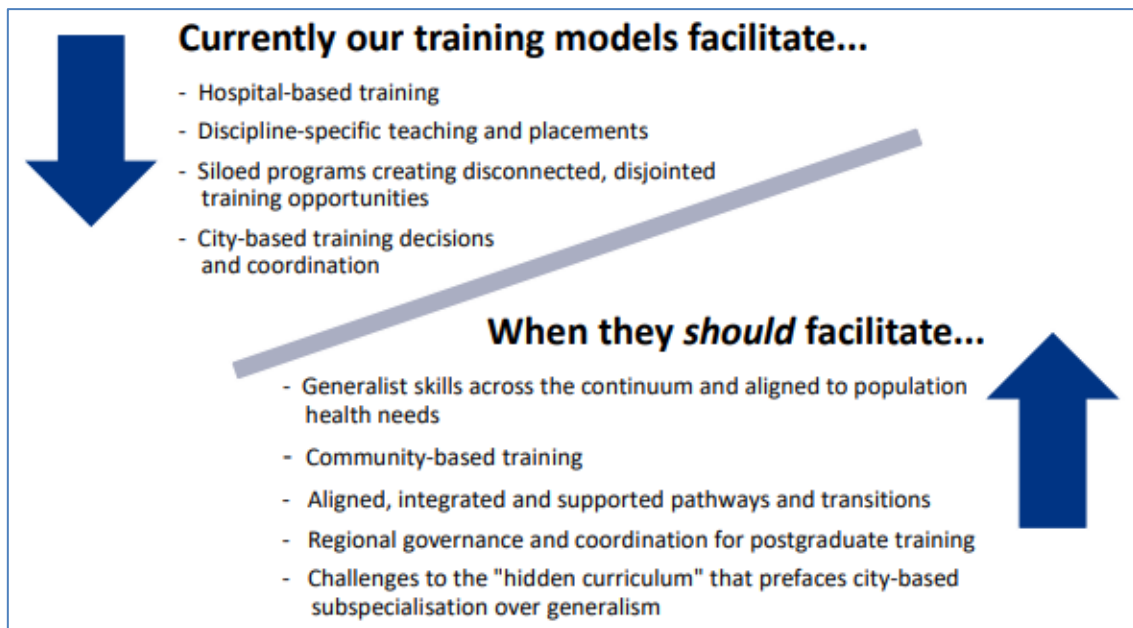


Figure 3: From Medical Deans' *Training Tomorrow's Doctors* discussion paper

Generalism at the forefront

Generalist skills – including communication, critical thinking, situational assessment and judgement, patient-centredness, complex case management – need to be at the forefront of students' learning, and nowhere is generalism demonstrated more than in primary care, aged care, disability services and Aboriginal Community Controlled Health Organisations. Support is needed to ensure that the curricula has a strong focus on generalism and sufficient and contemporary content.

Medical Deans' Medical Education Collaborative Committee, which has representation from all member schools, is currently scoping work on reviewing the core competencies for medical graduates to consider the specialist skills that can be learnt whilst in a generalist setting and conversely the generalist skills inherent in a specialist placement.

Work-integrated learning extended into more diverse settings

The Discussion Paper recognises the value of work-integrated learning and while this has always been fundamental to medical education, the settings for this learning are predominantly large, tertiary hospitals. Many forces are increasingly demonstrating that this needs to change and that student placements need to be extended out into the community-based settings where healthcare is provided: primary care and general practice, aged care, the disability sector, Aboriginal Community Controlled Health Organisations, and healthcare in the home. We need to redress the situation where our students are learning and experiencing a curriculum and set of clinical placements developed through a specialist lens of acute, episodic care despite society's needs being primarily for long-term, coordinated, complex and preventive care.

For example, mental health is a growing area of need for our society, and at the same time an area of significant labour shortage. The majority of mental health services are provided by GPs¹¹ and the

¹¹ Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW, 2020

Royal Australian College of General Practitioners' 2019 Health of the Nation report showed that people consult with their GP about their mental health more than any other issue¹². However too often the first experience of a mental health clinical setting for our students is a hospital's acute psychiatric ward. Students' learning experiences must become better aligned with society's and health services' needs.

If we are to graduate a **digitally competent** medical workforce, having students in authentic workplace learning environments where innovations are occurring and being utilised will be critical. Often, there can be impediments to this, for example additional insurance or licensing costs identified by state health departments or individual health services for student access.

We also need to expand opportunities for students to have **experiences in teaching, research, advocacy, and leadership**, so that even their early years, students can see the rewards – to themselves personally and professionally, and to their patients, communities and colleagues – of a well-rounded and socially-focused career.

For industries such as health, where state and territory governments are responsible for or closely involved with the industry / labour market, these changes will require **constructive and effective collaboration across Federal and jurisdictional governments**.

We recommend the Accord Panel:

11. Support Medical education providers to ensure that curricula and placements have a sufficient focus on generalist skills and the provision of care for people with long-term conditions, and their role as part of a multidisciplinary team.
12. Require the Regulator/s to progressively reflect in their accreditation standards an increased emphasis on generalist skills, multidisciplinary care, and the provision of care across traditional boundaries and in community and home-based settings.
13. Identifies as a priority funding reforms to enable a substantial growth of WIL in community-based (healthcare) settings, working in collaboration with those providers and their funders.
14. Establish strengthened arrangements to ensure students can be connected into workplaces settings where they will experience digital (health) and AI innovations, recognising the placement training costs in these areas. This needs to improve students' access to work-based systems – such as Electronic Medical Records' systems.

¹² The Royal Australian College of General Practitioners. General Practice: Health of the Nation 2019 Report. Melbourne: RACGP 2019

Section 5: Partnerships with graduates' future employers and educators

In this section, we respond to the following questions in the Discussion Paper.

Q8: What reforms are needed to promote a quality learning environment and to ensure graduates are entering the labour market with the skills and knowledge they need?

Q10: What role should higher education play in helping to develop high quality general learning capabilities across all age groups and industries?

Q38: What governance or higher education reforms are needed to allow the higher education sector to meet contemporary demands?

We strongly support the Discussion Paper's assertion that building more extensive, systemic and stronger partnerships between universities and industry/employers is vital. In the context of health, those partnerships also need to extend to the medical colleges who are responsible for our graduates' future specialty training.

There are a number of aspects that are central to the work of medical schools and to our students:

- Employers' (i.e., health services) involvement and contribution to the learning and experiences of students;
- Ensuring a shared understanding of the knowledge, skills and behaviours needed by health services of their commencing interns;
- Employers' role in the transition of graduates' transition into practice and employment;
- The continued learning and training of doctors post-graduation; and
- Factors that influence graduates' subsequent career options and choices.

For all of these, partnerships between the institutions involved are key. We must move to a model of collaborative, shared responsibility for the education, development and support of our future health workforce.

Postgraduate health partnerships need to extend beyond large, tertiary hospitals

As highlighted in the previous section, medical education and training remains dominated by the large tertiary hospital sector, despite the fact that the majority of healthcare is provided in community or home based settings¹³. We need to extend our interpretation of medical graduate employers and our healthcare partners to include community-based healthcare providers, including those in the regions.

¹³ Annual Medicare statistics showing that 90% of the Australian population claimed medicare benefits related to GP attendance vs 33% who claimed for specialist attendance in the 2021-2022 financial year
<https://www.health.gov.au/resources/publications/medicare-annual-statistics-state-and-territory-2009-10-to-2021-22?language=en>

Supervisors' educational needs and work pressures

Studies have repeatedly noted the positive contribution of medical students to patient care^{14,15}, however it is also recognised that their supervisors need the time, support and expertise to undertake their teaching role.

In a high-intensity clinical environment, the ability to slow down in order to incorporate student learning opportunities can come under significant pressure. Teaching as part of a health professional role can too often be assumed, rather than actively promoted and rewarded, leading to more of the teaching load being borne by fewer clinicians. Dealing with these issues needs a partnership approach to ensure a high quality teaching and training experience during students' clinical placements.

In addition, the educational needs of supervisors are also too often overlooked. The higher education sector could play a valuable role in supporting supervisors' learning of adult education methods.

Job-ready graduates

As mentioned earlier, medicine is unusual in that as long as the person is fit to practice, domestic graduates are guaranteed a job when they complete their primary medical degree. Whilst there is this high level of job security, the fact that medical degrees are longer than many other degrees with a high proportion of immersive learning in their program, medical graduates still often feel underprepared for internship. Whilst we should be cautious over seeking too high levels of confidence considering the importance of patient care and safety (noting one the key outcomes graduates must achieve is competence around knowing when to escalate a patient issue to a more experienced clinician) supporting graduates through the transition into clinical practice is of vital importance for all involved – patients, the graduates' colleagues, and the graduate themselves. The stresses on them during this stage are significant.

There are a number of developments – some long-standing, others more recent – that have been shown to improve the readiness and confidence of new interns, and this Accord provides an opportunity to further explore these in a national, Australian context.

i) The New Zealand Trainee Intern (TI) role

In Aotearoa New Zealand final year medical students undertake a full year of training in a clinical workplace. Via their university, students receive a Government-funded stipend during this time and are mostly under the jurisdiction of the university. The primary purpose of the experience is to ease the transition into the workplace, applying their skills clinically whilst under supervision and working as part of several healthcare teams. Research¹⁶ has shown that *“trainee interns reported significantly greater competence and performance levels”* and there are widespread positive views about this model.

¹⁴ https://medicaldeans.org.au/md/2021/09/MDANZ_Clin-placements-as-sites-of-learning-and-contribution_Feb-2018.pdf

¹⁵ <https://www1.racgp.org.au/ajgp/2022/march/medical-students-value-adding-to-general-practice>

¹⁶ Training the Intern: the value of a pre-intern year in preparing student for practice
https://www.researchgate.net/publication/26878100_Training_the_intern_The_value_of_a_pre-intern_year_in_preparing_students_for_practice

ii) The NSW Assistant in Medicine (AiM) role

In 2020, during the COVID-19 pandemic, a partnership between the NSW Ministry of Health and NSW Medical Deans developed a workforce role for final year medical students. The Assistants in Medicine role allowed students to opt in and work part-time (up to 32 hours per week) as part of a health care team in participating hospitals. Students were employed by the health services and earned 75 per cent of a NSW Medical Intern Salary. Both medical schools and health services had shared responsibility for the students' learning.

"AiMs reported that by working alongside JMOs, and in cases where there was no intern/RMO on the team partially stepping-up into their role, provided them with firsthand experience as a junior doctor that was not achievable during their placements."

"The AiM role was effective in achieving the intentions of the program and was also valued by the medical workforce and medical schools as an opportunity to further integrate students in the team and utilise their skills and capabilities in managing the workload."¹

¹ NSW Health (2021) Assistant in Medicine Evaluation Report, Pg22
<https://www.health.nsw.gov.au/workforce/medical/Pages/aim-evaluation-report.aspx>

The role was more transparent about the competencies expected of final year students, clearly articulated students' health service responsibilities, and supported the students' transition into clinical practice and their confidence to take on the greater responsibilities of internship.

Over 400 students participated across 41 facilities in the pilot, representing about 40 per cent of the NSW final year students that year. The key findings of the NSW Health evaluation are shown below.

Key findings

The evaluation found that overall, the AiM role was effective in achieving the intentions of the program and students were able to fulfil the requirements of the role. The AiM was valued by the medical workforce and medical schools as an opportunity to further integrate students in the team and utilise their skills and capabilities in managing the workload. The evaluation found that:

- Final year medical students employed as AiMs had the skills and capabilities required for the role and were able to perform the tasks required.
- The AiM role provided a different experience to that of a clinical placement.
- The AiM position clarified the student's role in the team, gave them responsibility and empowered JMOs to delegate to them. In comparison, feedback identified that medical students undertaking clinical placements usually don't have specific tasks and responsibilities within the medical team.
- The hours worked per week by AiMs was a factor in their effectiveness in the team. AiMs who worked 16 hours or more per week were well-integrated into the team and overall added more value to the team than those who worked less than 16 hours per week.
- Final year medical students who worked as AiMs reported feeling better prepared and more confident for internship.
- The AiM position provided paid employment to final year medical students at a time when many had lost their part-time jobs in non-healthcare settings as a result of the pandemic.
- There was strong support from a range of stakeholders for the role to continue in a non-pandemic scenario.
- The AiM program provided a means by which the relationships between the Ministry of Health, medical schools and LHD/SNs was further strengthened and provided greater opportunities for collaboration.

Figure 4: NSW Health AiM Evaluation Report, key findings, page3

Transition to internship

More clearly defined partnerships between universities, the postgraduate employers (health services), and those responsible for their further specialty training (medical colleges) would help better align and connect the different stages of training, and support an appropriate balance being found between service provision and protected learning time.

The shared responsibilities cover a broad range of aspects including those for learning, professional behaviours, orientation to practice, the culture of the clinical environment, support for those experiencing difficulties, and the flexibility of the program and work environment.

A supportive culture and environment

Both institutions need to take responsibility for delivering a more supportive culture that supports students and graduates in their learning, and in reaching out to request more support or reasonable adjustments. We know that too often that is not the case and that both students and new interns are often reluctant to reach out for help.

It is thought that up to 10% of medical graduates experience times of difficulty during their internship. These issues might not last long, nor deter them from progressing through their work and continued learning, however without doubt they cause stress and distress, doctors leave the profession, and at times there are catastrophic consequences where doctors suicide. As well as ensuring a more supportive culture, and trusted and effective systems for the appropriate sharing of information on students'/graduates' support needs, this is an area where medical schools' relationship with their recent graduates could be hugely beneficial.

Increased flexibility

As raised in section 2, there must be an acceleration of the move to more flexibility – in program structures, in immersive learning approaches, and in the health work environment. There is a need for a collaborative approach to this so that the complexities of all those involved are properly understood and taken into account.

Consideration needs to be given on how to adapt to an increasing number of part-time students and those who wish to progress at different rates through the program. As well as creating an education model that is better matched to contemporary needs, different students' situations, and more suited to supporting wider participation, it should be noted that having one intern intake per year in the health system has been associated with adverse impacts on patient care^{17, 18, 19}.

Students' postgraduate experiences and influences

In addition, the early intern years are often those that have a major impact on graduates' choices about their future career. For example, we are still seeing many doctors practicing in metropolitan areas despite an earlier preference for more regional/rural areas, with over 41% of the 2010 medical graduates who expressed a preference to work in a smaller town working in a metropolitan area a decade later. Similarly, with the strong focus on hospital care during the two intern years, graduates

¹⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2743809/>

¹⁸ <https://www.bostonmagazine.com/health/2013/11/15/hospital-mortality-rates-july/>

¹⁹ <https://theconversation.com/happy-black-wednesday-every-doctors-nightmare-16106>

often lose connection to general practice when that is one of the careers we most want interns to progress into.

In order to realise the potential offered, universities should be playing a stronger role in supporting postgraduate groups – both health services/employers, and those involved in postgraduate medical training.

We recommend the Accord Panel:

15. Develop a set of shared principles between the higher education sector and the jurisdictions on the common aims of collaboratively recruiting, educating, developing and supporting Australia's future workforce.
16. Support the development of a pre-intern role for medical students, with shared responsibility between universities and health services, and sufficient flexibility to allow for adaptation to local needs and contexts whilst retaining consistency at a national level.
17. In conjunction with the jurisdictions, explore how to enable a more flexible approach to WIL, internship and students' needs, including the feasibility of enabling more than one intern intake each year.
18. Explore the higher education sector's role in educating and supporting the workplace based supervisors of our students and graduates.

Section 6: Teaching, Training & Research

In this section, we respond to the following questions in the Discussion Paper.

In this section, we respond to the following questions in the Discussion Paper.

Q27: How can we improve research training in Australia including improving pathways for researchers to gain experience and develop high-impact careers in government and industry?

Q41: How should research quality be prioritised and supported most effectively over the next decade?

The Discussion Paper makes strong references to the importance of the academic workforce. There are huge demands for and on this workforce, amplified by the move to – and need for – more regionally-based campuses. More needs to be done to value, support and grow the educators and researchers who are fundamental to higher education. Whilst interest in these two careers is high, with 86 per cent of final year medical students indicating an interest in teaching and just under 60 per cent indicating an interest in research as part of their future medical careers²⁰, it is widely recognised that Australia has a workforce shortage in these areas.

As highlighted in the Discussion Paper, a common theme is the high levels of job insecurity and underfunding for these roles – particularly at the early-mid career stages.

The Educator workforce

In particular, there is a need to overhaul university mechanisms around the **employment, support and career progression of educators** and attract more to the profession. This is a wider issue than the profession of teaching. With the increasing move to work-integrated learning – long-established and fundamental within medicine and health education and training – the role of adjuncts and those educating and supporting the learning of our students in the workplace needs to be re-considered. Universities should be playing a more substantial role in the competence and support of those ‘external educators’ of our students.

The Researcher workforce

Having a skilled and sufficient clinician-researcher workforce – who are both clinically qualified and active in research – is vital to drive innovation and the delivery of high-quality healthcare. Currently, the strength of our clinician researcher workforce is compromised because the pathways into clinical medical research are disjointed and lack support. The range of options within medical schools is sometimes unclear and, in particular, there is a gap in opportunities during pre-vocational training, and varying ability to conduct research during specialist training. As called for by a number of groups including Medical Deans²¹, the Group of Eight universities²², the government’s National Medical

²⁰ Medical Schools Outcomes National Data Report 2022 <https://medicaldeans.org.au/md/2022/08/MSOD-National-Data-Report-2022-1.pdf>

²¹ Medical Deans’ Training Tomorrow’s Doctors 2021 <https://medicaldeans.org.au/md/2021/09/Training-Tomorrows-Doctors-all-pulling-in-the-right-direction-September-2021.pdf>

²² Strengthening Australian Clinical Research <https://go8.edu.au/wp-content/uploads/2020/12/Go8-AICRTP-FINAL.pdf>

Workforce Strategy²³, and endorsed by the Australian Academy of Health and Medical Sciences²⁴, there is an urgent need for a **coordinated and better supported clinician researcher career pathway**, running from medical school through to post-vocational training research.

The focus should be on early, preferential selection into a designated clinician researcher pathway that identifies, nurtures and develops clinician researchers. This should include a national target for clinician researchers (with an initial target of at least five per cent of medical graduates to enter a research training pathway leading to a PhD), and the establishment of an Integrated Clinician Researcher Transition Program in the first two years of postgraduate training available to a small percentage of internship positions each year.

Supporting those in the workforce

As well as being inextricably linked to the development of our future workforce, education and training plays an important role in sustaining those in the professions. In the context of medicine, having a **well-rounded career that involves teaching, research, leadership and management** provides support, fulfilment and continuing challenges and rewards. As well as making vital contributions back to society as a whole, evidence shows that involvement in teaching, research and leadership keeps clinicians working at their best – it stimulates them to stay abreast of developments and contributes to individuals' and teams' continuous quality improvement.

Research-rich curricula

Having **research learning embedded across the curricula** is vital; for medicine, this is not only for those who progress into clinician-researcher careers but for all graduates. Despite the pressures on curriculum content, it is important that this not be undervalued and that the concept of research training includes aspects core to students' future professions and professionalism, including for example partnering with communities in research projects, data governance and security, participant consent and privacy, and cultural safety and self-determination.

We need to ensure our graduates have experienced learning in areas such as teaching, research and administration, and accreditation is an important lever that should support this and, particularly in health, help the consolidation of learning in the undergraduate and postgraduate spaces.

Investment in translational and systems-level research

More investment is needed in areas of research that are often overlooked; that might not make the headlines, but that are vital to Australia's higher education sector remaining amongst the global leaders. This includes more **research into pedagogy and student learning, effective assessment of learners' capabilities and behaviours** – particularly prominent at the moment with the rapid

²³ Australian Government National Medical Workforce Strategy, recommendation 13.3
<https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031?language=en>

²⁴ Our vision to integrate research in the health system, AAHMS Report October 2022,
<https://aahms.org/news/vision-2022/>

advent of generative AI and large language models – and **workforce development** and the role of education.

For example, universities have substantial data on the backgrounds, experiences, and future career preferences of graduates. Medical Deans has undertaken work to match and link data from a 15-year long survey of exiting medical graduates with that of the Australian medical register, enabling a longitudinal view to be taken. We are now able to start exploring whether earlier preference plays out, and finding answers to some of the questions about what influences medical graduates' career choices. More support for these types of impactful research is needed.

We recommend the Accord panel:

19. Develop targets for the proportion of educators within a program, including ensuring sufficient management-level support for the roles.
20. Recommends the development of new university employment structures for educators and researchers that redresses the current high levels of job insecurity, underpayment, and lack of career progression.
21. Recommends the funding and implementation of the proposed Australian Clinician Researcher Training Pathway to identify, train and support future medically qualified research leaders.
22. Recommends the establishment of new funding for research into educational best practice.
23. Sets national targets for the proportion of research funding provided to research into translational and systems-level research, and specifically including workforce development research.

Conclusion

The Accord comes at a pivotal time for Australia's university sector and Australia's society and economy. COVID-19 was a disruptor the like of which has not been experienced in decades, yet amongst its many challenges it brought about some welcome changes – not least the level of **collaboration** and clear and rapid decision-making that we saw. Effective **leadership** was recognised as a necessary strength. **Equity** and **fairness** was forefront in peoples' minds.

Many of the matters we raise in this response are echoed in our mid 2021 paper '[Changing for Good: What we Learning in 2020](#)' about the impact of COVID-19 on medical schools in Australia and New Zealand, where we explored the innovations and challenges that had arisen under the topics:

- The role of online learning
- Shared responsibilities for clinical learning, and
- From collaboration to partnership

With this Review, there is the chance to make some step changes that will help Australia realise the ambitions highlighted in the Discussion Paper for our higher education sector to be more accessible, equitable, effective, and sustainable. There are opportunities for Australia to learn from others and to lead.

Our members' context of medical education and training is overlaid with ever increasing demands on healthcare, expectations of and from our future doctors, the rapid technological advances, and society's changing norms demanding more inclusiveness and safer learning and working environments. The recommendations in this response are needed for medical schools to respond to and balance these demands, and leverage the opportunities that come with wider participation in our universities and healthcare professions, from technological developments, from the success of our regional medical education infrastructure and connections, and from the strong relationships medical schools have forged with health services and medical education partners.

We hope that our recommendations are of interest to the Panel and we look forward to continuing to contribute to this important Accord.

Contact:

Helen Craig, CEO Medical Deans Australia and New Zealand

hcraig@medicaldeans.org.au