

Building the General Practice Workforce to Strengthen Medicare

Impact Analysis

Department of Health and Aged Care



Australian Government

**Department of Health
and Aged Care**

Contents

1. Introduction.....	6
2. Current state of play.....	8
3. Problem statement.....	14
4. Policy objectives.....	25
5. Policy options analysis.....	31
6. Multi-criteria analysis of investment packages.....	68
7. Risks and mitigations.....	78
8. Evaluation plan.....	80
9. Governance.....	88
Appendix A: Supply and demand projections – state by state.....	89
Appendix B: GP training programs.....	92
Appendix C: 2024 CSPs.....	94

Key definitions

Aboriginal Community Controlled Health Service (ACCHS): a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community that controls it.

Australian College of Rural and Remote Medicine (ACRRM): one of two specialist GP colleges in Australia offering GP training, with a focus on rural and remote medicine and rural generalism.

Australian General Practice Training (AGPT) Program: a Commonwealth funded, college-led GP training program offering 1,500 training places per year across Australia. See Appendix B for more information.

Australian Universities Accord: a 12-month review of Australia's higher education system, with the aim of improving the quality, accessibility, affordability and sustainability of higher education in Australia.

First Nations/First Nations people: refers to Australian Aboriginal and/or Torres Strait Islander people

Commonwealth supported places (CSPs): a place at an Australian university or approved higher education provider where the Australian Government pays a portion of the fee. In this document, the CSPs referred to are for places at a medical school.

General practitioner (GP): a medical practitioner who holds specialist registration with the Medical Board of Australia (MBA) in the specialty of general practice.

GP fellowship: a qualification awarded by either of the two specialist GP colleges allowing a medical practitioner to be registered as a specialist general practitioner.

International medical graduate (IMG): a medical practitioner who gained their primary medical qualification outside of Australia or New Zealand.

Internship: the first year of postgraduate medical training (PGY1) following successful completion of a primary medical degree. It is a requirement to complete accredited intern training to become eligible for general registration with the MBA.

Medical Board of Australia (MBA): as established by the *Health Practitioner Regulation National Law Act 2009*, the MBA regulates the medical profession, helping to protect the public by setting standards and policies that all registered medical practitioners must meet.

Medicare Benefits Schedule (MBS): Medicare is Australia's universal health insurance scheme. It guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at low or no cost. The MBS is one component of Medicare and describes the medical services, hospital services, tests, imaging and scans for which a patient rebate is available for services obtained as a private patient.

Medical practitioner: a person holding registration as a medical practitioner with the MBA.

Modified Monash Model (MMM): a geographical classification system used to define whether a location is metropolitan, rural, remote or very remote. The MMM measures remoteness and population size on a scale of Modified Monash (MM) categories MM1 to MM7. MM1 is a major city and MM7 is very remote.

National Agreement on Closing the Gap: an agreement developed in partnership between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations to enable Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians.

National Consistent Payments (NCP) Framework: a nationally consistent framework of support payments available to AGPT program participants. Payments are made by Services Australia directly to participating registrars, supervisors and practices.

National Terms and Conditions for the Employment of Registrars (NTCER): an agreement that outlines the minimum employment terms and conditions for GP registrars on the AGPT program. It is negotiated between General Practice Registrars Australia and General Practice Supervision Australia.

Other specialist / non-GP specialist: a medical practitioner who holds specialist registration with the MBA in a specialty other than general practice.

Primary care / primary healthcare: generally the first service people go to for health care outside of a hospital or specialist. It includes diagnosis and treatment of health conditions and long-term care. General practice is the medical component of primary care in Australia.

Remote Vocational Training Scheme (RVTS): a Commonwealth funded three or four-year GP training and workforce retention program, with 32 commencing places per year. The program delivers structured distance education and supervision towards GP fellowship, while doctors provide services to remote and First Nations communities. See Appendix B for more information.

Regional, rural and remote: any area outside of Australia's major cities. Areas classified as MM2-7 are considered to be regional, rural or remote.

Royal Australian College of General Practitioners: one of two specialist GP colleges in Australia offering GP training.

Rural generalist (RG): a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.

Rural Generalist Training Scheme (RGTS): a Commonwealth funded four-year GP training program offering structured RG education, with intended outcomes of increasing access to primary healthcare in rural and remote communities. The program is delivered by ACRRM and provides up to 100 RG commencing places per year.

University Compact agreement: an agreement between the Commonwealth and a higher education provider. Entering into a compact is one of the quality and accountability requirements which a higher education provider must meet under the *Higher Education Support Act 2003* as a condition of receiving a grant.

1. Introduction

Australia's population is growing and ageing, and our healthcare needs are becoming increasingly complex.¹ Our primary care system must become increasingly agile and robust to keep pace with the burden of disease to ensure Australians are receiving the care they need when and where they need it. Based on supply and demand modelling undertaken by the Department of Health and Aged Care, there is a shortfall of the numbers of GPs required, now and into the future. This impacts access to general practice services in parts of Australia.

Despite growth in the number of medical graduates (who may go on to train in a large number of different specialties, of which general practice is only one), modelling suggests that without further action, the shortage of GPs would increase over time, with the unmet demand gap growing to 7,700 GPs (5,560 full-time equivalent (FTE)) in 2033, and to 12,400 GPs (8,900 FTE) in 2048.² A continued undersupply of GPs undercuts broader efforts to improve accessibility and affordability of healthcare. Workforce shortages also increase reliance on locums at an elevated cost and add burden to already overstretched hospital services.³ Insufficient access to GP services can lead to a sicker population and increase the reliance on the hospital system. This can also lead to downstream impacts including lower economic productivity and increased health system costs.

Regional, rural and remote communities, and other vulnerable communities, typically experience a higher burden of disease and lower access to health services.⁴ Data shows that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and preventable hospital admissions. These populations also have poorer access to, and use of, primary health care services, than people living in major cities.⁵

One of the causes of the increasing GP shortage is the demographic makeup of our GP workforce. GPs are an ageing cohort, which means more GPs retiring in the coming years. At the same time, the hours worked per week by GPs is steadily reducing, with the national average FTE per GP projected to decrease from 0.74 in 2023 to 0.72 in 2048.⁶ This projected decline is, in part, driven by an increase in the proportion of the GP workforce who are female (from 42.4% of total FTE in 2023 to 50.2% in 2048), and a reduction in the average FTE per male GP (from 0.85 to 0.81). While a higher proportion of female GPs and a more equal balance of part-time employment between male and female doctors are positive shifts, they are expected to decrease the supply of GPs across

¹ [National Medical Workforce Strategy 2021–2031 \(health.gov.au\)](https://www.health.gov.au/national-medical-workforce-strategy-2021-2031).

² [Supply and Demand Study \(health.gov.au\)](https://www.health.gov.au/supply-and-demand-study).

³ [Independent review of Australia's regulatory settings relating to overseas health practitioners \(regulatoryreform.gov.au\)](https://www.regulatoryreform.gov.au/independent-review-of-australia-s-regulatory-settings-relating-to-overseas-health-practitioners).

⁴ Beggs 2003 as cited in Roberts R (2019) 'Vale Bob Hawke: What impact has Medicare had on rural Australia?', *The Australian Journal of Rural Health*, 27(3):194-195, <https://doi.org/10.1111/ajr.12532>.

⁵ www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.

⁶ [Supply and Demand Study \(health.gov.au\)](https://www.health.gov.au/supply-and-demand-study).

Australia. International Medical Graduates (IMGs) play an important role in addressing GP workforce gaps⁷, with around 41 per cent of GPs in Australia being IMGs.⁸

Positively, demand for GP training has increased, with Commonwealth-funded GP training programs likely to be fully subscribed in 2025. While this is a welcome development, it will not fully address the growing GP shortfall, and existing GP training places are capped at just over 1,600 places per year across Commonwealth-funded training programs.

Stakeholders, such as the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA) and General Practice Registrars Australia (GPRA), have noted that pay and entitlement disparities between hospital doctors and GP trainees are barriers to encouraging more junior and prevocational doctors to pursue a career in general practice.^{9 10 11}

The policy objective to increase population access to primary care services aligns with those of the [National Medical Workforce Strategy 2021-2031](#), and the National Health Reform Agreement (NHRA), which commits all governments to work collaboratively to ensure our health system functions effectively to meet the needs of the community. In pursuit of this objective, this Impact Analysis examines several options for Australian Government action to grow Australia’s GP workforce to better meet community need, now and into the future. It considers the impact of options across population groups, stakeholders and medical training, and makes recommendations based on viability, impact, public value creation and fiscal responsibility. Options considered are scalable and not necessarily mutually exclusive. In fact, consistent with ‘smart regulation’ principles,¹² many of the options considered in this Impact Analysis could be implemented as complementary measures that increase the overall effectiveness of Government action.

Costing assumptions in this Impact Analysis represent a point-in-time and may not align with final costings.

Table 1: Status of the Impact Analysis at each major decision point

Decision point	Timeframe	Status of IA
Consultation across government	October 2024 – December 2024	Preliminary assessment undertaken determining need for in depth IA. Consultation with OIA and early draft sent for feedback.
Initial consideration by government	December 2024	First Pass IA completed.
Decision and announcement	February 2025	Second Pass IA completed.

⁷ [Independent review of Australia's regulatory settings relating to overseas health practitioners \(regulatoryreform.gov.au\).](#)

⁸ National Health Workforce Dataset.

⁹ RACGP (2024) *Mid-Year Economic and Fiscal Outlook 2024-25 Submission*.

¹⁰ AMA (2024) *Pre-Budget Submission 2025-25: Chapter 1: General Practice*.

¹¹ GPRA (2024) *GPRA 2024 Federal Budget Submission*.

¹² <https://researchprofiles.canberra.edu.au/en/publications/smart-regulation>.

2. Current state of play

Existing investment and outcomes

The [National Medical Workforce Strategy 2021-2031](#), endorsed by Health Ministers in December 2021, is guiding long-term collaborative medical workforce planning and reform across Australia. A key priority arising from the Strategy includes rebalancing supply and distribution of the medical workforce. This includes increasing the number of trainees in undersupplied medical specialities and removing barriers for doctors to work and train in rural and remote communities.

Box 1: Snapshot of Australia's medical workforce

In Australia, in 2023, there were more than 136,000 registered medical practitioners.

This included:

- more than 111,000 employed clinicians
- more than 39,400 GPs*
- more than 44,000 specialists
- almost 93,000 (FTE) in major cities
- more than 24,000 (FTE) in regional and rural areas
- more than 1,500 (FTE) in remote and very remote areas
- more than 52,000 in hospitals
- more than 37,000 in group private practices
- about 45 per cent women
- about 64 per cent qualified in Australia
- about 42 per cent born in Australia

Source: [National Health Workforce Dataset](#)

*Source: [Supply and Demand Study](#) (GPs include Specialist GPs (31,900), GP trainees (6,000) and Non-Vocationally recognised GPs (1,500) providing primary care services)

The Australian Government provides more than **\$2 billion a year** in funding for programs that develop the healthcare workforce and support more equitable distribution of professionals to areas of need, especially in regional and rural locations.

Since 2022, this investment has delivered the following supports to develop the medical workforce, particularly in primary care:

- More than **13,000 students studying medicine each year**, resulting in around **2,800 government-funded graduates each year**.
 - In 2023 almost 40 per cent of these graduates spent a year or more studying in rural locations.

- In 2023, there were 120 First Nations medical students enrolled in medical school – up 22.5 per cent from 2022.
- The establishment of **eight new end-to-end medical programs in regional and rural areas**, allowing students to undertake their whole study program in a regional setting.
 - This includes new end-to-end medical programs in Darwin, Broome, Burnie, Ararat and Warrnambool, Moss Vale and Nowra, Rockhampton, Cairns and regional South Australia.
 - Once mature, this will see around 220 new doctors graduating each year from these rural clinical schools.
- **Expansion of the Northern Territory medical program** by a further 6 places per year, which will increase the number of graduates under the program to 36 per year from 2028.
- **Enabled 433 pre-vocational rotations in 2023 for junior doctors** in primary care settings to experience general practice in rural locations, with another 600 rotations funded in 2024 and funding growing to allow 1,000 rotations by 2026.
- **Funding more than 5,400 GPs in training each year**, including around 1,570 junior doctors starting their GP fellowship in 2024 alone. Around half of these doctors are doing all, or some, of their training in rural and regional locations.
 - In particular, there has been huge growth in demand for rural generalist (RG) training, with the Rural Generalist Training Scheme (RGTS) oversubscribed by almost 70 per cent in 2024.
- **Expansion of the single employer model trials**, enabling regions to pilot innovative employment models for GP and RG trainees.
 - Eight trials underway across New South Wales, Tasmania, South Australia and Queensland, with further single employer model trials expected to commence in 2025 and 2026.
 - This will include a First Nations-led trial where the Single Employer is an Aboriginal Community Controlled Health Organisation based in South-West Queensland, and a new trial in Victoria.
- Investment of approximately **\$23 million each year** to support post-fellowship training for rural GPs to undertake continued professional development, as well as further training in advanced and procedural skills such as anaesthetics and obstetrics.

In the 2024 Budget, the Australian Government announced further investments to strengthen and support the health workforce, including the primary care medical workforce. This includes:

- **\$90.0 million** over three years from 2023–24 to fund the implementation of the health related recommendations of the Independent review of Australia’s regulatory settings relating to overseas health practitioners (the Kruk Review) to grow and support the health workforce.
- **\$24.6 million** for Charles Darwin University to establish a new medical school in the Northern Territory from 2026.

- **\$4.7 million** over five years from 2023–24 for the Northern Territory Medical Program to increase the number of First Nations medical practitioners and to address recruitment and retention challenges in the Northern Territory.
- **\$4.0 million** over four years from 2024–25 to the Australian Indigenous Doctors' Association to continue to support First Nations doctors to become medical specialists.

The Australian Government's Workforce Incentive Program (WIP) also provides incentives to doctors to work in regional, rural and remote areas – specifically Modified Monash Model (MM) 3-7 regions – and funding to practices to support the employment of multidisciplinary health workers to encourage team-based care. In 2023, the Government invested a further **\$445.1 million** over 5 years to increase the WIP – Practice Stream, including:

- increases to payments (from July 2023);
- indexation changes (from August 2024); and
- data and accountability changes.

The NHRA is a commitment between the Australian Government and all states and territories to improve health outcomes for all Australians through coordinated, joined up care. In 2021-22, **\$59.2 billion** in Australian Government and state and territory health system funding was administered under the NHRA. In 2023, a mid-term review of the NHRA recommended that delivering a sufficient and skilled workforce be more prominently reflected in the next NHRA, reflecting shared commitments and actions, accountabilities and performance milestones.¹³ The current NHRA has been extended for a further 12 months, with an additional \$1.7 billion provided in 2025-26. The development of the next NHRA remains under negotiation.

Box 2: Australia's hospital medical workforce

In 2022–23, there were 56,700 (FTE) salaried medical officers in public hospitals. This represents 13 per cent of public hospital employees. These staff numbers do not include visiting medical officers in public hospitals and most medical officers who provide services in private hospitals.

Source: [Hospital workforce - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au)

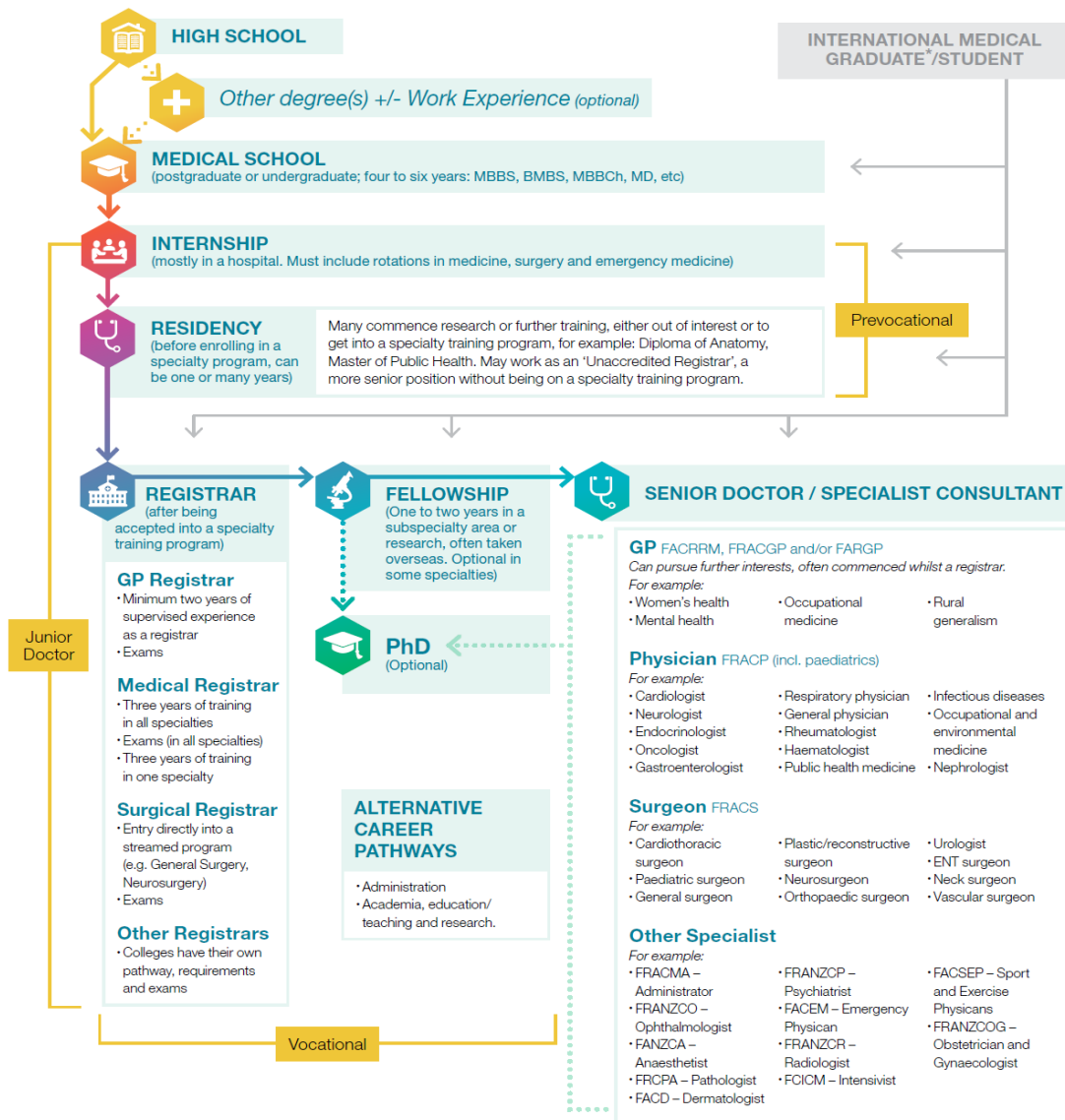
GP training pathways

GPs undergo significant training in medicine, such as the completion of a five to six year Bachelor of Medicine and Bachelor of Surgery (MBBS), followed by two years of post-graduate hospital training and at least three years of supervised general practice training. Prospective GPs must then pass examinations of an accredited general practice training program, such as Fellowship of the Royal Australian College of General Practitioners (FRACGP), before being able to use the specialist general practitioner title. After completing these requirements and registering with the Australian

¹³ Huxtable R (2023) *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report*.

Health Practitioner Regulation Agency (Ahpra), GPs undertake ongoing quality improvement and continuing professional development activities each year to maintain their registration. The path to specialist qualification for medical practitioners encompasses a number of stages, as outlined in Figure 1.

Figure 1: Australian medical training pathways^{14 15}



¹⁴ From the National Medical Workforce Strategy, adapted from Australian Medical Association (AMA), 'How to become a doctor', AMA, n.d., accessed 6 November 2024. Australian Medical Council 'Overview of Assessment Pathways' www.amc.org.au/assessment/pathways/overview/ accessed 6 November 2024.

¹⁵ International medical graduates' (IMGs) qualifications and experience determine their entry point into Australian medical training employment. IMGs who complete the Australian Medical Council requirements are equivalent to Australian graduates who gain general registration after internship.

The Australian Government-funded GP training pathways (vocational training in Figure 1) consist of:

- Australian General Practice Training program (AGPT) – a college-led training program providing three to four years of full-time training for registrars to obtain fellowship and gain specialist GP registration, through either the Royal Australian College of General Practitioners (RACGP) or Australian College of Rural and Remote Medicine (ACRRM). The AGPT program currently offers 1,500 new places each year. The Government provides around **\$250 million** per annum for the program's operation.
- Rural Generalist Training Scheme (RGTS) – a four-year training program offering a structured Rural Generalist (RG) education program, with intended outcomes of increasing access to primary healthcare in rural and remote communities. The program is delivered by ACRRM and provides up to 100 RG commencing places per year. All training is delivered in MM2-7 locations where possible. The Government is providing **\$71.5 million** between 2020-21 and 2025-26 for the program.
- Remote Vocational Training Scheme (RVTS) – a three or four-year GP training and workforce retention program, with 32 commencing places per year, including up to 10 places in Aboriginal Community Controlled Health Services (ACCHS). The program delivers structured distance education and supervision towards GP fellowship, while doctors provide services to remote and First Nations communities. The Government is providing **\$44.5 million** between 2019-20 and 2025-26. An additional \$5 million was provided in 2021 for the RVTS Extended Targeted Recruitment pilot, as part of the department's innovative employment model trials.

GP training places are capped at just over 1,600 new places each year under these 3 programs. These programs are producing successful outcomes with upwards of 1,000 GPs following each year¹⁶ and an increase in demand for training places in recent years.¹⁷ However, existing caps are restricting the speed at which this important workforce is growing.

Both RACGP and ACRRM also deliver self-funded GP training pathways: namely the Fellowship Support Program (delivered by RACGP) and the Independent Pathway (delivered by ACRRM). Trainees on these pathways must be based in MM 2-7 locations. Between 2017-18 and 2021-22, the Government provided \$46 million in time-limited subsidies for non-vocationally recognised doctors on a self-funded pathway to achieve GP fellowship. This funding, announced in the 2018-19 Budget, was provided to support a cohort of doctors who were working as GPs without GP qualifications. The intention was that in future the AGPT and RVTS would be the pathway into general practice.

See [Appendix B](#) for further detail on these programs.

¹⁶ National Health Workforce Dataset.

¹⁷ GP college selection data analysis undertaken by the Department of Health and Aged Care.

Recent reviews

While existing activities are having a positive impact, growing the GP workforce remains one of the biggest challenges facing Australia's health system. To inform broader health workforce reform pathways, a number of workforce policy reviews were commissioned by the Government and have recently been completed. This includes:

- [Unleashing the Potential of our Health Workforce – Scope of Practice Review](#). This was an independent review, which looked at the available evidence about health professionals' ability to deliver on their full scope of practice in primary care. The review identified opportunities to remove the barriers stopping health professionals, including GPs, working to their full scope of practice, drawing on examples of multi-disciplinary teams where members are working to their full scope of practice to deliver best practice primary care. The review's final report was published in November 2024.
- [Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners](#) (Kruk Review). This was an independently-led, rapid review of Australia's regulatory settings relating to health practitioner registration and skills and qualification recognition for overseas trained health professionals and international students who have studied in Australia. The review was tasked with delivering recommendations designed to ease skills shortages in key health professions, while ensuring that quality and safety standards designed to protect patients are maintained. The review's final report was endorsed by National Cabinet in December 2023.
- [Working Better for Medicare Review](#). The independent review examined the effectiveness of our current distribution levers. These are laws and policies used to encourage or require health professionals to work in areas of workforce shortage. These levers include: sections 19AA and 19AB of the *Health Insurance Act 1973*, and workforce classifications – specifically the Distribution Priority Area (DPA), District of Workforce Shortage (DWS) and Monash Modified Model (MMM) classifications. The review's final report was published in October 2024.
- [Review of General Practice Incentives](#). The independent review identified ways to redesign current general practice incentive programs to better support quality, patient-centred primary care. The review's final report was published in October 2024.

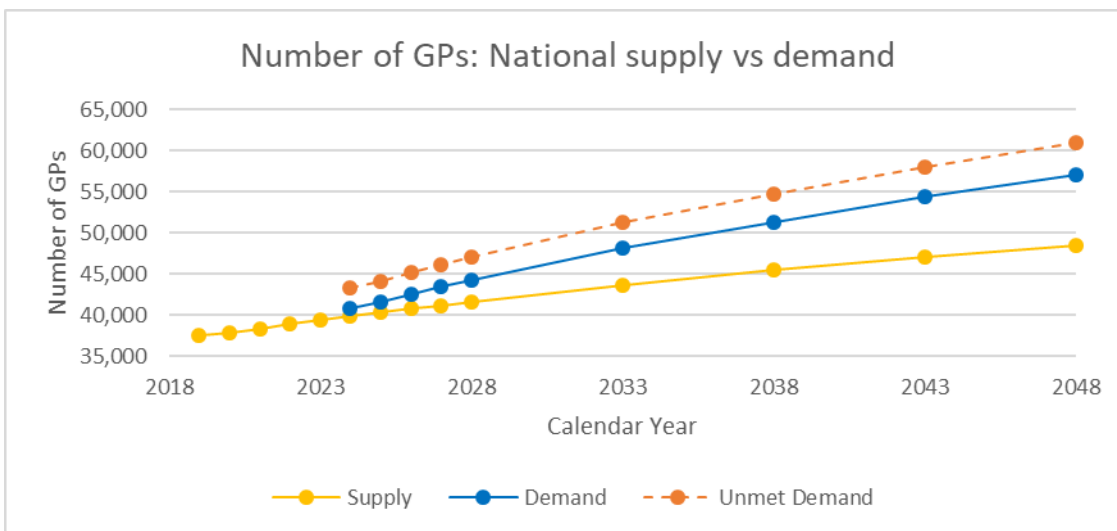
In the context of future GP shortages, the Australian Government is considering reforms required to grow and better distribute Australia's GP workforce. This Impact Analysis focuses on specific actions to grow the GP workforce, noting the reviews above will also be important in informing broader health and medical workforce policy settings.

3. Problem statement

Australia is not generating enough GPs to meet community need now and into the future.

Modelling demonstrates a growing shortage of GPs, with 7,700 more GPs needed by 2033 and without action and reform, shortages worsening in every jurisdiction. The national average FTE per GP is also projected to decrease over this period.¹⁸ There is insufficient growth in the medical workforce pipeline to address this gap. While general practice has reclaimed its position as the most popular career choice for medical students, with 18 per cent of medical students reporting an interest in general practice or rural generalism (which is expected to become a recognised area of practice within the speciality of general practice), this interest level must increase further to deliver the GP workforce we are projected to need in the future.¹⁹ [Appendix A](#) provides a snapshot of GP supply and demand projections across each state and territory.

Figure 2: National GP supply and demand projections



There are a number of factors contributing to this growing projected shortfall of GPs.

¹⁸ [Supply and Demand Study \(health.gov.au\)](#).

¹⁹ MDANZ 2024, [Medical Schools Outcome Database](#).

Cause 1: Distribution issues within the medical workforce shortage

The medical workforce is not well distributed in Australia, and broader workforce shortages are occurring in a number of specialities, not only general practice, despite continuing growth in the number of medical school graduates and employed practitioners. Advice from state and territory health officials is that they cannot fill all currently available internship positions in hospitals with medical graduates.²⁰ Effectively, medical specialities are competing for the current pool of medical graduates, with general practice at distinct disadvantage due to structural barriers and pay disparities compared to other specialities.

Since 2022-23, an additional 140 medical Commonwealth Supported Places (CSPs) have been funded by the Australian Government. While this investment will help grow the overall medical pipeline, this in isolation will not address GP workforce shortages in the short to medium term. A typical medical training pathway takes 10-14 years for a student to become a qualified practitioner, and takes time for investments in CSPs to be realised, as is true for other interventions to support a greater proportion of medical graduates too become GPs.

Cause 2: The medical workforce is geographically maldistributed

The medical workforce is maldistributed, with a strong preference for metropolitan-based practice.²¹ Variances in the number of doctors across geographies has led to unsustainable reliance on locums in lieu of permanent staff,²² which impacts the longer-term viability of medical practices in these areas.

The IMG workforce plays an important role in addressing gaps in areas of medical workforce shortage, including for general practice. Regulatory settings under section 19AB of the *Health Insurance Act 1973* (Cth) require IMGs to work in regional and rural areas, typically for up to 10 years, in order to provide services that are eligible for Medicare patient rebates.²³ Work is also underway to streamline the complex regulatory landscape for IMGs. However, an over-reliance on IMGs carries inherent risk of creating workforce shortages in times of crisis, as demonstrated during the COVID-19 pandemic, when there was a reduced inflow of IMGs. This further exacerbated the access challenges experienced in underserved communities, particularly in rural and remote areas.²⁴

²⁰ Advice from Jurisdictional Coordination Units.

²¹ [National Medical Workforce Strategy 2021–2031 \(health.gov.au\)](https://www.health.gov.au/national-medical-workforce-strategy-2021-2031).

²² [National Medical Workforce Strategy 2021–2031 \(health.gov.au\)](https://www.health.gov.au/national-medical-workforce-strategy-2021-2031).

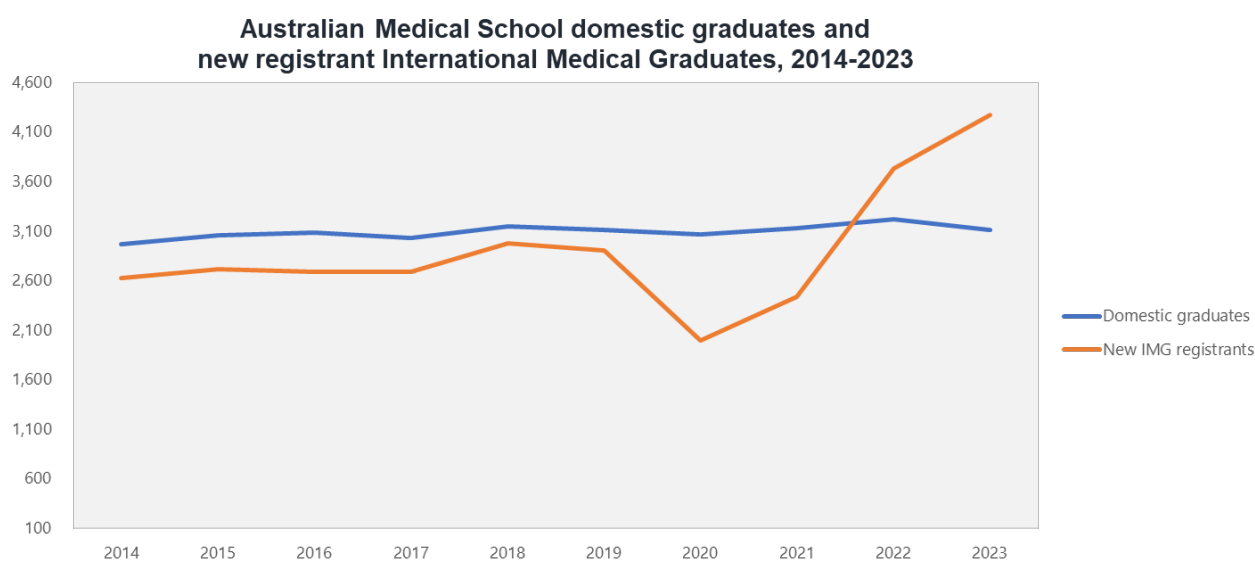
²³ Mason J (2013) *Review of Australian Government Health Workforce Programs*, Commonwealth of Australia, accessed 26 May 2024. www.voced.edu.au/content/ngv%3A74229.

²⁴ [National Medical Workforce Strategy 2021–2031 \(health.gov.au\)](https://www.health.gov.au/national-medical-workforce-strategy-2021-2031).

Evidence further demonstrates that junior doctors and trainees from rural or regional backgrounds are more likely to remain in these regions once qualified, which underscores the need for a sufficient domestic medical workforce.²⁵ Many IMGs relocate to metropolitan areas once they have satisfied their section 19AB requirements.²⁶ Some rural and regional areas are reliant on a transient medical workforce (including locums), which can undermine local health service viability and sustainability.^{27 28}

Forty-one per cent of GPs are IMGs²⁹ and this is expected to increase, with more IMGs likely to enter the workforce pipeline following the implementation of the fast-tracked pathways for GP IMGs, in response to the Kruk Review.

Figure 3: Domestic medical graduates versus IMGs 2014-2023



²⁵ [National Medical Workforce Strategy 2021-2031](#).

²⁶ Zubaran C and Douglas S (2014) 'Peers or pariahs? The quest for fairer conditions for international medical graduates in Australia', *Medical Journal of Australia*, 201(9):509-510, doi:10.5694/mja14.00038.

²⁷ Australian Medical Association (AMA) (2019) 'AMA Position Statement: Geographic Allocation of Medicare Provider Numbers - 2002. Revised 2019', *Australian Medical Association*, accessed 26 May 2024, www.ama.com.au/articles/geographic-allocation-medicare-provider-numbers-2002-revised-2019.

²⁸ Shenouda A (2017) 'Keeping them there: shifting our focus toward IMG retention, beyond moratorium obligations', 14th National Rural Health Conference, accessed 26 May 2024, www.ruralhealth.org.au/14nrhc/sites/default/files/Shenouda%2C%20Ayman_C2.pdf.

²⁹ National Health Workforce Dataset.

Cause 3: The medical workforce needs diversity

Demographics influence medical workforce distribution outcomes.³⁰ People from lower socioeconomic and rural backgrounds are more likely to choose GP careers (compared with other medical specialties) and are more likely to work in rural areas. A medical graduate pipeline that perpetuates socioeconomic inequities may further exacerbate Australia's workforce distribution gaps. Investments in medical places that are aimed at rural medical graduates, and that support long term rural and primary care clinical placements, are likely to result in greater retention rates for doctors working in primary care settings, including in rural areas.^{31 32}

Only 1 per cent of doctors are First Nations people. This cohort is most likely to choose to work in First Nations health settings. Taking into account the broader health workforce, First Nations people only constitute 1.8 per cent of the health workforce, despite making up 3.3 per cent of the population. Growth of the First Nations health workforce is important to addressing cultural safety across the health system and to Close the Gap in health outcomes. Australia has a target of achieving a First Nations medical workforce consistent with population parity (3 per cent of working age population), which also aims to address workforce participation gaps.³³

Cause 4: There are barriers to doctors entering GP training

There are structural barriers for medical graduates pursuing a career in general practice. A high proportion of prevocational training occurs in the hospital system. Hospitals can be a bottleneck in training and hospital registrars (or unaccredited registrars) often spend years trying to gain entry to specialty training. High prevocational and registrar coverage in acute specialties, with high inpatient or emergency demand, is influential in encouraging junior doctors toward these specialities and away from general practice.³⁴

Noting the evidence base that positive, early exposure is a major influencer for future career choices,³⁵ a lack of exposure represents a major barrier to growing the future GP workforce. The Australian Government's primary lever to support early primary care exposure for junior doctors is through the John Flynn Prevocational Doctor Program (JFPDP), which currently provides primary

³⁰ [The role of medical schools in UK students' career intentions: findings from the AIMS study | BMC Medical Education | Full Text \(biomedcentral.com\).](#)

³¹ [Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects - Ogden - 2020 - Medical Journal of Australia - Wiley Online Library.](#)

³² [Interventions for health workforce retention in rural and remote areas: a systematic review | Human Resources for Health \(springer.com\).](#)

³³ [National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 | Australian Government Department of Health and Aged Care.](#)

³⁴ [National Medical Workforce Strategy 2021–2031 \(health.gov.au\).](#)

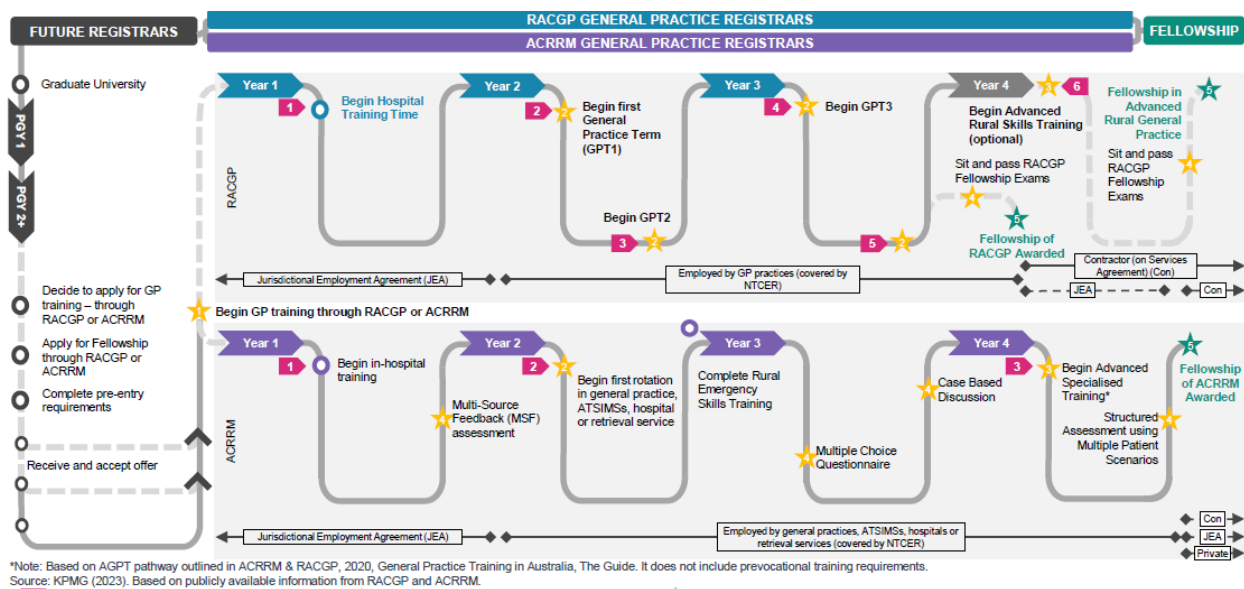
³⁵ Parker J, Hudson B, Wilkinson T. Influences on final year medical students' attitudes to general practice as a career. *J Prim Health Care* 2014;6(1):56–63.

care rotations in regional and rural locations. The JFPDP currently offers limited opportunities for metropolitan based junior doctors to undertake primary care placements.

Pay and entitlements under state hospital awards and employment agreements encourage junior doctors to remain in the hospital system, with GP trainees typically losing their employment entitlements when they transition into community general practice. To fulfil their training requirements, GP trainees are generally required to change placements (and usually employers) every 6-12 months. They are therefore disadvantaged in accruing employment-based entitlements throughout their training tenure, which generally takes between three to four years. GP trainees also experience an estimated average \$30,000 pay drop when transitioning from hospital employment into community general practice settings.³⁶ In 2024, 55 per cent of all surveyed AGPT and RVTS participants reported they were earning less than they had during their prevocational training.³⁷

The Victorian and Queensland governments have attempted to counter the pay drop experienced by GP trainees with time limited incentive payments for a capped number of GPs, noting the Victorian Government scheme is due to end in 2025 and the Queensland Government scheme is due to end in 2026. These incentive payments have created some positive outcomes for those individual states, with Victoria and south-eastern Queensland oversubscribed for GP training applications in 2025.³⁸ However, these incentives have also likely exacerbated workforce maldistribution by drawing GP trainees away from other states and underserved regions.

Figure 4: GP training pathways and employment arrangements



³⁶ State and territory medical doctor award and salary rates analysis undertaken by the Department of Health and Aged Care.

³⁷ Department of Health and Aged Care, National Registrar Survey 2024 [unpublished data].

³⁸ GP college selection data analysis undertaken by the Department of Health and Aged Care.

Community impacts of GP shortages

The community impact of medical workforce maldistribution, including GP shortages, is significant. The evidence base supporting the health-promoting impact of primary care access is well established,^{39 40} with adequate primary healthcare provision associated with a lower burden of illness and mortality.^{41 42} The Australian healthcare system operates on the principle that no individual or community group should face disadvantages when seeking healthcare services. Therefore, enhancing the availability, retention and equitable distribution of a skilled GP workforce should remain a priority for all governments.⁴³

The importance of the Australian population having access to quality primary healthcare is underscored by the increasing prevalence of chronic diseases, including mental health disorders, and of co-morbidities that require more complex care.⁴⁴ The inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population served.⁴⁵ As healthcare delivery becomes more effective it improves population health. The corollary is that if such care is delivered inequitably, inequalities in health will widen.⁴⁶ The distribution of needs-based care is socially patterned. The consequences are unmet need, poorly coordinated care, and greater reliance on unscheduled care services.⁴⁷

Negative impacts from a lack of primary care access are disproportionately felt in rural and regional areas and by culturally and linguistically diverse (CALD), First Nations and lower socio-economic populations. Chronic diseases, such as asthma, osteoarthritis and diabetes, are more common in these populations.⁴⁸ A lack of appropriate primary care access for CALD populations puts them at greater risk of poorer health outcomes including mental health conditions.⁴⁹

³⁹ Baird B, Reeve H, Ross S, et al (2018) Innovative models of general practice, *The King's Fund*.

⁴⁰ Association of Family Health Teams Ontario, Valuing comprehensive primary care: the Starfield Principles, www.afhto.ca/sites/default/files/wp-content/uploads/Valuing-comprehensive-primary-care.pdf.

⁴¹ Starfield B, Shi L and Macinko J (2005) 'Contribution of Primary Care to Health Systems and Health', *The Milbank Quarterly*, 83(3): 457-502, www.doi.org/10.1111/j.1468-0009.2005.00409.x.

⁴² Jerant A, Fenton J J and Franks P (2012) 'Primary Care Attributes and Mortality: A National Person-Level Study' *The Annals of Family Medicine*, 10(1) 34-41, www.annfammed.org/content/10/1/34.

⁴³ Department of Health and Aged Care, Supply and Demand study: General Practitioners in Australia, August 2024.

⁴⁴ Australian Institute of Health and Welfare (2022) *Australia's health 2022*, AIHW Canberra.

⁴⁵ Hart JT. The inverse care law, *Lancet*, 1971.

⁴⁶ Mercer SW, Zhou Y, Humphris GM, et al. Multimorbidity and socioeconomic deprivation in primary care consultations, *Ann Fam Med*. 2018.

⁴⁷ Hart JT, Thomas C, Gibbons B, et al. Twenty five years of case-finding and audit in a socially-deprived community, *BMJ*, 1991.

⁴⁸ [National Medical Workforce Strategy 2021-2031](#).

⁴⁹ Australian Institute of Health and Welfare, Chronic health conditions among culturally and linguistically diverse Australians, 2021.

Health workforce shortages disproportionately impact First Nations people. First Nations people continue to experience higher rates of 'disease burden' than the Australian population as a whole. First Nations people experience disease burden at 2.3 times the rate of non-Indigenous Australians. Workforce shortages impact on the capacity to grow and improve health outcomes for First Nations communities. Vacancies in organisations providing First Nations Primary Health care have increased from 444.7 FTE in 2017-18 to 780.5 FTE in 2021-22. The proportion of total medical practitioners who were First Nations people increased from 0.8% to 1.4% between 2013 and 2021, although First Nations people represent 3.1% of the working age population.^{50 51}

The accessibility of a health service goes beyond its physical availability and also encompasses other aspects, such as whether it is culturally safe.⁵² Growing the First Nations workforce, including in general practice, is critical to increasing cultural safety across the health care system, and enabling easier access and participation for First Nations people. The use of health services by First Nations people increases when they can receive culturally appropriate care.⁵³

Health service impacts of GP shortages

Patients that have lower access to primary healthcare often experience poorer health outcomes and require greater medical intervention. As such, an insufficient GP workforce places more downstream pressure on services delivered in hospital settings, which are more expensive than those delivered in community settings.⁵⁴ Hospitalisations that could have been prevented become more common as geographic isolation increases.⁵⁵

The primary healthcare sector also plays a vital role in supporting patients discharged from hospital settings. Prompt transfer of care to a GP is considered best practice and studies illustrate that

⁵⁰ AIHW, Australian Burden of Disease Study 2018: key findings for Aboriginal and Torres Strait Islander people, 2023.

⁵¹ Australian Institute of Health and Welfare & National Indigenous Australians Agency Measure 3.12 Aboriginal and Torres Strait Islander people in the health workforce, Aboriginal and Torres Strait Islander Health Performance Framework website, AIHW, Australian Government, 2023.

⁵² Scrimgeour M & Scrimgeour D 2008. Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: a review of the literature, Cooperative Research Centre for Aboriginal Health.

⁵³ Roseby R, Adams K, Leech M, Taylor K & Campbell D 2019. Not just a policy; this is for real. An affirmative action policy to encourage Aboriginal and Torres Strait Islander peoples to seek employment in the health workforce. *Internal Medicine Journal* 49:908-10.

⁵⁴ Royal Australian College of General Practitioners (RACGP) (2020), *Economic benefits of the RACGP's Vision for general practice and a sustainable healthcare system*, RACGP, accessed 10 September 2023. www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice/economic-benefits-of-the-racgp-vision.

⁵⁵ Australian Institute of Health and Welfare, Australia's Health 2024: data insights.

patients who were able to follow-up with their GP within two days of an unexpected hospital admission resulted in 32 per cent fewer readmissions in the first week.⁵⁶

Economic impact of GP shortages

A high functioning general practice sector can produce economic benefits across the whole of health sector, and the broader community.⁵⁷ The combination of continuity of care, comprehensive medical oversight, coordination, and highly trained medical professionals can produce excellent preventative population health outcomes.^{58 59}

In 2018, the World Health Organization (WHO) assessed a range of economic benefits of primary health care.⁶⁰ Although the focus of this review was primary health care, most of the evidence presented related to programs or health services involving general practice. The paper presented a conceptual framework of primary healthcare that is based on three known macroeconomic benefits of healthcare: health outcomes, health system efficiency and health equity. The authors found strong evidence linking better primary health care, specifically general practice, to a range of economic benefits through its potential to improve the three factors outlined in the conceptual framework (Figure 5).

⁵⁶ NSW Health – Lumos. (2022). *Readmissions to hospital* [Fact sheet]. NSW Government. www.health.nsw.gov.au/lumos/Factsheets/readmissions-to-hospital.pdf.

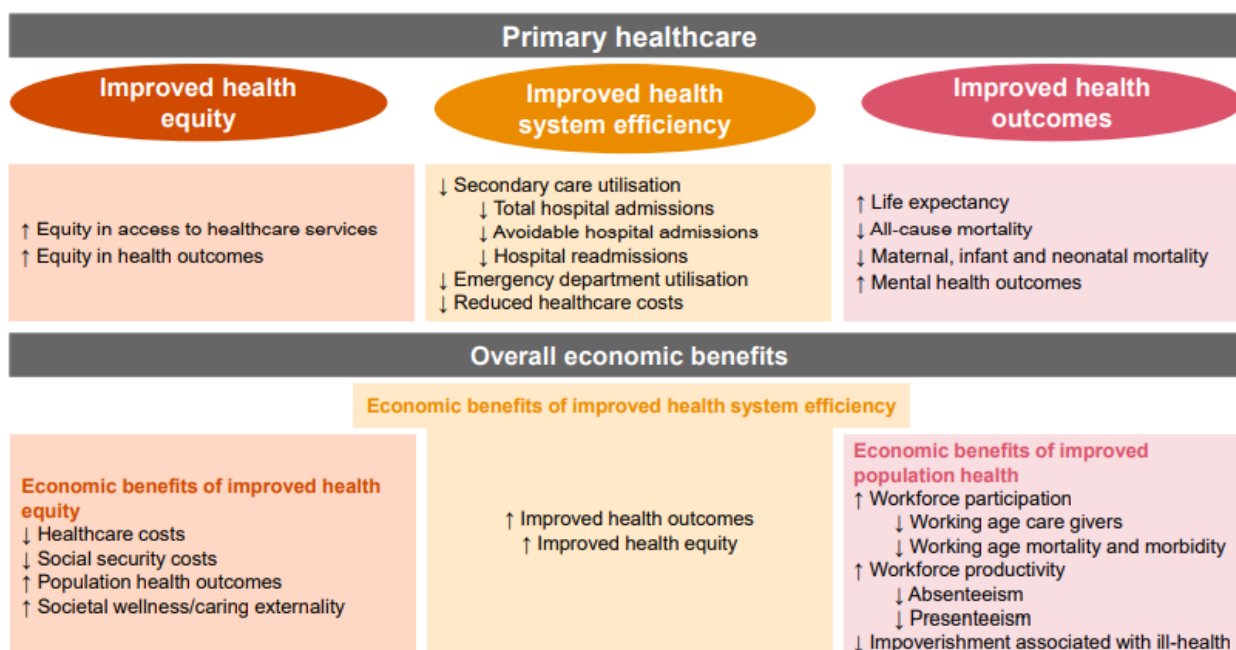
⁵⁷ Royal Australian College of General Practitioners (RACGP) (2020), *Economic benefits of the RACGP's Vision for general practice and a sustainable healthcare system*, RACGP, accessed 10 September 2023. www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice/economic-benefits-of-the-racgp-vision.

⁵⁸ RACGP position statement – the role of specialist GPs, October 2020.

⁵⁹ Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*, www.bmjopen.bmj.com/content/bmjopen/8/6/e021161.full.pdf.

⁶⁰ World Health Organization. Technical Series on Primary Health Care. Building the economic case for primary health care: a scoping review. Geneva: WHO, 2018.

Figure 5: WHO conceptual framework to assess the economic benefits of primary healthcare



Without a sufficiently resourced primary healthcare sector with adequately trained GPs, these economic benefits cannot be realised.

Data quality and gaps

This Impact Analysis has been informed by data from various sources, including the GP colleges and GP support organisations, as well as data and reports from the Australian Institute of Health and Welfare (AIHW),⁶¹ academic literature and the department’s databases.

The General Practitioner (GP) Supply and Demand Study⁶² and the Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool are important sources that inform health workforce policy and planning⁶³ and informed the development of this Impact Analysis. The GP Supply and Demand Study is a health workforce model that projects the supply and demand of Australia's primary health care GPs over a 25-year period. The GP model has been designed to simulate complex policy scenarios and analyse geo-spatial GP workforce implications. The future projections in supply and demand in the model are based on certain assumptions, including about population growth rates, annual GP training places, GP services per capita growth rates and the duration of GP consultations.

The HeaDS UPP Tool is an integrated source of health workforce and services data that informs workforce planning and analysis. HeaDS UPP brings health data together to visually highlight how

⁶¹ The Australian Institute of Health and Welfare (AIHW) Data and Reports, www.aihw.gov.au/reports-data.

⁶² Supply and Demand Study, www.hwd.health.gov.au/supply-and-demand/gp-supply-demand-study.html.

⁶³ Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool, www.hwd.health.gov.au/headsupp.

the community uses and accesses health services and the health workforce. It provides a single access point to workforce data from a number of datasets such as the Medicare Benefits Schedule, Australian General Practice Training, Royal Flying Doctor Service Program, National Health Workforce Dataset, National Health Service Directory and others. The HeaDS UPP Tool is available to be accessed by select government and non-government organisations involved in health workforce planning.

While the department has access to significant data on all points along the GP training pipeline and the shortages of GP services in regional, rural and remote areas, there is a lack of comprehensive data on where GP registrars choose to practice after they have completed their qualifications and training, particularly in the period of 5-10 years post training. These data limitations are further outlined in the GP Supply and Demand Model - Methodology Paper.⁶⁴ One of the recommendations of the mid-term review of the AGPT grant agreements was the adoption of an outcomes focus, including measuring rural retention rates post-fellowship of GP registrars. The department is currently working to support improvements in the scope and quality of the data to better inform workforce planning efforts.

⁶⁴ General Practitioner (GP) Supply and Demand Model - Methodology Paper, www.hwd.health.gov.au/resources/primary/gp-supply-and-demand-model-methodology-paper-august-2024.pdf.

4. Policy objectives

Why should the Australian Government act to grow the GP workforce?

Noting the growing supply and demand shortfall for GPs, the Australian Government has considered options to intervene and take action to grow the GP workforce. General practice care caters for complex issues and provides whole of person care for all ages, genders and cultures, and across all disease categories, and GPs treat patients within their social, cultural and environmental contexts. This holistic, patient-centred and relationship-based approach is unique amongst doctors and other medical specialists. GPs are experts in longitudinal relationship-based care, whole patient differential diagnosis and healthcare management planning.⁶⁵

GPs are trained in diagnosis and treatment, prevention and management of both acute and chronic conditions and coordination and supervision of care arrangements. These advanced and diverse clinical skills are essential to their role, as patients often present with undifferentiated symptoms and multi-morbidities. GPs have advanced clinical training and skills in diagnostics, therapeutic interventions and care coordination and leadership. GPs also holistically and objectively promote patient health and wellbeing across the range of physical, mental and social experiences, including multi-morbidity.⁶⁶ These are distinctive facets of general practice and GPs are unlike other health professionals in Australia. As primary care professionals, GPs provide cost-effective services that prevent disease and promote health, keeping patients out of hospitals and relieving pressure on other parts of the health system.⁶⁷ Some GPs, particularly those in rural and remote areas, also provide advanced procedures such as surgical, anaesthetic and obstetric care.^{68 69}

⁶⁵ Murtagh J, Rosenblatt J, Coleman J, Murtagh C. The nature, scope and content of general practice. *Murtagh's General Practice*. 7th edn. Sydney: McGraw-Hill Education, 2018.

⁶⁶ Royal Australian College of General Practitioners. The role of specialist GPs. Melbourne: RACGP, 2020. Available from <https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/shared-care-model-between-gp-and-non-gp-specialist#ref-num-8>

⁶⁷ Royal Australian College of General Practitioners. The role of specialist GPs. Melbourne: RACGP, 2020. Available from <https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/shared-care-model-between-gp-and-non-gp-specialist#ref-num-8>

⁶⁸ Royal Australian College of General Practitioners. The role of specialist GPs. Melbourne: RACGP, 2020. Available from <https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/shared-care-model-between-gp-and-non-gp-specialist#ref-num-8>

⁶⁹ Pashen D, Murray R, Chater B, Sheedy V, et al. The Expanding Role of the Rural Generalist in Australia – A Systematic Review. Australian Primary Health Care Research Institute. Canberra: ANU, 2007. Available at

Access to a GP for follow-up and management of side effects is critical for patients who experience chronic health conditions, and there is also a strong push in the health sector for GPs to play a greater role in disease survivorship and management of treatment-associated side effects. Current models of care are unsustainable and lack the personalised model of care required.⁷⁰ This transfer of care to GPs also aligns with Cancer Australia's *Australian Cancer Plan*, which aims to build the capacity of GPs and increase their involvement in parts of cancer treatment and follow-up from as early as November 2025.⁷¹

General practice leadership of healthcare teams can multiply these benefits and produce greater efficiencies. The Government is considering scope of practice reforms that could increase the availability of primary care services. However, this will not 'substitute' the work of GPs, but complement the work of GPs and ensure all primary care health professionals are supported to work closer to full scope of practice or in some cases, extend scope of practice.

A GP's ability to detect early warning signs of disease and provide early intervention (particularly in the common clinical context of complex and undifferentiated symptoms) will continue to be a critical component in the delivery of effective primary care services.^{72 73}

Governments benefit from increasing population access to high quality primary care services through reduced downstream healthcare costs in the hospital system. State and territory governments have recognised the impacts of reduced access to primary care on the hospital system, and some state and territory governments have made recent investments in the primary care workforce, even though traditionally most primary care has been delivered by private sector services supported by MBS patient rebates funded by the Australian Government.

What levers are available to enable Government action?

Primary healthcare is predominantly funded through MBS rebates provided by the Commonwealth government. However, the whole of medical training pipeline is a complex space, with responsibility for producing a fully qualified GP shifting between the private sector and both state and national levels of government. The Commonwealth funds university places, with states and territories largely overseeing internship and residency prevocational training, and the Australian

https://www.acrrm.org.au/docs/default-source/all-files/expanding-role-of-rural-generalists.pdf?sfvrsn=d21a9feb_6

⁷⁰ Jefford M, et al. (2022). Improved models of care for cancer survivors. *The Lancet*, 339(10334), 1551-1560. [https://doi.org/10.1016/S0140-6736\(22\)00306-3](https://doi.org/10.1016/S0140-6736(22)00306-3).

⁷¹ Cancer Australia (2023). *Australian Cancer Plan*. The Australian Government. www.australiancancerplan.gov.au.

⁷² Western Australia Primary Health Alliance. *Comprehensive primary care: What Patient Centred Medical Home models mean for Australian primary health care*. Belmont, WA: WAPHA, 2016.

⁷³ Sripa P, Hayhoe B, Garg P, Majeed A, Greenfield G. Impact of GP gatekeeping on quality of care, and health outcomes, use, and expenditure: A systematic review. *Br J Gen Pract* 2019 May, www.bjgp.org/content/69/682/e294.

Government funding GP training programs delivered in the private sector. Intergovernmental and stakeholder forums, such as the General Practice Training Advisory Committee, Health Workforce Taskforce, Medical Workforce Advisory Collaboration, Health Chief Executive Forum, and Health Ministers' Meeting, enable constructive discussion and consideration of medical workforce issues and solutions. Further, the National Health Reform Agreement is a key mechanism for transparency, governance and financing of healthcare services in Australia, including significant investments in teaching and training.

Significant investments in vocational GP training to date have served to provide assurance that the quality of care provided under the MBS provides value for public money. However, the evidence surrounding what works for medical workforce attraction and retention is mixed.⁷⁴ There are strong indicators that financial considerations, positive exposure and working conditions play a key part. Other factors that drive attraction and retention include career and professional development options; perceptions of prestige; personal factors; culture; and living conditions.^{75 76 77 78 79 80 81 82 83} The possibility of a better work-life balance (including the ability to work part-time) is influential, as is the opportunity to build a connection with patients and community through the provision of comprehensive, holistic and person-centred health care.⁸⁴

⁷⁴ WHO 2021.

⁷⁵ Mohammadiaghdam N, Doshmangir L, Babaie J, Khabiri R and Ponnet K (2020), 'Determining factors in the retention of physicians in rural and underdeveloped areas: a systematic review', *BMC Family Practice*, 21:216, <https://doi.org/10.1186/s12875-020-01279-7>.

⁷⁶ McGrail M, Adegbija O, Kondalsamy-Chennakesavan S (2021), Characterising Australia's rural specialist physician workforce: the professional profile and professional satisfaction of junior doctors and consultants. *Med J Aust*, 215(1 Suppl): S7–S14, <https://doi.org/10.5694/mja2.51122>.

⁷⁷ Peel R, Young L, Reeve C, Kanakis K, Malau-Aduli B, Sen Gupta T and Hays R (2020), The impact of localised general practice training on Queensland's rural and remote general practice workforce. *BMC Med Educ* 20, 119, <https://doi.org/10.1186/s12909-020-02025-4>.

⁷⁸ Ogden J, Preston S, Partanen R, Ostini R and Coxeter P (2020), Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects. *Med. J. Aust.*, 213: 228-236, <https://doi.org/10.5694/mja2.50697>.

⁷⁹ Robinson M, Slaney G (2013), Choice or chance! The influence of decentralised training on GP retention in the Bogong region of Victoria and New South Wales. *Rural and Remote Health*; 13: 2231, <https://doi.org/10.22605/RRH2231>.

⁸⁰ Woolley T, Hogenbirk J, Strasser R (2020), Retaining graduates of non-metropolitan medical schools for practice in the local area: the importance of locally based postgraduate training pathways in Australia and Canada. *Rural and Remote Health*, 20: 5835, <https://doi.org/10.22605/RRH5835>.

⁸¹ Kumar S and Clancy B (2021), Retention of physicians and surgeons in rural areas—what works?, *Journal of Public Health*, 43(4): e689–e700, <https://doi.org/10.1093/pubmed/fdaa031>.

⁸² Wearne S, Brown J, Kirby C, and Snadden D (2019), International medical graduates and general practice training: How do educational leaders facilitate the transition from new migrant to local family doctor? *Medical Teacher*, 41(9), 1065–1072, <https://doi.org/10.1080/0142159X.2019.1616681>.

⁸³ Sivey, S. Scott, A. et al. Junior doctors' preferences for specialty choice, *Journal of Health Economics* Vol 31: 6. 2012.

⁸⁴ [RRH: Rural and Remote Health article: 8808 - Factors associated with early-career GPs' retention as independent specialists in former training practices.](#)

While some of these attraction elements are subject to influences outside of the direct control of the Australian Government (e.g. social determinants), Australian Government levers to reduce the GP shortfall include:

- Subsidisation of university medical places and caps on the number of subsidised places, including through grant agreements for Rural Health Multidisciplinary Training (RHMT) and Murray Darling Medical Schools Network (MDMSN). The Government also facilitates strong relationships with peak bodies such as Medical Deans Australia and New Zealand, and provides support for the Universities Accord.
- Funding of prevocational GP training placements (and restriction of these through Medicare access requirements). This ensures junior doctors can access high quality training experiences during a time when they are making decisions about their careers.
- Funding and capping of vocational GP training places, including managing grant arrangements, and policy advisory committees to guide the future direction and priorities of the GP workforce.
- Direct payments to GP registrars to support training through the National Consistent Payments (NCP) Framework administered by Services Australia. Direct payments are targeted to those with the greatest workforce need.

While the Government already invests in GP training, the value of this investment has not always been maximised, with the undersubscription of GP training places in the past. Current trends show a positive uptake in GP training places in more recent years, with GP training places likely to be fully filled in 2025. Increased interest in GP training, along with existing investment and maturity of GP training programs, can be leveraged to further drive-up demand for GP training places and add additional training capacity. This should be supported through upstream investments in the pipeline to increase attraction into GP training. Increased demand for GP training places points to the opportunity to drive increased GP growth and address future workforce shortages.

Alternatives to Government action

Given the increasing priority of this issue among GP sector stakeholders, many stakeholders have considered what can be done to increase population access to quality, safe primary care services, and have called on Government to boost GP workforce supply.^{85 86 87 88}

Steps already being undertaken to address the issues in the GP training pipeline include universities encouraging a greater focus on general practice in their medical programs, and the GP colleges filling additional GP training places. However, addressing GP shortages is not a problem that can be solely addressed by the GP colleges, universities and the private sector, in the absence of Government support. In the current economic environment, significant change is unlikely to occur without additional government investment.

Furthermore, there are many points along the GP training pipeline where effective interventions cannot be made without Government intervention. For example, even if more medical students graduated with an interest in general practice, current caps on GP training program numbers would continue to limit the number of qualified GPs attaining fellowship each year. Similarly, while more medical students may be interested in becoming a GP, many may choose other medical specialties during the prevocational period. This period currently offers little to no exposure to general practice outside of the JFPDP, which has limited availability of rotations and eligibility requirements that limit access. Many junior doctors are also dissuaded by the initial financial barriers to entering GP training, noting starting base salary rates are often lower than in hospital settings. Private GP practices are generally small to medium businesses which rely on Government funding streams (through Medicare and other programs), and do not have capacity to overcome these barriers for the GP registrars through service profits.

Without Government action, there is likely to be a significant and growing shortfall of GPs in the future. This is analysed further below under Option 1, which examines the impact of maintaining the status quo.

⁸⁵ Medical Deans Australia and New Zealand (2019), *The Doctors our Communities Need: Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand*, accessed 9 January 2025, <https://medicaldeans.org.au/md/2023/10/MDANZ-General-Practice-Paper-Sep-2023.pdf>.

⁸⁶ Australian Medical Association (2024), *AMA Pre-Budget Submission 2024-25*, accessed 9 January 2025, www.ama.com.au/articles/ama-pre-budget-submission-2024-25.

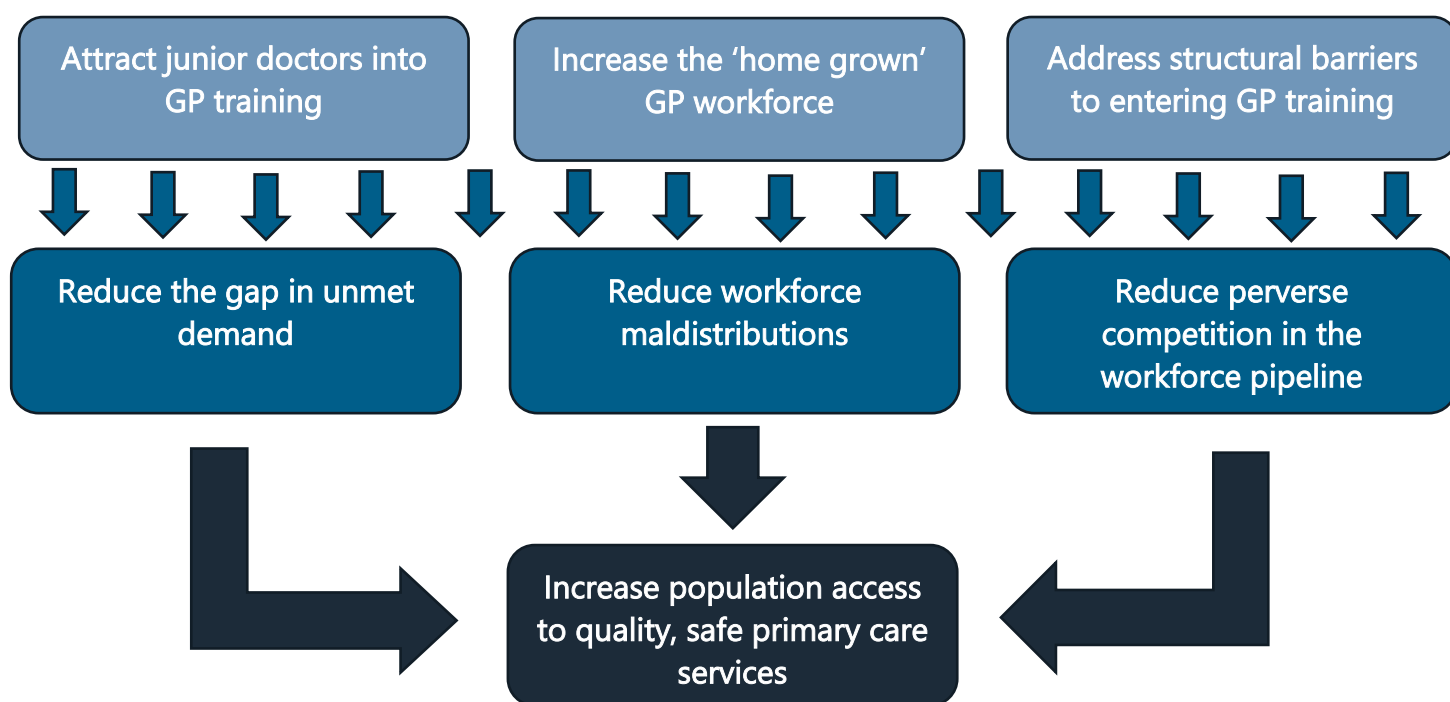
⁸⁷ Royal Australian College of General Practitioners (2024), *Pre-Budget Submission 2024-25*, accessed 9 January 2025, www.racgp.org.au/getmedia/091a51bc-7d79-416f-bcc4-2bfb580218d7/RACGP-Pre-Budget-Submission-2024-25.pdf.aspx.

⁸⁸ Australian College of Rural and Remote Medicine (2024), *Pre-Budget Submission 2024*, accessed 9 January 2025, www.acrrm.org.au/docs/default-source/all-files/acrrm-pre-budget-submission-2024.pdf?sfvrsn=fd77e5e9_16.

What is the policy objective of Government action?

Consistent with broader health workforce policy aims, the overall policy objective of Government action to reduce the growing GP shortage should be to increase population access to quality, safe primary care services. To achieve this objective, action must simultaneously improve attraction to the GP profession, particularly for the 'home grown' workforce, and reduce unintended barriers. To avoid perverse impacts on other in-need medical specialities, action should support the growth of Australia's medical workforce pipeline, assisting to address broader medical workforce inequities and maldistribution. Figure 6 illustrates how these intended outcomes combine to achieve the overall objective of increasing primary care access for the whole population.

Figure 6: Policy objectives for building the GP workforce



What is the overall SMART target of policy action?

The target for the above objectives will be to increase GP workforce supply, such that the identified unmet demand gap of 7,700 GPs by 2033 is significantly reduced. While eliminating the unmet demand gap is unlikely in the immediate term, modelling suggests that, with increased training capacity and incentivisation, material reductions in the unmet demand gap can be achieved.

SMART Target:

- Reduce the national gap in unmet demand for GP services by approximately 30 per cent by 2033.

5. Policy options analysis

Option 1 – Status Quo

Description

The option involves remaining with the status quo, consistent with existing investment and policy authorities. This consists of:

- Around 14,000 CSPs in total, producing around 3,000 medical graduates each year.⁸⁹
 - This includes 402 commencing CSPs attached to rural medical schools, with 1,785 students studying at any one time at full capacity.
 - None of the nationally allocated CSPs possess a specific focus on general practice or primary care settings.
- Around 600 JFPDP rotations in MM2-7 regions in 2024, progressively increasing to 1,000 in 2026.
- AGPT training places capped at 1,500 commencements per annum.
 - Tiered payments for AGPT registrars, supervisors and practices, based on rurality, under the [National Consistent Payments](#) (NCP) framework.
 - 50 per cent target of AGPT training to occur in MM2-7 locations.
- 100 RGTS training places per annum.
- 32 RVTS training places per annum, including 10 places in Aboriginal Community Controlled Health Services (ACCHSs).
- Independent, self-funded GP training pathways remaining uncapped.

In 2023, the AGPT program followed 1,079 new GPs.⁹⁰ With high demand for GP training places, it is likely that fellowship rates will increase in the coming years. Allowing for a 20 per cent variance to factor in attrition and part time arrangements, a full subscribed Commonwealth-funded GP training pipeline should be following around 1,280 GPs per annum.

The Commonwealth is due to enter into new grant agreements with the GP colleges and RVTS for the continuation of the Commonwealth funded GP training programs from 1 January 2026. The Commonwealth currently has no financial or contractual arrangement with the self-funded pathways.

Option 1 SMART target

Commonwealth-funded GP training programs to achieve and maintain a fellowship rate of 1,280 GPs per annum from 2028.

⁸⁹ 2024 Australia-wide CSP numbers.

⁹⁰ GP College data.

Additional cost estimates to Health portfolio (\$m)

Nil – covered by existing appropriations.

Analysis

As previously stated, GP training places are likely to be fully subscribed in 2025. For AGPT and RGTS collectively, the Minister for Health and Aged Care has approved additional training capacity within the current funding, using funding for unfilled 2023 and 2024 training places to offset any 2025 oversubscription. While this ensures we are keeping pace with demand for training places in 2025, these solutions will not flow onto future years without additional investment.

While the current AGPT program settings require 50 per cent of training to occur in MM2-7 regions, regions of critical workforce shortage, such as western New South Wales, western Queensland and the Northern Territory, continue to be significantly undersubscribed for GP training. Training and supervision capacity can also be lacking in these areas, though there has been a shift toward remote supervision arrangements to support training capacity where such challenges persist. While quality training should always be the primary objective of GP training programs, there is opportunity to consider how distribution mechanisms can be improved to better address maldistributions and maximise retention for communities in need. This was the subject of recommendations by the *Working Better for Medicare Review*, which are now being considered by the Government. There is opportunity for a future AGPT program to adopt improved distribution mechanisms to maximise training outcomes across communities.

Given applications for GP training are increasing, continuing with the status quo will likely result in applicants being turned away from the Commonwealth-funded GP training programs. While a small proportion of these applicants may syphon onto the self-funded GP training pathways, with arguably less quality control over their education or supervision, many may be lost to general practice. Many will remain in the hospital system as unaccredited registrars or leave medicine altogether.

If there are no investments made to the GP training pipeline, Australia will continue to face a shortage of GPs. As previously stated, modelling by the department demonstrates a growing shortfall of GPs, with 7,700 (5,560 FTE) more GPs needed by 2033 growing to 12,400 (8,900 FTE) more GPs needed by 2048, and shortages worsening in every jurisdiction between now and 2048. While the gap will increase for all states and territories, NSW is expected to need the most additional GPs (2,200 by 2033). The NT, which is already experiencing critical shortages, will need to grow its GP workforce by almost 50 per cent (to 1,158 by 2033).⁹¹

Increased GP shortages would mean that Australians would increasingly face difficulty accessing primary care. As described in Section 3, a lack of primary care access adversely impacts population health. GP shortages would therefore have negative impacts on communities across Australia –

⁹¹ [Supply and Demand \(health.gov.au\)](https://www.health.gov.au).

more disproportionately in those areas already experiencing poorer health outcomes. There would also be adverse economic impacts, through reduced early intervention and additional health services being delivered in more expensive hospital settings. There are also broader productivity impacts through poorer population health, resulting in less economic participation.

Option 1 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none"> • Nil immediate cost impact. 	<ul style="list-style-type: none"> • Progressively lower access to primary healthcare, particularly in regional and rural areas. • Downstream pressure on acute care system. • More care being provided in more expensive settings. • Poorer population health leading to lower economic participation and productivity. • Does not grow the regional and rural proportion of GP trainees, which is likely to exacerbate maldistributions. • GP training colleges will become increasingly overstretched from demand outstripping training capacity. • Junior doctors will receive fewer opportunities to enter GP or RG training even if they have met eligibility criteria. This may result in viable junior doctor candidates turning away from GP careers.

Option 2 – 150 new primary care CSPs

Description

This action would see 150 new medical Commonwealth Supported Places (CSPs) allocated on a competitive basis among universities. Once mature, this would see new medical graduates each year pursuing GP careers. These CSPs would be intrinsically linked to general practice to drive early career decisions.

Translating these CSPs into more GPs could be achieved via the following regulatory mechanisms:

1. To receive funding, universities would be required to show evidence-based strategies for delivering more GPs, particularly in rural and underserved metropolitan areas. These could include demonstrating the success of existing activities and their outcomes, demonstrating tailored curricula and programs with a primary care focus, recruitment strategies focused on

increasing uptake of GP senior academics, demonstrating strong clinical training relationships and activities with training placements and supervisors. This would place responsibility on universities to ensure medical students are encouraged into a GP training pathway. CSPs would be re-contestable after 6 years based on GP training pipeline outcomes achieved. Ongoing student funding would only be available if university targets for students to pursue primary care careers were met. This would also incentivise universities to select students more likely to undertake GP training and ensure quality primary care-focused education. This would also drive universities to provide better primary care experiences to all medical students, supported by GP educators and quality clinical placements in GP practices.

2. A more stringent regulatory option would involve a bonded approach for the CSPs, requiring participants to reimburse government if they do not enter general practice. This would involve an approach commensurate with the existing Bonded Medical Program (BMP), which aims to address the shortage of medical professionals in regional, rural and remote areas by providing a CSP in a medical course in exchange for participants completing a Return of Service Obligation (RoSO) in general practice, which would require general practice training to be undertaken.

In 2006, through Council of Australian Governments (COAG) forums, all states and territories agreed to guarantee internships for all CSP graduates. While the intention would be for these CSPs to be primary care focused, it would still be expected that hospital placements would be required to fulfill requisite competencies. Under this option, the Australian Government would continue to hold states and territories to account for guaranteeing these placements, including for the primary care CSPs.

Timeline

GoG development and release:	4 months
Assessment and negotiation:	2 months
Agreement execution:	3 months – funding agreements to be executed by February
Start date:	February or March of commencing year – ongoing

Option 2 SMART target

An additional 1,500 medical graduates with an interest in entering general practice (over 10 years from 2030).

Roles and responsibilities

Commonwealth	States and territories	Universities	GP colleges
<ul style="list-style-type: none"> Draft and administer grant opportunity guidelines (GoGs) Select grantees and administer grant agreements Set key performance indicators (KPIs) Evaluate performance outcomes 	<ul style="list-style-type: none"> Ensure availability for hospital-based internships, where required and necessary Facilitate seamless transitions across hospital and primary care placements 	<ul style="list-style-type: none"> Develop primary care focused curriculum Employ GP academics Comply with review/evaluation requirements Collaborate with GP colleges to increase early exposure and facilitate quality placement experiences Meet KPIs 	<ul style="list-style-type: none"> Collaborate with universities to increase early exposure and facilitate quality placement experiences Comply with review/evaluation requirements

Additional cost estimates to Health and Education portfolios (\$m)

	2025-26	2026-27	2027-28	2028-29	TOTAL
Health	\$0.7	\$2.0	\$3.6	\$5.5	\$11.8
Education	\$1.7	\$5.2	\$9.8	\$15.4	\$31.8

Note: Indexed for WCI1

Analysis

CSPs are an important component of growing the overall medical workforce. This is a view shared by states and territories, who consistently advocate for more medical CSPs to fill workforce gaps in public hospitals.

There are currently around 14,000 medical students in Australia that are supported through CSPs (see [Appendix C](#) for CSP allocations). Medical student numbers have grown from 17,146 in 2018 to 18,920 in 2024, contributing to an increase in the number of medical graduates (around 3,500 in 2017 to 3,600 in 2023). The data suggests that around 70-80 per cent of medical students are on a CSP, with the number of CSP medical graduates expected to grow from 2,774 in 2023 to 3,071 in 2033.⁹²

Distribution and specialty maldistribution remains a pressing issue. As previously discussed, general practice is projected to be in increasing shortage. Other specialties experiencing shortages include ophthalmology, dermatology and psychiatry. Insufficient numbers of specialists can exacerbate

⁹² Medical Deans Australia & New Zealand (MDANZ) data dashboard.

geographic shortages as those in undersupply are more likely to be offered and obtain work in metropolitan areas.⁹³

In 2023 and 2024, the Australian Government announced a further allocation of 140 rurally based medical CSPs, which universities matched with 86 existing CSPs (226 in total). These places were allocated to rural medical schools to help address geographical medical distribution inequities across regional, rural and remote Australia. However, due to the considerable lag between investment and outcomes, the data is currently inconclusive regarding what professional outcomes the CSPs are producing. While the recently announced 140 CSPs for rural medical schools is an important test for how studying in a rural area influence workforce outcomes, this will take years to reach outcomes that can be evaluated.

Noting that the evidence base is developing, a bonded regulatory approach would likely generate a greater perception of certainty for retention into general practice. However, the evidence base does not necessarily support this. Medical students would be required to sign up at the start of medical school, when they are likely to be unsure of what career they will want to pursue. A 2021 systematic literature review highlighted that regulatory interventions requiring return of service in rural areas were associated with low rural retention, especially once the return of service period was complete.⁹⁴

Furthermore, a bonded approach would carry a significant regulatory burden, with the high potential of negatively impacting the Australian Government, GP practices, the GP training colleges and GP trainees themselves. For examples, this approach would embed considerable restrictions on where GP trainees would work and how long they work there for, noting that such restrictive levers are rarely effective at driving positive outcomes. Legislative change would also likely be required to implement a new scheme or adapt the existing bonded program, delaying implementation and creating added complexity to the GP training landscape.

Evidence suggests that improved workforce outcomes would be achieved by shifting away from the more traditional forms of medical school curriculum and adapting eligibility criteria to capture a greater diversity of students.^{95 96} Given that perceptions of prestige are influential factors that guide decision-making, a curriculum approach that includes GP educators and positive exposure to GP clinical settings would be more likely to have a positive impact. Placing influence on universities to make these adaptations through targets and basing recurrence of funding on outcomes achieved presents a sensible and 'smart'⁹⁷ regulatory option to achieve these outcomes, while also driving greater reform across the university sector.

⁹³ [National Medical Workforce Strategy 2021–2031 \(health.gov.au\)](https://www.health.gov.au/health-research/national-medical-workforce-strategy-2021-2031).

⁹⁴ [Interventions for health workforce retention in rural and remote areas: a systematic review | Human Resources for Health \(springer.com\)](https://www.springer.com/journal/10975/10).

⁹⁵ [The role of medical schools in UK students' career intentions: findings from the AIMS study | BMC Medical Education | Full Text \(biomedcentral.com\)](https://www.biomedcentral.com/10.1186/s12916-021-02000-0).

⁹⁶ [United Kingdom medical student expansion – Can new medical schools seize the initiative? - ScienceDirect](https://www.sciencedirect.com/science/article/pii/S0926641021000000).

⁹⁷ Delivering optimal outcomes in the least burdensome manner.

While evidence does support that medical students who come from and study in rural areas are more likely to stay and practice rurally, there are questions with regards to the capacity of a number of regional and rural medical schools to support more dedicated CSPs. Option 2 therefore provides a variation by capturing medical students across both regional/rural and metropolitan areas and nudging them towards general practice careers through more targeted curriculum. This would not only capture a greater number of medical students but also increase the diversity of the participating cohort. Under this model, decisions to place CSPs in rural areas would need to be supported by applications from universities demonstrating internal and regional capacity to facilitate the education and clinical supervision of students.

There is an argument that steering medical graduates toward careers in general practice only places greater pressure on other areas of medical workforce shortage, including the hospital system. However, there is currently inconclusive supporting evidence. Any addition of new CSPs boosts the overall pipeline, including by creating downstream benefits for the hospital system through added capacity.

Given the inequities in health workforce participation, CSPs would also be used more proactively as a lever to boost the number of First Nations medical graduates to achieve parity by 2031. Funding would be provided to uncap places for all First Nations students who meet the entry requirements to enroll in courses in medicine. This approach addresses one of the recommendations of the Universities Accord and could be formalised through University Compact agreements and supports the Australian Government's commitments under the National Agreement on Closing the Gap, to improve cultural safety across the health system and increase economic participation. Implementation would require legislative change. Noting the alignment with Closing the Gap objectives, the ACCHS sector, in particular, would likely support this investment.

Australia is not alone in undertaking an investment in, and expansion of, its medical schools to increase medical workforce capacity and address shortages. The United Kingdom's Long-term Workforce Plan articulates the goal of increasing the number of medical school places from 7,500 to 15,000 in 2031, with an additional funding injection of £2.4 billion. This is with the intention of growing the domestic medical workforce and reducing the reliance on international recruitment, and boosting the number of medical graduates entering GP training to better meet community need.⁹⁸ While the outcomes of this investment are yet to be seen, it demonstrates that similar approaches are being undertaken internationally, underpinned by modelling and evidence.

Noting that recent CSP expansions may be stretching parts of the university sector, a scaled approach will allow for universities to adapt their curriculum and increase capacity in a fiscally responsible manner. The aforementioned GP supply and demand modelling underscores the risks associated with waiting and suggests that approaches that expand the entire GP training pathway are warranted to maximise the likelihood of optimal outcomes.

⁹⁸ NHS England (2023) *NHS Long Term Workforce Plan*.

Option 2 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none">• Increased medical school pipeline, leading to more medical practitioners over the longer term.• Would drive wider reform to eligibility processes and medical school curriculum to support improved workforce distribution outcomes.• Contestability drives value for money outcomes.• More equity in the medical student cohort will likely result in more graduates with an interest in working in areas of higher need, including regional and rural locations.• Low regulatory burden.	<ul style="list-style-type: none">• Considerable lead time between investments in CSPs and outcomes• Increasing medical school pipeline without increasing GP training capacity could create latent demand in the system and place GP colleges under increased pressure to deliver more training.• Without complementary capacity increases in GP training sector, would likely place more pressure on already limited clinical supervisor capacity.

Option 3 – A new prevocational program with 400 additional rotations

Description

The JFPDP program commenced in 2023 and is a key component of the National Rural Generalist Pathway and the broader National Medical Workforce Strategy to enable and coordinate primary care prevocational training in MM2-7 regions. JFPDP is the main Commonwealth-funded mechanism providing GP rotations for interns and junior doctors in primary care. In doing this, the program aims to increase rural medical training capacity through the placement and retention of medical graduates in rural and regional areas.

The JFPDP is currently limited to regional and rural areas, leaving metropolitan junior doctors – who form half of the GP training cohort – with limited exposure to rural primary care. The JFPDP is funded via Federation Funding Agreements (FFAs) under the Federal Financial Relations Framework, with FFAs in place with all states and the Northern Territory for the 2022-23 to 2026-27 period. The ACT is currently not eligible as it is considered a wholly metropolitan jurisdiction.

Option 3 provides opportunities for more junior doctors to undertake primary care rotations outside of the traditional hospital internship placements at a time when they are choosing their future specialty career. This outcome would be achieved by expanding the existing JFPDP and widening its eligibility to form a new primary care prevocational program.

The new program would continue to prioritise regional and rural rotations, maintaining 1,000 rotations in these areas per year from 2026, but would allow metropolitan based doctors able to take up a regional rotation. In addition the program would offer an additional limited number of rotations for metropolitan based doctors in a metropolitan setting, starting with 200 new rotations in 2026, increasing progressively to 400 new rotations from 2028. As most junior doctors are in major cities, this will substantially expand the cohort who have the opportunity to be exposed to general practice. As previously noted, early exposure has been shown to increase interest in general practice.^{99 100 101 102 103 104 105} Expanding eligibility to the Post Graduate Years 6+ (PGY6+) cohort of AMGs would also provide an avenue for hospital-based doctors who are not on a specialist pathway to transition into general practice.

Eligibility requirements would avoid overlap and duplication with the existing Pre-Fellowship Program (PFP), which is aimed at IMGs and non-vocationally recognised (non-VR) doctors. Consistent with the JFPDP, the new program would be delivered by jurisdictions through FFAs, with co-contributions from states and territories.

Option 3 SMART target

Deliver an additional 400 primary care prevocational rotations per year from 2028, with three quarters of these doctors proceeding to apply for GP/RG specialist training.

⁹⁹ Mohammadiaghdam N, Doshmangir L, Babaie J, Khabiri R and Ponnet K (2020), 'Determining factors in the retention of physicians in rural and underdeveloped areas: a systematic review', *BMC Family Practice*, 21:216, <https://doi.org/10.1186/s12875-020-01279-7>.

¹⁰⁰ McGrail M, Adegbija O, Kondalsamy-Chennakesavan S (2021), Characterising Australia's rural specialist physician workforce: the professional profile and professional satisfaction of junior doctors and consultants. *Med J Aust*, 215(1 Suppl): S7–S14, <https://doi.org/10.5694/mja2.51122>.

¹⁰¹ Peel R, Young L, Reeve C, Kanakis K, Malau-Aduli B, Sen Gupta T and Hays R (2020), The impact of localised general practice training on Queensland's rural and remote general practice workforce. *BMC Med Educ* 20, 119, <https://doi.org/10.1186/s12909-020-02025-4>.

¹⁰² Ogden J, Preston S, Partanen R, Ostini R and Coxeter P (2020), Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects. *Med. J. Aust.*, 213: 228-236, <https://doi.org/10.5694/mja2.50697>.

¹⁰³ Robinson M, Slaney G (2013), Choice or chance! The influence of decentralised training on GP retention in the Bogong region of Victoria and New South Wales. *Rural and Remote Health*; 13: 2231, <https://doi.org/10.22605/RRH2231>.

¹⁰⁴ Woolley T, Hogenbirk J, Strasser R (2020), Retaining graduates of non-metropolitan medical schools for practice in the local area: the importance of locally based postgraduate training pathways in Australia and Canada. *Rural and Remote Health*, 20: 5835, <https://doi.org/10.22605/RRH5835>.

¹⁰⁵ Kumar S and Clancy B (2021), Retention of physicians and surgeons in rural areas—what works?, *Journal of Public Health*, 43(4): e689–e700, <https://doi.org/10.1093/pubmed/fdaa031>.

Timeline

FFA development and negotiation:	6 months
FFA finalisation:	Mid-year
Start date:	Start of calendar year – ongoing

Roles and responsibilities

Commonwealth	States and territories	GP colleges
<ul style="list-style-type: none"> Negotiate and agree new FFAs with states and the ACT Support governance mechanism Set KPIs Evaluate performance outcomes Develop program-specific program logic and guidelines Set reporting requirements to track program progress 	<ul style="list-style-type: none"> Negotiate and agree new FFAs Support joined up governance Meet KPIs Meet reporting requirements Facilitate seamless transitions across hospital and primary care rotations Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Support joined up governance through the Jurisdictional Coordination Units Collaborate with states and the ACT to increase early exposure and facilitate quality placement experiences Comply with review/evaluation requirements

Additional cost estimates to Health portfolio (\$m)

	2025-26	2026-27	2027-28	2028-29	TOTAL
Option 3	\$4.0	\$10.0	\$14.0	\$16.0	\$44.0

Note: Indexation does not apply as disbursed through FFAs.

Analysis

In 2023, JFPDP filled 84 per cent of its rotations, which represents a strong outcome for a program in its first year. The remaining 16 per cent (unfilled rotations) has been attributed to limited supervision capacity and broader workforce shortages. This underscores the need to grow the GP workforce with investments across the full GP training pathway.

Table 2: Current numbers of funded, delivered and forecast JFPDP rotations^{106 107}

	2023 Target: 500			2024 Target: 600		2025 Target: 800		2026 Target: 1000
	Funded	Forecast	Delivered	Funded	Forecast	Funded	Forecast	Funded
National	513	499	433	613	634	800	811	TBC
NT	67	67	66	74	74	104	TBC	TBC
QLD	128	115	92	129	146	184	TBC	TBC
NSW	96	98	77	133	132	168	TBC	TBC
VIC	44	44	42	70	70	80	TBC	TBC
TAS	32	32	18	32	32	56	TBC	TBC
SA	116	113	108	125	130	160	TBC	TBC
WA	30	30	30	50	50	48	TBC	TBC

Stakeholders continue to advocate for the Australian Government to reinstate the Prevocational General Practice Placements Program (PGPPP), which ceased in 2014. The key points of difference between the JFPDP and PGPPP are:

- JFPDP provides primary care rotations in MM2-7 regions only. PGPPP encompassed metropolitan regions.
- While metropolitan based junior doctors can participate in a JFPDP program, their places are currently capped and they must do their rotations in an MM2-7 location.
- Junior doctors on the PGPPP could bill MBS. This is excluded on JFPDP to prevent 'double dipping' and significantly reduce the program's cost with the same outcomes.

While the PGPPP had inefficiencies, its conclusion has created a gap in the medical training pipeline for the GP profession. While the Rural Junior Doctor Training Innovation Fund (ceased) and now the JFPDP fills this gap in MM2-7 locations, the significant metropolitan-based junior doctor cohort only has limited access to prevocational primary care exposure and they must relocate in order to undertake a rotation. Noting the strong evidence base that positive primary care exposure is an influential factor in selecting a career in general practice, failure to bridge this gap would be a lost opportunity.

A new and expanded primary care prevocational program would be co-funded between the Australian Government and the states and territories, expanding into the Australian Capital

¹⁰⁶ Total number of Funded Rotations offered does not equate to number of rotations announced due to the rotations applied for, versus anticipated, are in locations with greater rurality.

¹⁰⁷ Actual rotations funded for each training year will not be known until March the following year, when Annual Performance Reports are submitted to the Department.

Territory to provide national coverage. A new program expanded into metropolitan areas would have the added benefit of driving improved general practice outcomes in metropolitan areas by growing the number of GPs working in general practices, including underserved outer metropolitan localities. Recent changes by the Australian Medical Council (AMC) to the National Framework for Prevocational Medical Training make it easier for junior doctors to demonstrate key competencies in community-based settings, such as general practice.

Given Commonwealth-supported GP training programs are at full capacity, it is recommended that any policy change with respect to prevocational capacity be coordinated with a commensurate increase in GP training places. Implementing this option in the absence of broader GP training capacity would create latent need for GP training places and would be unlikely to produce the net impact desired. Upstream changes that improve positive exposure to general practice would further support optimal outcomes.

Option 3 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none"> • Plugs key exposure gap in the GP training pipeline for a majority of junior doctors. • Takes advantage of AMC changes to prevocational doctor training framework. • Is likely to increase the cohort of junior doctors interested in general practice careers. • Continuing to prioritise regional and rural rotations will likely translate to more junior doctors with an interest in practising in these areas, creating community benefits. • Expands application of program to the ACT, which is experiencing significant GP shortages. • Implementation in tandem with Option 2 and Option 4 would maximise value creation through complementary throughput and capacity increases across the workforce pipeline. 	<ul style="list-style-type: none"> • Implementation in the absence of broader reforms to GP training capacity (see Option 4) would create latent demand and undermine outcomes. • Conversely, without upstream reform (see Option 2), there is potential for undersubscription, undermining value for money outcomes. • Hospital capacity may be stretched to accommodate additional places. • Increasing prevocational primary care exposure without increasing GP training capacity would create latent demand in the system and place GP colleges under increased pressure to deliver more training.

Option 4 – Increase GP training capacity by 400 places to 2,000 places overall

Description

This option boosts GP training numbers across the AGPT and RVTS programs from 2026, increasing progressively to 400 additional places per year from 2028. RGTS is not factored in due to the possibility of program consolidation from 2026. An increase in demand for the National Consistent Payment (NCP) framework, which provides support payments directly to participant trainees, supervisors and practices, would increase costs due to the increased number of participants claiming these payments.

Option 4 SMART target

Increase new GP trainee numbers to 2,000 per annum from 2028 (through a graduated increase in capacity), with the aim of increasing GP fellowship numbers to 1,600 per annum from 2030 (allowing for attrition and part-time arrangements).

Timeline

GoG development and release:	6 months
Assessment and negotiation:	3 months
Agreement execution:	4 months ahead of implementation
Start date:	Start of calendar year – ongoing

Roles and responsibilities

Commonwealth	States and territories	GP colleges	RVTS	Sector support agencies
<ul style="list-style-type: none"> Develop program settings for 2026 GP training pathways Establish GP training distribution requirements Draft and administer GoGs 	<ul style="list-style-type: none"> Adapt Single Employer Model (SEM) trials to new program structure Facilitate seamless transition from hospital to community 	<ul style="list-style-type: none"> Adapt AGPT training to align with new program settings Deliver training to a high standard Facilitate quality GP placements Meet distribution targets 	<ul style="list-style-type: none"> Adapt RVTS training to align with new program settings Meet KPIs Deliver training to a high standard Facilitate quality GP placements 	<ul style="list-style-type: none"> Support sector engagement and communication

for AGPT and RVTS for 2026 and beyond	general practice placements	<ul style="list-style-type: none"> • Meet KPIs • Comply with review/evaluation requirements 	<ul style="list-style-type: none"> • Comply with review/evaluation requirements
<ul style="list-style-type: none"> • Negotiate and administer grant agreements • Administer NCP payments through Services Australia • Set KPIs • Undertake sector engagement and communication • Evaluate performance outcomes 			

Additional cost estimates to Health portfolio (\$m)

	2025-26	2026-27	2027-28	2028-29	TOTAL
Option 4	\$27.3	\$59.9	\$76.6	\$85.4	\$249.2

Note: Indexed for WCI1

Analysis

As already detailed in this Impact Analysis, evidence indicates that current GP training capacity is insufficient to meet community demand. As evidenced in [Appendix A](#), shortages will grow over time and have a compounding impact on population health. Vulnerable people and communities will be the most adversely impacted. Existing training programs are fully utilised, underscoring the opportunity to take action.

While improving access to multidisciplinary, team-based primary care is part of the solution (as discussed in the *Scope of Practice Review*), communities will still need access to GPs providing coordinated, safe, high quality primary care. Evidence supports a strong correlation between GP access and reduced hospitalisations, lower mortality and improved compliance with medication

regimes.^{108 109 110} GPs also have a pivotal role to play in enabling multidisciplinary teams, including through care coordination and clinical leadership. Growing our GP workforce to meet the needs of our communities is an important policy objective.

Current GP training intake numbers across AGPT and RGTS are capped at 1,600 per annum, while RVTS is capped at 32 per annum. While uncapped self-funded pathways are available through both GP colleges, they are less attractive for many due to the costs borne by the participant (around \$60,000) and the pathways having less structured learning approaches. More often than not, the self-funded pathways are pursued by IMGs who do not satisfy the eligibility criteria for a Commonwealth-supported GP training program. It is more likely that those turned away from GP training due to capacity limitations will choose another medical specialty, and not pursue a career in general practice.

Adding indexation to NCP payments would help to address the opportunity cost faced by practices and supervisors to support and enable quality training placements and experiences. This would increase system capacity to accommodate a larger number of GP trainees. It would also be likely to translate into higher fellowship rates, noting that the AGPT program is already producing upwards of 1,000 GP fellows each year.¹¹¹

Building capacity in GP training is about more than placement numbers and meeting commencement targets. It is also about the capacity and capability of training practices and supervisors to provide enriched learning and training. As previously discussed, evidence suggests that positive support and early experiences are key to influencing career choices. While GP colleges advise that there is strong capacity across accredited practices and supervisors, stretching existing resources too thin will not support positive, quality training experiences.

Increasing supports for supervisors and practices, such as through indexing the NCP, will help cover the opportunity cost associated with giving up clinical time to support and supervise training. This is particularly important for placements in rural and regional locations, where retention of the workforce can be a considerable challenge. This also needs to be balanced with clinical workforce need and capacity to ensure minimal disruptions to frontline practice.

Additional investment in building GP training capacity should ideally build over time as the GP training pipeline expands and additional supervisor and practice capacity is identified and

¹⁰⁸ Pereira Gray DJ, Sidaway-Lee K, White E, et al. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8:e021161. doi: 10.1136/bmjopen-2017-021161.

¹⁰⁹ Jeffers H, Baker M. Continuity of care: still important in modern-day general practice. *Br J Gen Pract*. 2016;396–7. 10.3399/bjgp16X686185.

¹¹⁰ Kang M, Robards F, Luscombe G, Sancu L, Usherwood T. The relationship between having a regular general practitioner (GP) and the experience of healthcare barriers: a cross-sectional study among young people in NSW, Australia, with oversampling from marginalised groups. *BMC Fam Pract*. 2020 Oct 28;21(1):220. doi: 10.1186/s12875-020-01294-8. PMID: 33115430; PMCID: PMC7592545.

¹¹¹ GP Training Minimum Dataset.

supported. It will take time to grow the pipeline, as it takes 10 to 14 years between a future doctor starting medical school and becoming a fellowed GP.

While doubling current expenditure in GP training to drive progress toward meeting supply and demand projections would no doubt increase training capacity, it could possibly result in unfilled places. A more sensible approach to ramping up training capacity would involve increasing training places progressively to deliver 400 additional GP training places per year, resulting in a total of over 2,000 commencing training places per year across all GP and RG training programs. The target to increase the number of GPs following each year from around 1,000 to 1,600 would result from the proposed training place uplift, while accounting for attrition and part-time training.

Option 4 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none"> • Benefits will be realised from date of implementation, with more GP trainees providing primary care services. • Over time, reduces gap in projected unmet community demand by around a third. It will complement other policy reforms to address this modelled gap. • Increases capacity for primary care practices to deliver care. • Continuing the existing 50 per cent regional/rural target for GP training will mean more trainees placed in these areas, benefiting communities. • Will benefit key vocational stakeholder groups, including the GP colleges and AMA, by fostering greater interest in medical careers. • Will benefit IMGs, as well as home grown junior doctors, by offering more training places for eligible participants. • Implementation in tandem with other options, would maximise value creation through complementary throughput and capacity increases across the workforce pipeline. 	<ul style="list-style-type: none"> • Requires significant ongoing investment. • Would not alone increase GP training capacity to a level that meets unmet community demand by 2033, noting that other reforms to address demand for health services and develop more sustainable and accessible models of care are needed alongside increase in the number of GPs. • Current distribution levers for GP training programs may not be yielding optimal outcomes.. This will take time to address and influence improved outcomes. • Increasing GP training capacity without upstream (e.g. Option 2 and Option 3) reform may result in lower demand than anticipated, undercutting community benefits.

Option 5 – Incentive payment to address first year pay gap for GP trainees

Description

This option addresses the estimated (average) \$30,000 (or 30 per cent) drop in baseline salary that junior doctors face when they leave hospital employment to become a GP trainee. Evidence suggests that, during the hospital year of early vocational training, GP trainees are eligible for a salary of around \$125,000 per annum.¹¹² This reduces to around \$95,000 per annum in the first 12 months of training in community general practice. 70 per cent of first year GP trainees working in a community setting report they earn less than they did in their last year working in a pre-vocational hospital position, and more than one third of GP trainees report they have a second job while working as a GP trainee.¹¹³ Key stakeholders report that this pay drop represents a considerable barrier for junior doctors selecting a career in general practice.^{114 115 116}

A nationally implemented \$30,000 incentive payment in a GP trainee's first year, indexed annually, would address the pay gap until junior doctors are experienced enough to make up the income gap through billing Medicare. This approach is consistent to that taken by several states to encourage more GP trainees to undertake training in their jurisdictions. Victoria (2024 and 2025) and Queensland (2025 and 2026) have introduced time-limited incentive payments for GP trainees totaling up to \$40,000 per eligible trainee. Incentives had a positive impact in Victoria in 2024, with strong interest continuing for 2025. Queensland has also experienced a surge for 2025 with the commencement of their scheme.

The costings below assume a 25 per cent increase to existing annual GP training commencement caps, noting the issues highlighted in the problem definition. The fiscal impact will vary based on the number of GP trainees on a Commonwealth-supported program.

Option 5 SMART target

Increase interest in a GP career (including rural generalism) to one in four medical students by 2028.

¹¹² Internal Departmental analysis.

¹¹³ Unpublished data, 2024 National Registrar Survey, Department of Health and Aged Care.

¹¹⁴ RACGP (2024) *Mid-Year Economic and Fiscal Outlook 2024-25 Submission*.

¹¹⁵ GPRA (2024) *2024 Federal Budget Submission*.

¹¹⁶ [AMA's plan to Modernise Medicare - Plan to improve access to GPs.pdf](#).

Timeline

NCP system upgrades:	8 months
Update NCP Guidelines:	6 months
Update GP college ICT systems:	6 months
Start date:	Start of calendar year – ongoing

Roles and responsibilities

Commonwealth	States and territories	GP colleges	RVTS	Sector support agencies
<ul style="list-style-type: none"> Develop eligibility criteria, policies and processes Upgrade NCP payment system through Services Australia Undertake sector engagement and communication Administer payments through NCP Payment compliance checking Evaluate outcomes 	<ul style="list-style-type: none"> Maintain existing, time-limited schemes, where applicable (e.g. in Vic and QLD). 	<ul style="list-style-type: none"> Update ICT systems Facilitate NCP payment application process Support compliance processes Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Update ICT systems Facilitate NCP payment application process Support compliance processes Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Support sector engagement and communication Participate in reviews/evaluations

Additional costs to Health portfolio (\$m)

	2025-26	2026-27	2027-28	2028-29	TOTAL
Option 5	\$21.5	\$50.6	\$59.6	\$61.1	\$192.8

Note: Indexed for WCI1

Analysis

One of the key barriers commonly cited by stakeholders to entering GP training is the pay drop and loss of entitlements experienced by trainees when they transition from hospital placements

(which they have experienced throughout their prevocational years) into training in a community general practice. As previously flagged, evidence suggests that trainees experience an estimated \$30,000 pay drop at this transition point.¹¹⁷ While trainees are often able to bridge this shortfall with proportional MBS billing remuneration later in their GP training, the pay drop impacts them throughout their first term of community-based training (GPT1).

A \$30,000 incentive payment in GPT1 would be an influential incentive for prospective GP trainees. The payment would be in addition to existing compensatory incentives for rurality (e.g. WIP payments) and rurally tiered NCP payments, which are intended to take account of the increased cost of living and working rurally. These payments are for separate purposes and do not bridge the pay gap experienced by GP trainees. An incentive payment would notionally overcome a disincentive barrier experienced by junior doctors, who might otherwise choose a different specialty.

As previously described in this report, evidence from the incentive payment schemes offered in Victoria and Queensland has shown they have been influential in driving uptake in these jurisdictions. However, they have also exacerbated existing workforce maldistributions. Victoria and south-eastern Queensland are already oversubscribed for GP trainees in 2025. Critical regions of workforce shortage, such as western Queensland and western New South Wales, remain significantly undersubscribed. These schemes may have contributed to a decline in GP training in other states and territories that do not have incentive payment schemes. A national payment would help to correct the geographical maldistributions that are being exacerbated by these jurisdiction-specific, time-limited schemes.

An incentive payment would also likely have a higher impact on those from socioeconomically disadvantaged backgrounds, for whom stability of income is a more pressing issue. The current cost of living crisis may exacerbate these concerns. However, if there were a high administrative burden associated with incentive payments, it could be counter to the intended outcomes. Those with fewer resources could be less likely to claim incentives under these circumstances.¹¹⁸ If an incentive payment is to have its desired impact, it is important that it was as administratively streamlined as possible for all concerned – most importantly GP trainees.

An incentive payment is also likely to be influential in rural and regional areas. Rural and regionally located GPs are more aware of applicable entitlements and more likely to be in the practice of claiming entitlements.¹¹⁹ It is possible that an incentive payment would see a proportionally higher uptake in these areas.

¹¹⁷ State and territory medical doctor award and salary rates analysis undertaken by the department.

¹¹⁸ Kecmanovic M and Hall J P (2015) 'The use of financial incentives in Australian general practice', *The Medical Journal of Australia*, 202(9):488-491, doi:10.5694/mja14.00252.

¹¹⁹ Kecmanovic M and Hall J P (2015) 'The use of financial incentives in Australian general practice', *The Medical Journal of Australia*, 202(9):488-491, doi:10.5694/mja14.00252.

While there is a strong evidence base that an incentive payment in GPT1 would have an immediate impact, the evidence base is not as strong for the longer term impact, particularly for GP retention¹²⁰ and the impact may be less significant in future terms of training. Whether it is good value for money to implement incentive payments is dependent on (a) GP training capacity caps and (b) how much value is placed on growing the GP training pipeline.

If GP training place caps are not increased, there is little value in implementing an incentive payment at this time. GP training numbers are already approaching capacity, and an incentive payment would only drive latent demand in the training pipeline. However, if Option 4 were to be adopted, an incentive payment would create considerable value in the short term by driving up demand for commencing GP training places, thereby reducing the potential for unfilled training places and underspends. Higher GP training places caps would likely translate into greater net present value from an incentive payment.

While financial incentives and employment entitlements are the most commonly cited barriers to entering GP training, there remain a range of systemic issues that also impact on choice of career. These cannot be easily or quickly addressed. Financial incentives would provide a much needed immediate boost to training numbers, however in the longer term there would need to be consideration of these wider systemic issues, including but not limited to:

- Prestige perceptions and the culture among medical specialist colleagues. Enforceable anti-denigration policies in universities and hospitals, increasing availability and visibility of senior GP academics, and compulsory or prioritised prevocational GP placements could be considered over time to build inter-specialty respect and understanding.
- Portfolio career options, career progression, such as through funded academic and research pathways, public recognition or rewards for GP leaders.
- Shifting the approach in medical schools to focus on selecting the right students to build the workforce we need, where we need it, rather than selecting only for academic marks. This could include alternative pathways to medical careers targeted to under-represented communities and consideration of broader skill sets in potential student candidates.
- Ensuring high quality general practice placement experiences at all stages of the training pipeline. This could include building consistency and flexibility of supervision standards, accreditation pathways, investment in infrastructure to support more flexible supervision and service provision, whole of practice learning models and near-peer support, and financial incentives for clinical and educational supervision.
- Teamwork and collegiality, including supports to reduce feelings of isolation such as networked practices, structured collaboration between practices and specialties, and funded time for practice improvement activities with the whole practice team

¹²⁰ Rourke J (2008) 'Increasing the number of rural physicians', *Canadian Medical Association Journal*, 178(3):322-325, <https://doi.org/10.1503/cmaj.070293>.

- Relocation supports that go beyond financial incentives, such as orientation programs, family supports (childcare, spousal employment, education), housing, and community buy-in.

The outcomes of reviews commissioned by the Strengthening Medicare Taskforce around scope of practice, distribution levers, and general practice incentives will impact on many of the issues above. As recommendations are considered by Government for implementation, the need for further action and investment to achieve long term workforce outcomes will be assessed.

Option 5 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none"> • Short term value creation by creating an influential nudge for junior doctor career choices. • Higher GP training commencement caps equals higher net present value. • Strong evidence that incentive payments bridge the pay gap for GP training work. • Would help correct geographical maldistributions created by jurisdictional inequities. • Incentivises more junior doctors into GP careers, which would result in more regionally and rurally based trainees if the current 50 per cent training target is maintained. • Would benefit junior doctors at a time when they may otherwise encounter financial stress. • Benefits would be realised from date of implementation, with more GP trainees providing primary care services. 	<ul style="list-style-type: none"> • Would not create value if GP training commencing places are not increased. • Would potentially influence states and territories to withdraw existing incentive payment schemes, noting these are time-limited schemes with minimal overlap. • Requires significant ongoing investment. • May raise expectations from other medical professions for a similar scheme. • In isolation, financial incentives may not be enough to sustain long term workforce attraction to general practice.

Option 6 – Leave provisions for GP trainees

Description

This option addresses the disincentive to enter GP training due to the loss of state government leave entitlements, such as study and parental leave, early in the training tenure. Most GP training placements are for six to twelve months throughout the (usually) three to four years of the

vocational training period. This does not enable GP trainees to accrue employment entitlements, such as leave. The National Terms and Conditions for the Employment of Registrars do not require practices – which are often small to medium business enterprises – to provide paid parental leave, or study and exam leave. This is a factor in junior doctors making career decisions away from general practice.¹²¹

This option includes two specific leave provisions to bring the entitlements closer in line with what trainees receive in state hospital systems:

- a. Paid parental leave (PPL): equivalent to 20 weeks in total.
- b. Study and exam leave: 5 days per year.

Payments would ultimately be made by Services Australia by expanding the existing NCP payment system. GP trainees, like trainees in other medical specialties, would remain eligible for the Government's paid parental leave scheme if they otherwise meet this scheme's eligibility criteria.

Offsets to the Medicare Benefits Schedule (MBS) are not anticipated for parental leave as GP practices would likely backfill this extended period with a locum or other GPs. However, offsets of around 50 per cent of the lost MBS billing volume are anticipated for study and exam leave. This is due to the GP practices being unlikely to backfill with locums for these shorter periods, and due to the limited capacity of existing GPs to perform the volume of services that would otherwise have been performed by the GP trainee. This limited capacity is underscored by the GP supply and demand modelling (see [Appendix A](#)).

The costings below assume a 25 per cent increase to existing annual GP training commencement caps. The fiscal impact will vary based on the number of GP trainees on a Commonwealth-supported training program.

Option 6 SMART target

Increase interest in a GP career (including rural generalism) to one in four medical students by 2028.

Timeline

NCP system upgrades:	8 months
Update NCP Guidelines:	6 months
Update GP college ICT systems:	6 months
Start date:	Full implementation from start of calendar year – ongoing

¹²¹ GPRA (2024) *2024 Federal Budget Submission*.

Roles and responsibilities

Commonwealth	States and territories	GP colleges	RVTS	Sector support agencies
<ul style="list-style-type: none"> Develop eligibility criteria, policies and processes Upgrade NCP payment system through Services Australia Administer payments through NCP Compliance checking Undertake sector engagement and communication Evaluate outcomes 	<ul style="list-style-type: none"> Provision of entitlements within hospital placements in accordance with individual state/territory awards 	<ul style="list-style-type: none"> Facilitate payment NCP application process Support compliance processes Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Facilitate payment NCP application process Support compliance processes Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Support sector engagement and communication Participate in reviews/evaluations

Additional cost estimates to Health portfolio (\$m)

	2025-26	2026-27	2027-28	2028-29	TOTAL
Option 6	\$11.6	\$25.2	\$27.5	\$30.0	\$94.5
(MBS offsets for Option 6)	(\$5.1)	(\$13.9)	(\$15.1)	\$16.4	(\$50.5)

Analysis

Younger doctors, both male and female, – are seeking a different work-life balance and approach to pay and entitlements compared to previous generations.¹²² Employment entitlements, such as PPL and other leave payments, have become more important to attracting and retaining the next generation GP workforce. Stakeholders, such as the RACGP, the AMA and GPRA, have noted that pay and entitlement disparities between hospital doctors and GP trainees are barriers to

¹²² [National Medical Workforce Strategy 2021–2031 \(health.gov.au\)](https://www.health.gov.au/national-medical-workforce-strategy-2021-2031).

encouraging more junior doctors to pursue a career in general practice.^{123 124 125} This reflects that public sector employers are offering higher benefits than smaller private sector GP employers.

Evidence supports that females are already choosing careers in general practice at a greater proportion than males.¹²⁶ Around 45 per cent of doctors in Australia are female, rising to around 50 per cent in general practice. The proportion of female GPs in Australia is likely to further increase, with females making up 58 per cent of new GP trainees in 2024, at an average age of 34 years.¹²⁷ Barriers to accessing PPL are an issue for both the male and female GP training cohort, who choose their specialty at an age when family planning may be a key consideration.

As previously stated, PPL is an important gender equity measure. Research by the International Labor Organization and the World Health Organization shows that, on average, women in healthcare earn 24 per cent less than men. For Australian GPs, female GPs spend more time on average with each patient than male GPs and consequently earn less under the MBS remuneration model.¹²⁸ Furthermore, female GP trainees taking parental leave are currently unlikely to be eligible for paid leave above the minimum wage provided through the Government scheme. As a result, they are more likely to experience financial impacts compared with their male counterparts, noting that females typically take PPL at a higher rate than males. This perpetuates broader inequities experienced across Australian society.

A drawback of this option is that the uptake of PPL during the training tenure will delay fellowship outcomes for those who take this leave. Conversely, PPL provisions act as an incentive to return to GP training for a cohort that may otherwise drop out at this juncture. This mitigates the negative impact of delayed fellowship outcomes. Additionally, evidence suggests^{129 130} that some trainees delay commencing GP training and remain in the hospital system for longer while they start their families. Therefore, provision of parental leave is likely to have a negligible impact on timeframes to fellowship (in years post medical school graduation).

Study and exam leave entitlements are particularly important for supporting GP fellowship outcomes. Given the lack of paid leave available to many GP trainees compared to other specialty training programs in hospital settings, they will likely minimise their leave to reduce the pay loss. At present this means that time taken for exam preparation is either unpaid, outside of and in addition to usual work hours, or trainees use recreation leave allowances. This can lead to higher rates of stress and burnout. While paid leave for both study and exams will result in some time

¹²³ RACGP (2024) *Mid-Year Economic and Fiscal Outlook 2024-25 Submission*.

¹²⁴ AMA (2024) *Pre-Budget Submission 2025-25: Chapter 1: General Practice*.

¹²⁵ GPRA (2024) *GPRA 2024 Federal Budget Submission*.

¹²⁶ GP Training Minimum Dataset.

¹²⁷ National Health Workforce Dataset.

¹²⁸ University of Melbourne (2018), *Medicine in Australia, Balancing Employment and Life survey*.

¹²⁹ www.ausdoc.com.au/news/back-at-work-two-weeks-after-having-a-baby-gp-registrars-want-fix-for-parental-leave-dilemma/

¹³⁰ Australian Medical Association (NSW) Ltd.

away from providing community services, the benefits will be realised through trainees being better prepared for their exams and, consequentially, increased pass rates. This translates into improved fellowship rates over time and frees up more training places for new entrants to the program. They will also experience better work-life balances.

This option presents good value for money. It responds to key issues being raised by stakeholders as barriers to entering GP training. It addresses broader gender equity outcomes and supports improved fellowship outcomes through greater attraction and retention of GP trainees.

Option 6 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none"> • Addresses a key structural barrier to pursuing GP training compared to other specialities. • Supports broader gender equity. • Provisions to support preparation for exams likely to translate to improved fellowship outcomes and GP wellbeing. • May incentivise a return to GP training for those who may otherwise drop out. • Incentivises more junior doctors into GP careers, which would result in more regionally and rurally based trainees if the current 50 per cent target is maintained. 	<ul style="list-style-type: none"> • In isolation of broader incentives, may not shift the dial significantly with respect to GP training uptake. • Noting GP shortages, practices may encounter challenges to backfill trainees during leave tenures. • May raise expectations from other medical professions for a similar scheme.

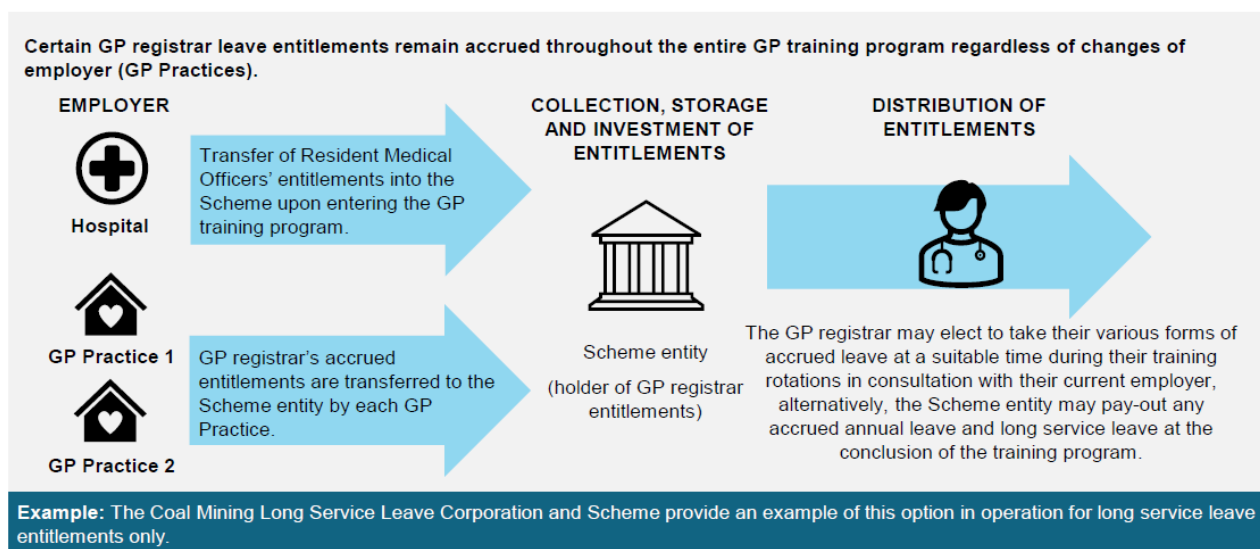
Option 7 – Portability of GP registrar entitlements

Description

A national portability scheme would enable GP trainees to accrue and port leave throughout their training tenure, which is usually for around three to four years. The term ‘portability’ in reference to entitlements refers to the continuation and accrual of entitlements across different employers or employer arrangements. Portable leave entitlements allow workers to take accrued leave with them when they change employers within the same industry. This differs from a single employer arrangement such as that currently being applied through the Single Employer Model trials.

The scheme would end for a GP trainee once they achieved their GP fellowship and exited the training program. The entitlements would need to be determined in harmonisation with varying state and territory industrial award systems.

Figure 7: Portability scheme for GP trainees – concept map¹³¹



The scheme would require the Australian Government to establish new legislation to create an approved and independent statutory entity to collect, store and distribute entitlements to GP trainees. The *Fair Work Act 2009* (Cth) may also require amendment. Given GP trainees do some training in hospital settings, consideration would be required as to whether a harmonised approach is needed to align state and territory entitlements with the Australian Government scheme. Legislation may also be required to enable mutual recognition requirements.

The newly established independent statutory entity would notionally be governed by a Board of Directors and led operationally by a Chief Executive Officer. Given that the entity would need to keep records of employers of GP trainees across pathways, compliance activity would be required by the GP colleges and RVTS Ltd to keep the entity informed of GP trainee employment arrangements, as well as transition into and off the training pathways. The entity would also need to validate employment arrangements to ensure the correct entitlements are being provided. Compliance activity would therefore also be required at the practice level. It is anticipated that the existing NCP system can be expanded to enable payment of entitlements to registrars directly and to practices.









It is assumed that GP trainees would use between five and 30 per cent of their leave entitlements per annum. There will be upfront costs with establishing a new entity and to create a technology platform to administer the scheme. Additional funding will be required to staff the new entity.

There is no current model in operation in Australia that sets a precedent for such a scheme (other models operate on a state/territory level, funded by employer levies). An assessment of the

¹³¹ Unpublished KPMG (2023) *Policy Options Paper: Employment Entitlement Portability Scheme for GP Registrars*.^c

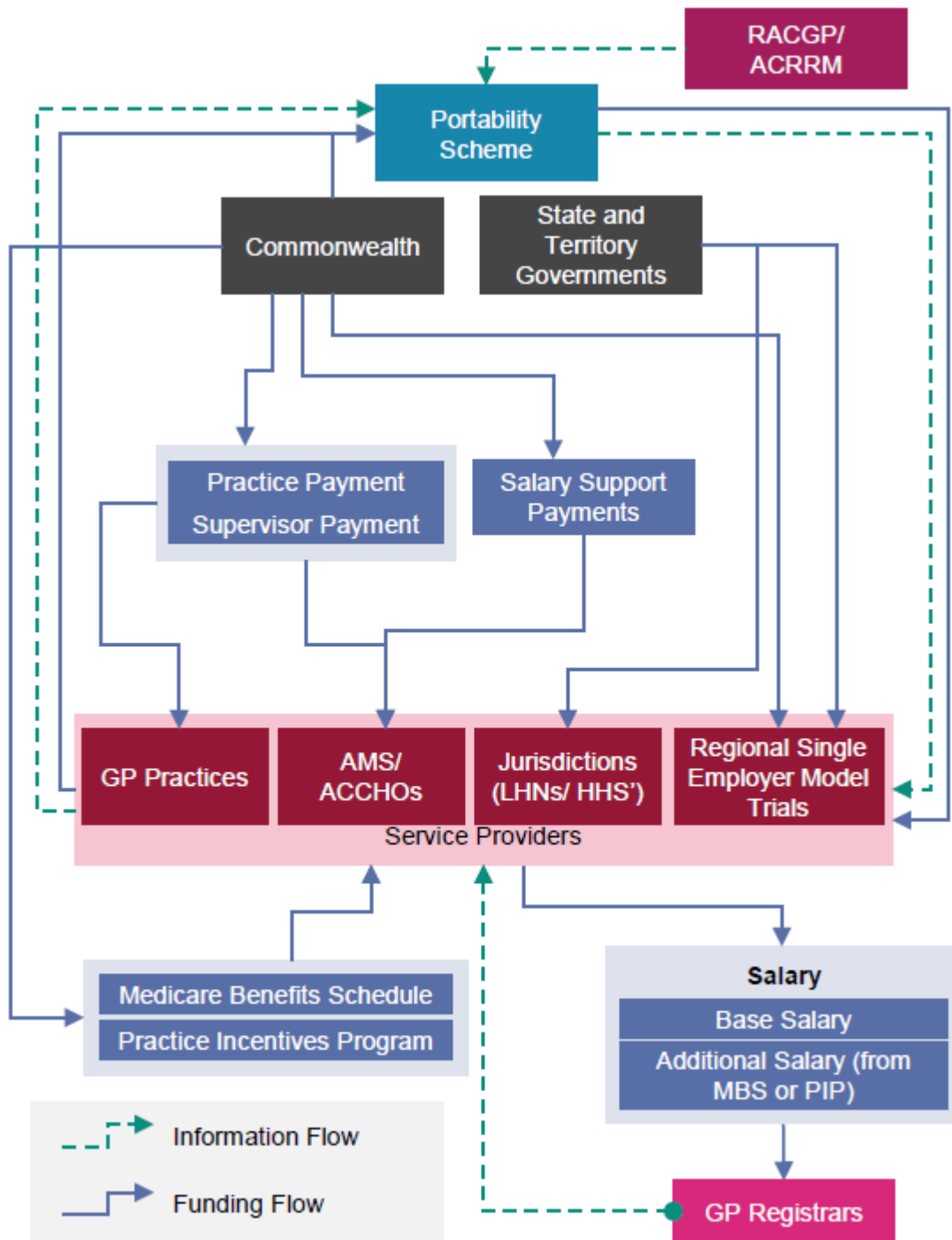
legislative and constitutional authority and risk to enable such a scheme would be essential. Privacy implications would also need to be considered.

Figure 8: Proposed scope of portability entitlements¹³²

Leave type	Accrual per 27 week rotation	Treatment at end of 27 week rotation
 Annual leave	2 weeks (assuming there is no shift-work)	<ul style="list-style-type: none"> Any unused leave to be paid into Scheme. Any leave taken beyond two weeks to be paid from Scheme to employer retrospectively.
 Compassionate Leave	2 days annually replenished	<ul style="list-style-type: none"> Notify Scheme of any payment of this leave to update balance. The balance will continue to the next rotation (or be replenished if annual anniversary is due).
 Family and Domestic Violence Leave	10 days annually replenished	<ul style="list-style-type: none"> Notify Scheme of any payment of this leave to update balance. The balance will continue to the next rotation (or be replenished if annual anniversary is due).
 Personal Leave	5 days	<ul style="list-style-type: none"> Notify Scheme of any payment of this leave to update balance. Any accrued balance will be held in the Scheme (paid by the Commonwealth) and accrue.
 Long Service Leave	Any long service leave taken will be paid by the Scheme to the employer	<ul style="list-style-type: none"> Ongoing continuous service. If leave is taken, it will have been updated by the Scheme when it was paid through the employer.
 Paid Parental Leave	Any paid parental leave taken will be paid by the Scheme to the employer	<ul style="list-style-type: none"> Ongoing continuous service. If leave is taken, it will have been updated by the Scheme when it was paid through the employer.
 Cultural Leave	5 days' paid leave annually replenished	<ul style="list-style-type: none"> Notify Scheme of any payment of this leave to update balance. The balance will continue to the next rotation (or be replenished if annual anniversary is due). Scheme to pay any difference between the EA/award/employment contract and the Scheme entitlement to the employer retrospectively.
 Exam/ Study Leave	Paid time off for mandatory exams and three days study leave prior	<ul style="list-style-type: none"> Notify Scheme of any payment of this leave. Scheme to pay any difference between the EA/award/employment contract and the Scheme entitlement to the employer retrospectively at the end of the rotation.
 Professional Development Leave	Up to a total of 3 weeks per year	<ul style="list-style-type: none"> Notify Scheme of any payment of this leave to update balance. Scheme to pay any difference between the EA/award/employment contract and the Scheme entitlement to the employer retrospectively.

¹³² Unpublished KPMG (2023) *Policy Options Paper: Employment Entitlement Portability Scheme for GP Registrars*.

Figure 9: Portability scheme funding and information flow¹³³



¹³³ Unpublished KPMG (2023) *Policy Options Paper: Employment Entitlement Portability Scheme for GP Registrars*.

Option 7 SMART target

Increase medical school interest in a GP career (including rural generalism) to one in four medical students by 2028.

Timeline

Legislative review/amendment (Cth): December 2024 – January 2026

Harmonisation (if required):	12 months
Negotiate entitlements:	12 months
Establish new entity:	12 months
Recruitment:	8 months
NCP system upgrades:	8 months
Draft program guidelines:	6 months
Update GP college ICT systems:	6 months
Start date:	Full implementation from start of calendar year – ongoing

Roles and responsibilities

Commonwealth	States and territories	GP colleges	RVTS	Sector support agencies
<ul style="list-style-type: none"> Enact legislative change Draft and maintain program guidelines Establish independent entity to support portability Appoint and support board/CEO Employ staff Negotiate entitlements across sector 	<ul style="list-style-type: none"> Negotiate entitlements Enact legislative harmonisation (if required) Facilitate portability of entitlements to new entity Participate in sector governance Comply with compliance requirements Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Facilitate sector engagement Participate in sector governance Comply with compliance requirements Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Participate in sector governance Comply with compliance requirements Comply with review/evaluation requirements 	<ul style="list-style-type: none"> Facilitate sector engagement and communications Inform reviews/evaluations

and states /
territories

- Review entitlements periodically
 - Compliance checking
 - Design and oversee sector governance, including sector levies and investment boards
 - Evaluate outcomes
-

Additional cost estimates to Health portfolio (\$m)

	2025-26	2026-27	2027-28	2028-29	TOTAL
Option 7	\$23.5	\$14.8	\$31.8	\$39.1	\$109.3

Note: Indexed for WCI1

Analysis

The department contracted KPMG in mid-2022 to conduct a feasibility study to scope options for an employment entitlement portability scheme. KPMG's feasibility study concluded that a portability scheme was not the best way to address employment disparities between GP registrars and hospital-based speciality trainees.

The report noted:

- The administrative overheads of the proposed model were high, which made the scheme not cost effective for such a small cohort.
- The inclusion of long service leave and a cost sharing arrangement between practices and the Commonwealth created considerable complexity.
- It requires a national entity to be established to enable the portability of accrued leave of GP registrars regardless of changes to employers during GP training, which would represent a significant administrative burden to the Commonwealth.
- Legislative change would likely be required, as well as negotiations across all states and territories. This would likely delay implementation.
- Harmonisation of the complex industrial relations systems across state and territory award systems will be highly contentious and challenging to achieve.
- There may be legal and constitutional considerations that impede implementation.

- The approach is untested. This would represent the first time a portability scheme in Australia covered leave types beyond long service leave or to only some workers within an industry (registrars only, during their training, which usually only extends to three or four years).

The potential need to achieve harmonisation across all Australian jurisdictions creates added complexity. In light of this, implementation timeframes are ambitious.

The department agrees that a portability scheme would be highly complex and would take considerable time (likely years) to negotiate and (if agreed) implement. Given the cost and administrative burden, and in light of the opportunity cost of not pursuing other options, a portability scheme does not represent value for money. The department’s assessment is that action is required in the more immediate future to grow the GP training pipeline, and that delays will only exacerbate workforce gaps over time.

Option 7 risks and benefits

BENEFITS	RISKS
<ul style="list-style-type: none"> • Addresses a key structural barrier to pursuing GP training. • Supports broader gender equity through inclusion of PPL. • Reduced stress regarding entitlements may support better fellowship outcomes. • Incentivises more junior doctors into GP careers, which will result in more regionally and rurally based trainees if the current 50 per cent target is maintained. 	<ul style="list-style-type: none"> • Requires significant ongoing investment. • Highly complex and administratively burdensome to implement and administer. • May not be constitutionally or legally feasible. • Implementation timeline is ambitious, and delays are likely. • High compliance burden for all involved. • May raise expectations from other medical professions for a similar scheme. • Would only apply to a small group of workers in an industry for three to four years, during which time they may not accumulate significant periods of leave.

Consultation

In April 2023, the Health Ministers’ Meeting discussed issues relating to GP attraction and committed to development of a GP Attraction Strategy. Following this decision, considerable consultation has occurred with the GP training sector, broader health workforce stakeholders and states and territories to inform the development of strategies to boost our GP workforce.

In particular, the [General Practice Training Advisory Committee](#) (GPTAC), which includes the key GP training sector stakeholders, has discussed these matters on a number of occasions in recent years. Key themes frequently discussed at GPTAC include:

- The importance of early and positive exposure to general practice in career decision making (see Option 2 and Option 3).
- GP exposure in the prevocational years (see Option 3):
 - Suggested changes to the JFPDP have been raised on a number of occasions, noting the geographical limitations.
- How medical schools can contribute to GP attraction
 - Medical Deans Australia and New Zealand (MDANZ) was recently added as a GPTAC member in recognition of the importance of this component of the GP training pipeline (see interface with Option 2).
- The importance of ensuring equality in pay and conditions between GP registrars and other specialty trainees (see Options 5, 6 and 7).
- The importance of Government investment in the above strategies.

The department also ran the 'Attracting medical student and junior doctors to general practice' project from October 2022 to May 2023. The project conducted 38 in-depth interviews with medical students and junior doctors to understand influences on their career choices. Although this is a small sample, the project achieved thematic saturation and a good demographic spread across age, gender, training stage, jurisdiction and rurality. The key findings were:

- Most medical students and junior doctors don't have fixed ideas about their future specialty and can be influenced favourably towards GP careers.
- Three main factors influence the choice of medical specialty: Personal factors, exposure, and expectations/understanding of general practice.
- As junior doctors progress through training, additional factors can sway their choices: the application process, pay, work-life balance, upskilling opportunities, working environment and culture.

In late 2023, the department consulted with a range of key stakeholders, including the members of the GPTAC, the [Medical Workforce Reform Advisory Committee](#), and states and territories on a GP Attraction discussion framework exploring the focus areas of early exposure (Options 2 and 3), pathway entry/eligibility (Options 2 and 3), registrar employment and incentives (Options 5, 6 and 7), supervision capacity (Option 4), accreditation and placement experience (interface with Options 4, 5, 6 and 7), IMG experience, location and distribution (interface with Option 4), culture and prestige (Option 2), post-fellowship sustainability and burnout, teamwork and collegiality, and recognition and retention. While this included action beyond the GP training pipeline, there was broad support for action that addressed these elements.

Extensive consultation has also occurred with the GP training sector for the mid-term review of the AGPT grant agreements and the review of the RGTS. The number of GP and RG training places and AGPT funding arrangements (including NCP) were considered by these reviews. Stakeholders across the sector support increasing the number of training places and the amount of training undertaken in regional, rural and remote areas. There was also significant stakeholder support to consolidate the AGPT program and the RGTS into a single GP/RG training program. Expanding community-based internship opportunities for junior doctors (see Option 3) was also one of the outcomes from a 2024 workshop on bias in the health system. This meeting was chaired by the Hon Ged Kearney MP, Assistant Minister for Health, and included representation from the AMA and RACGP.

Specific key stakeholder views on options

A number of stakeholders have called publicly for investment in growing the GP workforce. RACGP and ACRRM have publicly called for an increase in the number of GP training places¹³⁴¹³⁵. Both GP colleges have recently advised that supervisor capacity is high and could accommodate an increase in AGPT registrar numbers (see Option 4).

In discussions with the department, RACGP has advocated for GP training barriers to be removed, primarily the loss of work entitlements and pay cuts GP registrars encounter when they leave the hospital system and enter private practice (Options 5, 6 and 7).

The AMA has called for the Government to ramp up efforts to support and grow the GP workforce through greater opportunities for junior doctors to experience general practice early in their career and policy that ensures the number of GP training places each year is based on community need. The AMA also called for GP trainees to be provided parity with their hospital-based counterparts (Options 2, 3, 4, 5, 6 and 7).

GPRA reported that registrars participating in the AGPT program suffer a significant drop in pay and conditions from what they were receiving in the hospital system and have called for the Government to address the lack of access to parental, study and exam leave GP registrars experience when they enter community-based GP training, saying that the portability of this type of leave is a key barrier to doctors choosing General Practice as a specialty. GPRA proposed a GP Training Leave Support Fund to facilitate access to entitlements for GP registrars throughout their training (Option 7).

General Practice Supervisors Australia (GPSA) highlighted that there is a significant drop in remuneration for AGPT registrars when they move from the hospital system to training in a general practice. GPSA suggested that the shortfall in pay for these registrars could be paid directly

¹³⁴ Two rural generalist trainees for every spot - Medical Republic, <http://www.medicalrepublic.com.au/two-rural-generalist-trainees-for-every-spot/104703>.

¹³⁵ ACRRM calls for additional funded training places, www.acrrm.org.au/about-us/news-events/news/2024/05/09/acrrm-calls-for-additional-funded-training-places.

through the NCP Framework which would reduce pressure and stress on registrars and practices (Option 5).

The Rural Doctors Association of Australia (RDAA) supports greater experience in general practice and has called for an additional 150 John Flynn Prevocational Doctor Program positions (Option 3).

The Primary Care Business Council has said that reducing the salary gap for GP registrars will help address the long-term supply issues in general practice (Option 5). The Primary Care Business Council also called for better funding of GP supervisors (Option 4).

A summary of key stakeholder positions against each option (where known) is described in Table 3.

Table 3: High level summary of select key sector stakeholder views

Stake-holder	Status quo	Primary care CSPs/ primary care focus in medical school	Greater prevoc GP exposure	More GP training places	GP training incentives/pay gap reduction	Leave provisions for GP training	Portability of leave
RACGP	Not supportive	Supportive	Supportive	Supportive	Supportive – has proposed incentives	Supportive – has proposed direct payments for leave provisions	Not supportive (support implementation of entitlements through direct payments)
ACRRM	Not supportive	Supportive	Supportive (rural focus)	Supportive	Supportive as short term solution	Supportive as short term solution	Supportive as opt in only
RDAА	Not supportive	Supportive	Supportive (rural focus)	Not known	Supportive of reducing the pay gap between GP and other specialty registrars	Supportive of leave provisions but not through incentive type payments	Supportive of concept but not complexity of implementation
GPRA	Not supportive	Supportive	Supportive	Not known	Supportive of reducing the pay gap between GP and other specialty registrars	Supportive of leave provisions but not through incentive type payments	Supportive - has proposed a GP Training Leave Support Fund
GPSA	Not supportive	Not known	Supportive	Not known	Supportive	Supportive depending on impact on practices	Supportive
AMA	Not supportive	Not supportive	Supportive	Supportive	Supportive as short term solution	Supportive as short term solution	Supportive

Findings

A whole-of-pipeline approach is required to achieve the policy objective of increasing population access to primary care through reduced GP shortages. While focusing on one discrete part of the training pipeline may create some positive change, the greatest value creation lies in complementary investment and regulatory reform that ensure the programmatic and policy settings are working in tandem to create more medical graduates and guide them toward a career in general practice. This approach has the greatest chance of ensuring that Australia has enough GPs to meet future demand in our health system.

GP training capacity should be increased but in a responsible and sustainable manner. While eliminating the unmet demand gap entirely would be the most desirable outcome, this is likely not achievable by 2033. Building the medical workforce pipeline will take time, and there is unlikely to be commensurate demand for GP training places to completely close the gap. Modelling suggests that we would need to double (and fill) the number of commencing GP training places immediately to around 3,100 per annum to close the unmet demand gap. This is not an achievable target.. Reforms to models of care and team based delivery of care should also be considered to determine whether the projected increasing demand for GP services can be addressed.

While ramping up GP training capacity is a major driver in achieving the policy objective, increasing the number of GP training places alone will not generate the outcomes sought. With 18 per cent of current medical students indicating an interest in general practice (including rural generalism),¹³⁶ more junior doctors should be encouraged to undertake general practice training. Through a behavioural economics lens, 'strategic nudges' could be made, starting in university study, and across the training pipeline, to encourage greater interest in general practice. The preferred activity described under Option 2 and Option 3, as well as Option 4 and Option 5, will help provide these nudges through complementary activity that adopts 'smart' regulation principles, as opposed to coercive and restrictive approaches.

Linking new CSPs more explicitly to primary care outcomes will incentivise universities to prioritise GP outcomes while providing them with the flexibility to determine the best approach to achieve this through the medical school system. Plugging exposure gaps at the prevocational juncture represents strong value for money to drive improved uptake of GP training places. Addressing barriers to leaving hospital jobs – such as loss of pay and entitlements – will, through a behavioural economics approach, create an important nudge to influence junior doctor career choices. While the impact of the incentives may decrease over time, the value for money is in the immediate impact that will be created through driving these career choices now – rather than in five to ten years' time – which is what is needed to address expected workforce shortages by 2033. Delaying action risks more capped and time-limited state-based incentives being introduced, which disadvantage smaller and less wealthy jurisdictions and further skew distribution of the workforce.

¹³⁶ Medical Schools Outcomes Database National Data Report 2024.

Similarly, deferring decisions on CSPs will exacerbate our reliance on IMGs, which creates a risk in times of crisis.

6. Multi-criteria analysis of investment packages

The above findings have informed the development of three option packages. Each package is assessed against the status quo using a multi-criteria analysis, alongside an estimation of the regulatory cost of each package. This approach was chosen in recognition of the difficulty in quantifying the benefits and regulatory costs of each option for intervention, noting the high number of variables which will influence the impact of each option, as well as the significant number of Government interventions currently working towards the same or similar objectives. The multi-criteria analysis assesses the relative benefits for each option package against the policy objectives outlined in section 4, as well as for the different stakeholder groups impacted. A simple scale, ranging from -3 to +3 (with 0 representing no net change in benefit), has been chosen to illustrate and compare the relative benefits of each package.

Package 1 (Options 2, 3, 4, 5, 6)

- 100 new commencing primary care CSPs per year from 2026, increasing to 150 per year from 2028
- Uncapping medical CSPs for First Nations students from 2026
- 200 new prevocational rotations in primary care per year from 2026, progressively increasing to 400 from 2028
- 200 new GP training places per year from 2026, increasing to 400 from 2028
- Introduction of a \$30,000 incentive payment for GP trainees from 2026, indexed annually
- Introduction of up to 20 weeks of paid parental leave, and 5 days of study leave per year, for GP trainees from 2026

Package 2 (Options 2, 3, 4)

- 100 new commencing primary care CSPs per year from 2026, increasing to 150 per year from 2028
- Uncapping medical CSPs for First Nations students from 2026
- 200 new prevocational rotations in primary care per year from 2026, progressively increasing to 400 from 2028
- 200 new GP training places per year from 2026, increasing to 400 from 2028
- No incentive payments or additional paid leave for GP trainees

Package 3 (Options 4, 5, 6)

- No new CSPs
- No change to prevocational rotations in primary care
- 200 new GP training places per year from 2026, progressively increasing to 400 from 2028

- Introduction of \$30,000 incentive payment for GP trainees from 2026, indexed annually
- Introduction of up to 20 weeks of paid parental leave, and 5 days of study leave per year, for GP trainees from 2026

Table 4: Packages and their corresponding policy options

	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
Package 1	✓	✓	✓	✓	✓	X
Package 2	✓	✓	✓	X	X	X
Package 3	X	X	✓	✓	✓	X

Net benefit analysis

Rating scale:

-3	-2	-1	0	1	2	3
Significantly adverse	Moderately adverse	Slightly adverse	Neutral	Slightly beneficial	Moderately beneficial	Significantly beneficial

Overall impact of options on policy objectives:

Policy Objective	Package				Explanation
	Status Quo	1	2	3	
Attract junior doctors into GP training	0	3	2	2	Continuing the status quo will not have any positive impact on attracting more junior doctors into GP training. Package 1 (Options 2-6) will have the most positive impact on attraction of junior doctors in GP training, by increasing the GP focus and outcomes of university programs, increasing exposure to general practice in prevocational years, and removing disincentives to entry, through the incentive payment and access to leave entitlements. Package 2 (Options 2-4) improves attraction into GP training earlier in the pipeline, through universities and prevocational years, however does not include the incentives or leave entitlements, so will have a slightly lower impact. Similarly, Package 3 (Options 4-6) provides the incentives and leave entitlements, however many junior doctors may be lost to GP earlier in the pipeline where no action would be taken, before these entitlements become relevant.
Increase the 'home grown' GP workforce	0	3	2	2	The status quo will maintain the current rate of GP fellowship and will not increase the 'home grown' GP workforce. Package 1 (Options 2-6) will significantly improve the growth of our home grown GP workforce, through increasing the overall medical workforce, improving GP focus at universities, opening up additional GP training places and working to attract junior doctors into these places. As above, Packages 2 (Options 2-4) and 3 (Options 4-6) will be slightly less beneficial by not targeting all points in the pipeline.

Address structural barriers to entering GP training	0	3	1	2	No action will maintain the structural barriers which prevent entry into GP training for many junior doctors. Private GP practices are unable to overcome these, particularly in the current financially strained environment. Package 1 (Options 2-6) provides the most benefit in removing the structural barriers, including university and prevocational GP exposure, as well as salary reduction and loss of leave entitlements. Package 2 (Options 2-4) will provide some benefit in providing GP exposure early in the pipeline, but does not address the major barriers on entry to GP training. Package 3 (Options 4-6) does positively address the salary and entitlements related barriers, but does not address the lack of GP exposure in university and prevocational years.
Reduce the gap in unmet demand	-1	3	2	2	Maintaining the status quo will continue the current rate of GP training, which has not changed in several years. Noting that the training program size has not been adjusted to reflect population growth, continuing with the same number of training places will actually contribute to a growing gap in unmet demand. Package 1 (Options 2-6) will go the furthest to closing the gap in unmet demand. Packages 2 (Options 2-4) and 3 (Options 4-6) also increase training capacity, but without targeting all aspects of the training pipeline, the same risk of unfilled places exists.
Reduce workforce maldistributions	-1	2	2	1	None of the measures specifically target reducing workforce maldistributions, however, existing university programs, prevocational GP program and the GP training programs all have a strong focus on building a workforce which will inherently address workforce distribution. As per the above, maintaining the status quo will contribute to growing overall GP shortages, which will further exacerbate shortages in rural and remote and other underserved areas, as there will be more choice for GPs about where they want to practise. Noting that Package 1 (Options 2-6) will provide the greatest impact on growing the GP workforce, it will also have the most positive impact on reducing maldistributions, as these are more easily addressed when the workforce is not in acute shortage. Noting Package 2 (Options 2-4) will enhance early pipeline programs that already have a strong distributional focus, this will have slightly more impact than Package 3 (Options 4-6), which does not incorporate the university or prevocational elements.
Reduce perverse competition in the workforce pipeline	-1	3	3	-1	As above, the status quo will not grow the medical workforce beyond the current rate, and therefore competition between specialties will continue to increase. Package 1 (Options 2-6) and 2 (Options 2-4) will increase the overall medical workforce, through increases to medical CSPs, therefore reducing unhealthy competition between medical specialties for trainees. Package 3 (Options 4-6) does not

					increase the overall medical workforce and addresses some of the barriers into GP training, which may heighten perverse competition for trainees between specialties.
Increase population access to quality, safe primary care services	-1	3	2	2	Noting the analysis above that the status quo contributes to the increasing gap in unmet demand, exacerbates workforce maldistributions and increases competition between medical specialties, this will have an overall negative impact on population access to quality, safe and primary care services as the population continues to grow. Package 1 (Options 2-6) will have the greatest overall impact on access to primary care, by boosting the GP workforce and addressing maldistributions. Packages 2 (Options 2-4) and 3 (Options 4-6) will also have a significant positive impact, however it is likely that the impact will be lower due to not targeting all points in the training pipeline.
Overall score	-4	20	14	10	Package 1 (Options 2-6) will have the most positive impact on the policy objectives.

Overall impact of options on stakeholders:

Stakeholder Group	Package				Explanation
	Status Quo	1	2	3	
Medical students	0	2	2	0	Students will have more opportunity to study medicine under Packages 1 (Options 2-6) and 2 (Options 2-4) compared with the status quo. Medical students will also benefit from more exposure to general practice during university, especially those inclined towards general practice. Uncapping medical CSPs for First Nations students will provide more opportunity for First Nations students to study medicine and be supported by a larger cohort of First Nations peers throughout their studies. Like the status quo, Package 3 (Options 4-6) will have no impact for medical students.
Prevocational doctors	-1	2	2	1	The status quo will have a slight negative impact on prevocational doctors interested in a GP career, as competition for GP training places increases. Packages 1 (Options 2-6) and 2 (Options 2-4) will increase opportunities for junior doctors to gain broader exposure during their university and prevocational years, which is beneficial regardless of whether they choose to train as a GP. Those who do have an interest in GP will have more opportunity to develop their skills and understanding before entry into GP training. Package 3 (Options 4-6) will have a slight benefit for prevocational doctors, in reducing

					structural barriers to entry into GP training and providing more choice for those thinking about which specialty to choose.
GP trainees	-1	3	1	2	The status quo will have a slightly negative impact on GP trainees, as the increasing GP shortage will lead to more pressure on existing GPs and those in training to see more patients. Patient care will also become more complex as access to early primary care interventions decreases, contributing to further risk of burnout. Package 1 (Options 2-6) will have the greatest positive impact on GP trainees, who will have entered GP training with more GP exposure in their early years, therefore more ready and confident to begin their training. They will also benefit significantly from the incentive payment and additional leave entitlements. Package 2 (Options 2-4) provides some benefit through the early GP exposure, and Package 3 (Options 4-6) provides a moderate benefit through the incentives and entitlements, but without the benefit of early GP exposure.
GP practices	-1	3	2	2	Some GP practices face difficulties recruiting and retaining GPs. Modelling shows that, without intervention, this is likely to worsen, with population growth increasing the strain on practices to meet their communities' needs. Package 1 (Options 2-6) will have significant benefit for practices through access to more highly trained GPs, as well as GP trainees whose skills are more developed on entry into GP training and community practice. The incentives and leave entitlements will also assist practices to support trainees through their training without the significant financial strain that offering these to trainees would otherwise have. Packages 2 (Options 2-4) and 3 (Options 4-6) will also each provide some of the benefits of Package 1 (Options 2-6).
Universities	0	1	1	0	There will be no change for universities under the status quo or Package 3 (Options 4-6). Under Packages 1 (Options 2-6) and 2 (Options 2-4), there will be more requirements on universities to work towards and demonstrate their GP outcomes, however this will only be true for those universities that wish to take up the additional places. Those who do take up the additional places will benefit from being able to expand their medical programs and all medical programs will benefit from uncapping First Nations medical CSPs.
GP Colleges	0	2	2	2	There will be no change for the GP Colleges under the status quo. Both GP colleges have been calling for additional training places. As providers of the training program, the GP colleges will benefit from these additional places under all packages through being able to grow and expand their training programs.

Australian community	-1	3	2	2	These assessments are reflective of the analysis for the policy objective 'Increase population access to quality, safe primary care services' above. The Australian community will benefit from better access to primary care services through less interaction with the hospital system and better health outcomes.
Rural and remote communities	-1	2	2	1	These assessments are reflective of the analysis for the policy objective 'Reduce workforce maldistributions' above. Rural and remote communities will benefit from greater availability of the GP workforce and better access to primary healthcare.
Other marginalised groups	-1	2	2	1	These assessments are reflective of the analysis for the policy objective 'Reduce workforce maldistributions' above. Marginalised groups (e.g. low SES, CALD, First Nations) that tend to already have lower access to healthcare than the broader community will benefit from greater availability of the GP workforce and better access to primary healthcare in underserved areas. Uncapping CSPs for First Nations medical students will lead to more qualified First Nations doctors, able to provide culturally safe healthcare to their communities.
Overall score	-6	20	16	11	Package 1 (Options 2-6) has the most positive impact on the various stakeholder groups.

Estimated regulatory impacts:

The Packages under consideration have been developed with regulatory cost in mind. Options with a clearly high regulatory burden, such as a bonded approach to CSPs or a portability scheme, have not been developed further, so regulatory costs have not been included below. The regulatory costs of each of the packages have been considered in comparison to the status quo. There are not significant regulatory impacts for any of the packages, noting that most options expand upon existing programs and therefore generally do not introduce new administrative or compliance processes.

The key regulatory impacts considered when estimating the regulatory costs of the Packages are:

- University applications for new CSPs (Option 2)
 - There would be an application process to allocate new CSPs to Universities. Approximately 24 Universities would be expected to apply, and it is estimated that 100 hours of work would be required on average for each application. This is costed at the applicable rate for work-related labour costs of \$85.17 per hour. This process would be repeated after 6 years so would occur twice in the default ten-year period. The costs of two rounds have been averaged over the 10 years to determine an annual cost.
- Individuals filling out applications (Options 2 and 4)
 - With more medical school places and GP training places available, it is expected that there may be more individuals completing applications for these programs. Given that the number of medical school applications each year is well in excess of the CSPs available, application burden is not expected to increase for prospective medical students under Option 2. Noting that all packages aim to encourage more prevocational doctors to apply for GP training, it is expected that additional individuals at least equal to the number of additional places will be required to undertake the application process each year (Option 4).
 - For Option 4, completion of the written application and interview processes for the GP Colleges is estimated to take an average of 8 hours. This is costed at the applicable rate for non-work related labour costs of \$37 per hour.
- Assessment of applications (Option 4)
 - Following on from the above, the Colleges will be required to assess additional applications, however the costs associated with this will be fully offset by application fees and/or grant funding.
- Practices hosting learners (Options 2 and 3)
 - More primary care focused CSPs and additional prevocational doctors undertaking primary care rotations may create additional administrative burden for practices hosting these earlier learners. It is expected that each additional placement would create 2 hours of additional administration for the practice. This is costed at the applicable rate for work-related labour costs of \$85.17 per hour.

- Incentive payments and entitlements (Options 5 and 6)
 - Incentive payments (Option 5) are not expected to generate any additional regulatory burden. These payments will be made automatically through the existing National Consistent Payments system without action required by the registrar or College.
 - Registrars taking parental leave (Option 6) already must apply for leave from the training program. These existing processes will be leveraged to ensure minimal additional burden for registrars to receive the new payment. The Colleges may have to send additional information to Services Australia, however the costs associated with this will be fully offset by grant funding.
 - Registrars taking exam leave (Option 6) are expected to be required to complete 0.25 hours of additional administration to take this leave. All (approx. 5,250 headcount) registrars are expected to take the leave each year, with the non-work related labour cost of \$37 per hour used. This was then scaled for additional training places.

Table 5: Average annual regulatory costs over 10 year period from 2026 (from status quo)

Change in costs (\$m)	Business	Community organisations	Individuals	Total change in costs
Option 2	0.09	0.00	0.00	0.09
Option 3	0.06	0.00	0.00	0.06
Option 4	0.00	0.00	0.12	0.12
Option 5	0.00	0.00	0.00	0.00
Option 6	0.00	0.00	0.06	0.06
Package 1	0.15	0.00	0.17	0.33
Package 2	0.15	0.00	0.12	0.27
Package 3	0.00	0.00	0.17	0.18

Final recommendation

A whole-of-pipeline investment package be implemented, with Package 1 the preferred approach, noting:

- All options have relatively minor regulatory costs
- Package 1 has the most positive impact on the policy objectives and on the various stakeholder groups

Table 6: Package 1 average annual regulatory costs over 10 year period from 2026 (from status quo)

Package 1 average annual regulatory costs (from status quo)				
Change in costs (\$ million)	Business	Community organisations	Individuals	Total change in costs
Total, by sector	\$0.15	\$0.00	\$0.17	\$0.33

7. Risks and mitigations

Risk 1: GP training demand may not increase immediately

There is a risk that demand for GP training places will take longer to ramp up than anticipated, particularly given outcomes from increased pipeline capacity will only start to be seen from 2028.

Mitigation: There are strong indications that demand for GP training places will outstrip supply from 2025. The reforms to regulatory settings arising from the Kruk Review¹³⁷ will likely further increase demand. Phased implementation would support a gradual ramping up of capacity, minimising the opportunity for inefficiencies and underspends.

Risk 2: States may cease their existing GP incentives payments following the introduction of national program

There is a risk that Victoria and Queensland may withdraw their GP incentive payments in response to the introduction of a national scheme.

Mitigation: The implementation date for the national incentives will have minimal overlap with existing state incentives, which are time limited. Furthermore, withdrawal of these incentives before their expected end date would likely cause state-level backlash due to the impacts on the GP trainee cohorts in the respective states. The Commonwealth could also encourage state governments not to withdraw their existing incentives, such as through an exchange of letters. This could also be used as negotiation levers in new Federal Financial Agreements (FFAs), such as those required for an expanded prevocational program.

Risk 3: States and territories may not be in favour of hospital interns moving into primary care

States and territories may be reluctant to support measures that divert interns out of hospitals and into the primary care system.

Mitigation: State and territory governments have publicly asked for the Commonwealth to invest more to grow the GP workforce, to relieve pressure on the acute system. This proposal will support more workforce capacity across both hospitals and primary care by growing the overall pipeline of future medical graduates.

¹³⁷ [Independent review of Australia's regulatory settings relating to overseas health practitioners \(regulatoryreform.gov.au\)](https://www.regulatoryreform.gov.au).

Risk 4: More primary care training placements may stretch clinical supervision capacity

While the GP colleges report sufficient supervision capacity, increasing GP training places rapidly will stretch this capacity.

Mitigation: With the outcomes of the *Scope of Practice Review* under consideration, a stronger primary care workforce operating at the top of its scope of practice will build supervision capacity over time. Introducing more flexibility to allow colleges to fill otherwise unfilled GP training places will further motivate GP colleges to grow system supervision capacity. Indexation to National Consistent Payments (NCP) framework payments will incentivise greater participation by supervisors and practices in GP training, increasing system capacity.

8. Evaluation plan

An evaluation will aim to determine the success of the implementation of selected recommendations, subject to decisions of Government, against the primary outcome of Government action to reduce the growing GP shortage and increase population access to quality, safe primary care services. If implemented, these recommendations seek to grow Australia's GP workforce to better meet community need.

Table 7: SMART targets for recommended investment package

Target no.	Package element	Target
1	New primary care CSPs (Option 2)	1,500 additional medical graduates with an interest in entering general practice (over 10 years from 2030).
2	New prevocational primary care rotations (Option 3)	400 more junior and prevocational rotations per annum from 2028, with three quarters entering GP training.
3	New GP training places (Option 5)	Increase new GP trainee numbers to 2,000 per annum from 2028 (through a graduated increase in capacity), with the aim of increasing GP fellowship numbers to 1,600 per annum from 2030 (allowing for attrition and part-time arrangements).
4	Introduction of incentive payments to GP trainees in their first year of training (Option 5)	Increase interest in a GP career (including rural generalism) to one in four medical students by 2028.
5	Introduction of paid parental and study leave for GP trainees (Option 6)	Increase interest in a GP career (including rural generalism) to one in four medical students by 2028.
Overall	Increase population access to quality, safe primary care services	Reduce the national gap in unmet demand for GP services by approximately 30 per cent by 2033.

Scope and methodology

The scope of the evaluation will be governed by a refreshed GP Training Outcomes Framework and program logic for the AGPT program. The review will assess the impacts of the selected recommendations on the Australia's GP pipeline and workforce.

The evaluation will follow a mixed-methods quantitative and qualitative approach to measure the impacts and outcomes of the selected recommendations. This includes determining the effect of the investment package against:

- The number of junior doctors entering GP training and fellowship rates.
- Supply versus demand for GPs – nationally and regionally.
- The distribution of GPs trainees to meet high-needs and vulnerable communities, and retention post-fellowship.
- The growth of the First Nations GP workforce, and the delivery of effective cultural education to all GP trainees.
- Training of GPs to provide culturally appropriate and safe care to Aboriginal and Torres Strait Islander people.
- The objective of the evaluation.

Dependent on the recommendations adopted, the evaluation will aim to assess the effectiveness of the implemented recommendations against a suite of outcomes-based key performance indicators that will be developed based on a new program logic.

An evaluation will be undertaken within three years post implementation. This approach provides enough time for the effects of the measures to start to be realised and visible through available data sources. The evaluation is expected to be undertaken over a 12-month period and include analysis of data and information and stakeholder consultations. A final evaluation report will be expected to be provided to Government six months post completion of the evaluation activity.

Evaluation questions and data requirements

Evaluation question	Sub-questions	Indicators / data required to address the questions	Data collection methods	How this contributes to overall policy objective
<ul style="list-style-type: none"> Is Government investment attracting junior doctors into GP training? 	<ul style="list-style-type: none"> Are available GP training places being filled each year? <ul style="list-style-type: none"> Are available rural pathway/RG places being filled each year? Have GP training uptake trends for each pathway increased on previous years? What is the proportion of GP training being undertaken in community general practice versus hospitals? What is the rate of GP/RG fellowship? <ul style="list-style-type: none"> What is the rate of fellowship per year? What is the average length of time taken to fellow per college? What are the numbers of junior doctors interested in general practice as a career? 	<ul style="list-style-type: none"> Number of GP registrars by training year. Number of GP/RG registrars training in regional, rural and remote locations by training year. Number of GP/RG registrars that successfully fellow per annum. Average number of years taken by GP registrars to fellow. Number and FTE rates of GP registrars training in community general practice settings per year. Number of prevocational primary care rotations by training year. 	<ul style="list-style-type: none"> GP college data reporting GP college selection reports Medical Schools Outcomes Database (MSOD) National Data Reports 	<ul style="list-style-type: none"> Government investment in attracting junior doctors into GP training will see more junior doctors choosing general practice as a career, contributing to improving the maldistribution of the GP workforce and increasing the 'home grown' GP workforce, which will reduce the gap in unmet demand and increase population access to quality, safe primary care services.

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- Is Government investment in GP training increasing the 'home grown' GP workforce?
 - What are the numbers and percentages of primary care prevocational rotations undertaken per year?
 - What are the numbers of junior doctors interested in general practice as a career?
 - What are the numbers of medical students commencing in primary care CSPs per year?
 - What are the numbers of First Nations medical students commencing in primary care CSPs per year?
 - Number of fellowed GPs who undertook a prevocational primary care placement.
 - Retention of prevocational trainees in regional, rural and remote areas.
 - Number of medical graduates preferencing GP specialty for future practice.
 - Number of new junior doctors undertaking a prevocational rotation in primary care by training year.
 - Number of primary care CSPs taken up per year.
 - Number of primary care CSPs taken up by First Nations students per year.
 - GP college data reporting
 - MSOD National Data Reports
 - Australian Primary Care Prevocational Program performance reports
 - Government investment in increasing the 'home grown' GP workforce will see more junior doctors choosing general practice as a career and contribute to improving the maldistribution of the GP workforce, which will reduce the gap in unmet demand and increase population access to quality, safe primary care services.
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- Is Government investment reducing structural barriers to entering GP training?
 - Has the pay gap experienced by junior doctors moving to GP training from the hospital system decreased?
 - Are registrars receiving the incentive payment in their first year of community-based GP training through the NCP?
 - Are registrars receiving study and parental leave payments through the NCP?
 - What is the average number of paid parental leave weeks taken by GP registrars?
 - What is the average number of paid study leave days taken by GP registrars?
 - Number of GP registrars that received an incentive payment.
 - Number of GP registrars that received a study and/or parental leave payment.
 - The percentage of total eligible payments made in a timely and accurate manner.
 - Of the GP registrars that received a study and/or parental leave payment, the average number of paid parental leave weeks and/or study leave days taken per GP registrar.
 - GP college data reporting
 - NCP Data reports
 - GP college performance reports
 - AGPT National Registrar Survey
 - Government investment in reducing structural barriers to entering GP training will see more junior doctors choosing general practice as a career, contributing to improving the maldistribution of the GP workforce and increasing the 'home grown' GP workforce, which will reduce the gap in unmet demand and increase population access to quality, safe primary care services.
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<ul style="list-style-type: none"> Is Government investment in GP training reducing the gap in unmet primary care demand? 	<ul style="list-style-type: none"> What is the rate of GP/RG fellowship? <ul style="list-style-type: none"> What is the rate of fellowship per year? What is the average length of time taken to fellow per college? What are the numbers of junior doctors interested in general practice as a career? What are the numbers of GP registrars that undertook cultural safety training? <ul style="list-style-type: none"> Is this training effective? 	<ul style="list-style-type: none"> Number of GP/RG registrars that successfully fellow per annum. Average number of years taken by GP registrars to fellow. Number of new junior doctors undertaking a prevocational rotation in primary care by training year. Number and percentage of GP registrars satisfied with cultural safety training. Number and percentage of GP registrars that feel confident in providing culturally safe care. 	<ul style="list-style-type: none"> Department of Health and Aged Care - Supply and Demand Study GP college data reporting AGPT National Registrar Survey GP college performance reports Australian Primary Care Prevocational Program performance reports 	<ul style="list-style-type: none"> Government investment in GP training will see more junior doctors choosing general practice as a career and undertaking Government funded GP training, contributing to improving the maldistribution of the GP workforce and increasing the 'home grown' GP workforce, which will reduce the gap in unmet demand and increase population access to quality, safe primary care services.
<ul style="list-style-type: none"> Is Government investment in GP training reducing the maldistribution of the GP workforce? 	<ul style="list-style-type: none"> What is the number of available places that have been filled in each state and territory and in each MM region? What are the numbers and FTE rates of registrars training in high-needs communities, including regional, rural and remote areas? 	<ul style="list-style-type: none"> Number of GPs that have been retained in the same or similar (MM) region they undertook their GP training. Number of GP registrars that remain in a rural area post fellowship. Number of GP registrars by State, Territory and training year. Number of GP registrars training in each MM region. 	<ul style="list-style-type: none"> GP college data reporting GP college selection reports MSOD National Data Reports Australian Primary Care Prevocational Program performance reports 	<ul style="list-style-type: none"> Government investment in reducing the maldistribution of the GP workforce will see more junior doctors undertaking Government funded GP training and choosing to train in regional, rural and remote locations, which will reduce the gap in

	<ul style="list-style-type: none"> • What is the retention of registrars in rural locations 3, 5 and 7 years after fellowship? • What are the numbers and percentages of primary care prevocational rotations undertaken in regional, rural and remote areas? 	<ul style="list-style-type: none"> • Number of GP registrars with rural placement preferences. • Number of prevocational primary care rotations by state and territory and in each MM region. • Number of new junior and prevocational doctors undertaking a prevocational rotation in primary care in regional, rural and remote areas. 		<p>unmet demand and increase population access to quality, safe primary care services, particularly in regional, rural and remote areas.</p>
<ul style="list-style-type: none"> • Is Government investment creating perverse competition in the medical workforce pipeline? 	<ul style="list-style-type: none"> • Has the level of interest in general practice as a career by junior doctors increased on previous years? <ul style="list-style-type: none"> ○ What is the rate of increase? • Has the level of interest in commencing a primary care CSP from medical students increased on previous years? <ul style="list-style-type: none"> ○ What is the rate of increase? • Has the level of interest in undertaking a prevocational rotation in primary care by new junior doctors increased on previous years? 	<ul style="list-style-type: none"> • Number of medical graduates preferencing GP specialty for future practice. • Number of applications submitted by medical students for primary care CSPs per year. • Number of applications submitted by new junior doctors for a prevocational rotation in primary care per year. 	<ul style="list-style-type: none"> • MSOD National Data Reports • Australian Primary Care Prevocational Program performance reports 	<ul style="list-style-type: none"> • Government investment in the GP training pipeline, including in more primary care CSP places, seeks to incentivise universities to select students more likely to undertake GP careers rather than divert existing medical students from another pathway. Rather than disproportionately diminish interest in other medical specialties, this investment seeks to rectify the declining interest in general practice and GP

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- What is the rate of increase?

training, which will reduce the gap in unmet demand and increase population access to quality, safe primary care services.

9. Governance

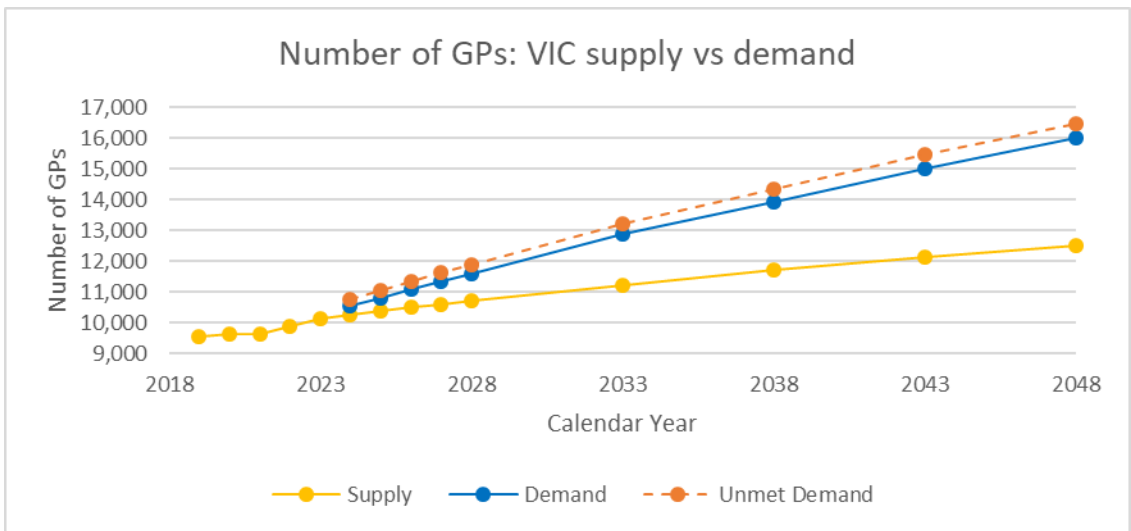
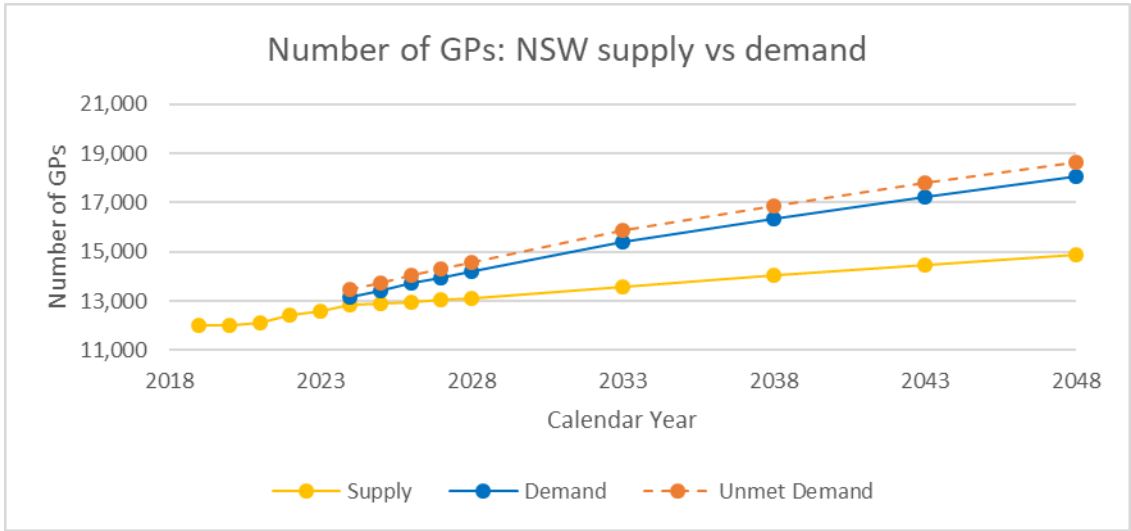
The General Practice Training Advisory Committee (GPTAC) will provide monitoring of the implementation of the selected policy options. The committee will act as a conduit between the department and the broader GP training sector. This would provide the department with information and feedback to inform the evaluation. Once agreed and announced, the GPTAC work plan will be updated to reflect its monitoring role.

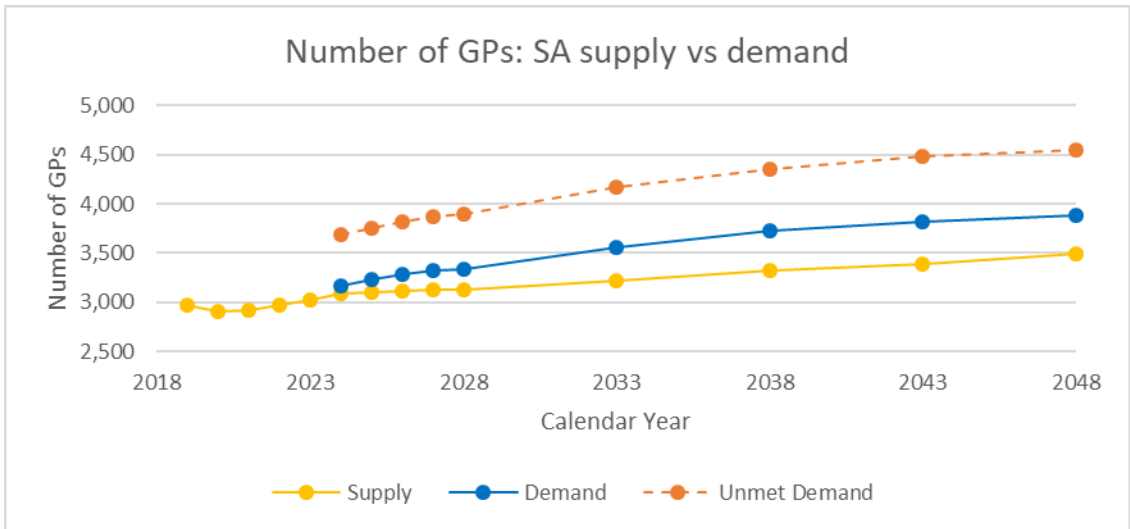
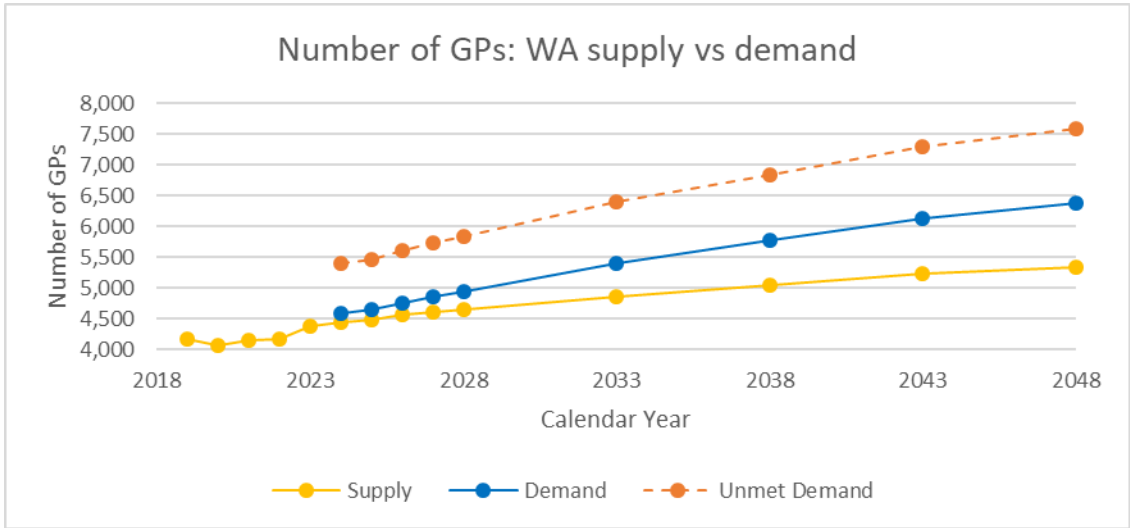
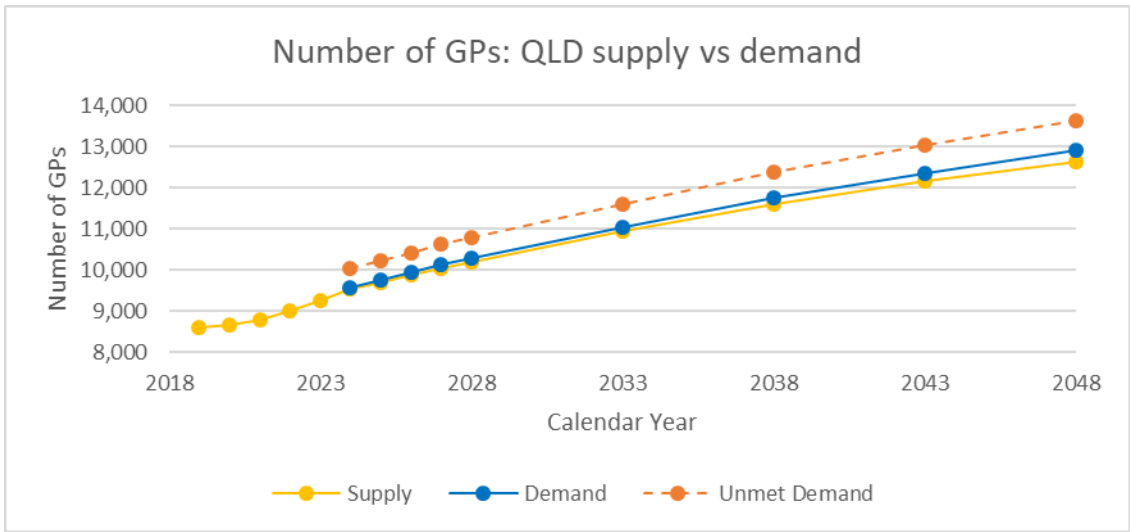
The program management teams in Health Workforce Division will have the responsibility of monitoring the performance activities, such as adherence to activity work plans and meeting key performance indicators for program evaluation, under the respective grant agreements and FFAs. Outcomes and updates will be reported to GPTAC.

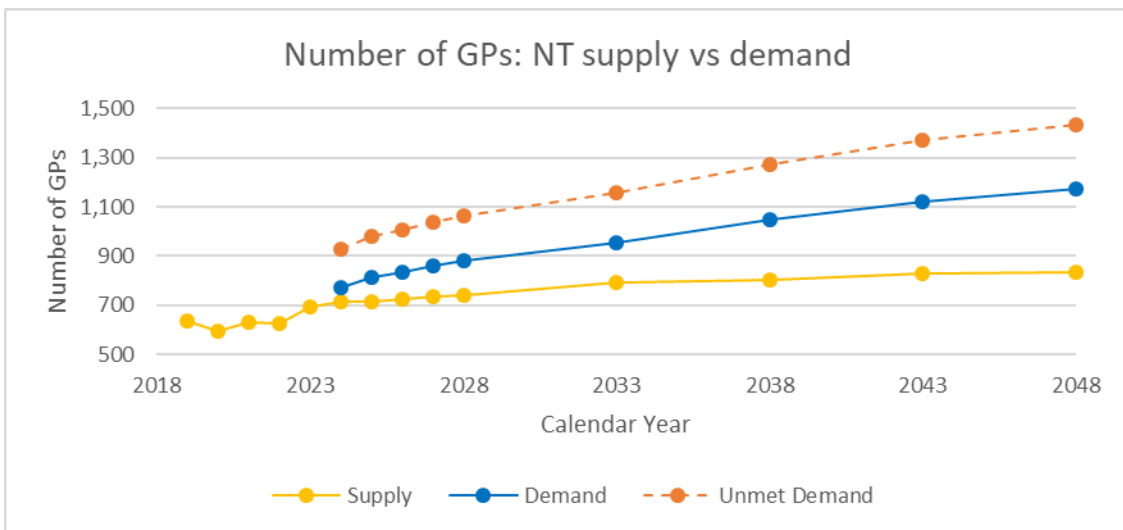
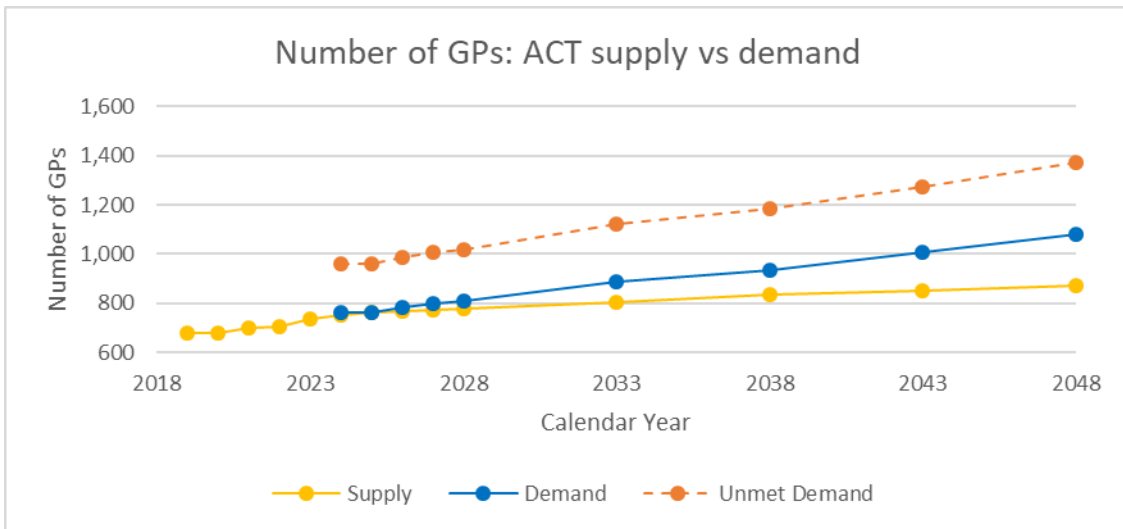
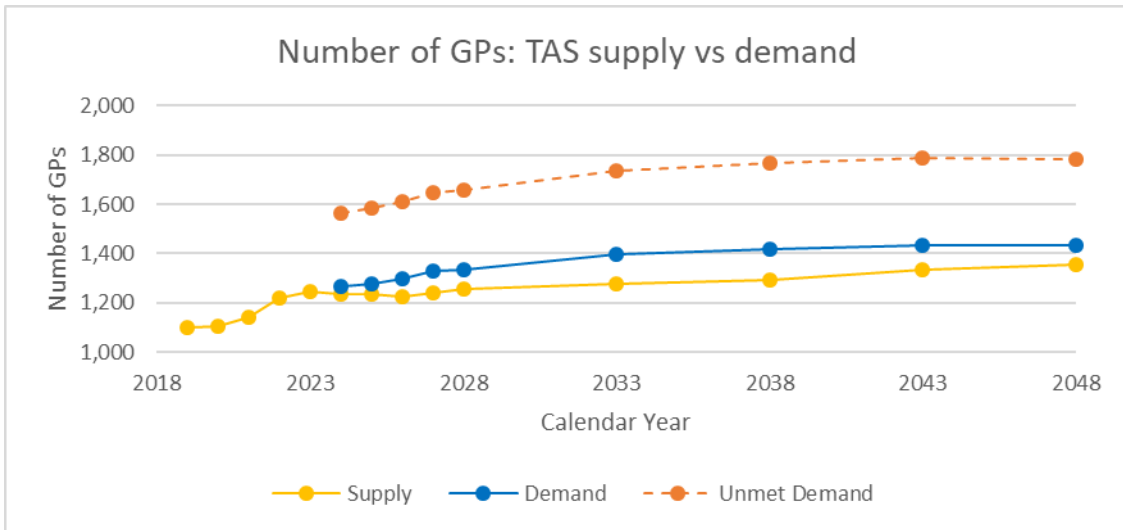
The clearance and approval of evaluation activities will align with departmental evaluation frameworks and mechanisms. Internal review and assurance mechanisms will align with legislative and departmental requirements.

The Medical Workforce Advisory Collaboration and the Health Workforce Taskforce will be consulted on implementation approach and provided with updates.

Appendix A: Supply and demand projections – state by state







Appendix B: GP training programs

The Australian General Practice Training program

The Australian General Practice Training (AGPT) college-led training program provides three to four years of full-time training for registrars to obtain fellowship and gain specialist GP registration, through either the Royal Australian College of General Practitioners (RACGP) or Australian College of Rural and Remote Medicine (ACRRM). The AGPT program offers 1,500 new places each year. In 2023, the program transitioned from a regional to a national training model. The Government provides around \$250 million per annum for the program's operation.

To be eligible for the AGPT program, doctors must hold general registration before commencement. Doctors must also be an Australian/New Zealand citizen or Australian permanent resident, or be working toward citizenship or permanent residency.

Rural Generalist Training Scheme

The Rural Generalist Training Scheme is a four-year training program offering a structured Rural Generalist (RG) education program, with intended outcomes of increasing access to primary healthcare in rural and remote communities. The program is delivered by ACRRM and provides up to 100 RG commencing places per year. All training is delivered in MM2-7 locations where possible. The Government is providing \$71.47 million between 2020-21 and 2025-26 for the program, with an additional \$1.1 million provided through an existing grant for establishment cost.

To be eligible for the RGTS program, doctors must hold general registration before commencement. Doctors with limited or provisional registration may be eligible if they have an individual training plan approved by the ACRRM Director of Training at commencement. Doctors must also be an Australian citizen or permanent resident, or be working toward citizenship or permanent residency.

Remote Vocational Training Scheme

The Remote Vocational Training Scheme (RVTS) is a three or four-year GP training and workforce retention program, with 32 commencing places per year, including up to 10 places in Aboriginal Community Controlled Health Services (ACCHS). The program delivers structured distance education and supervision towards GP fellowship, while doctors provide services to remote and First Nations communities. Trainees are encouraged to remain in rural, remote and First Nations communities post fellowship through opportunities like becoming RVTS supervisors, clinical teaching visitors or medical educators. The Government is providing \$44.495 million between 2019-20 and 2025-26. An additional \$5 million was provided in 2021 for the RVTS Extended Targeted Recruitment pilot, as part of the department's innovative employment model trials.

To be eligible for the RVTS program, doctors must hold General, Provisional or Limited Registration. In addition to Australian citizens and permanent residents, temporary residents are eligible so long as they have adequate time left on their visa to complete the training program.

Self-funded pathways

Both RACGP and ACRRM deliver self-funded GP training pathways: the Fellowship Support Program (RACGP), the Practice Experience Program (Specialist Stream) (RACGP) and the Independent Pathway (ACRRM). Previously, RACGP also provided the Practice Experience Program (Standard Stream), which ceased in 2022. Trainees on these pathways must be based in MM2-7 locations. Between 2017-18 and 2021-22, the Government provided \$46 million in time-limited subsidisation for non-vocationally recognised doctors on a self-funded pathway to achieve GP fellowship.

The eligibility criteria differs across the self-funded pathways, though they are generally open to doctors on general, provisional or limited registration. The self-funded pathways are generally open to temporary visa holders, in addition to Australian citizens and permanent residents.

Appendix C: 2024 CSPs

2024 medical places	Home state ¹³⁸	Maximum designated CSPs	Domestic full-fee paying commencement limit	Domestic completions limit
Charles Sturt University	NSW	148	0	0
Curtin University	WA	516	0	90
Deakin University	VIC	527	0	130
Flinders University	SA	440	36 ¹³⁹	135
Griffith University	QLD	792	0	200
James Cook University	QLD	934	0	154
Monash University	VIC	1461	0	310
The Australian National University	ACT	360	0	90
The University of Adelaide	SA	796	0	134
The University of Melbourne	VIC	988	45	295
The University of New England	NSW	300	0	60
The University of Newcastle	NSW	532	0	108
The University of Queensland	QLD	1082	0	271
The University of Western Australia	WA	808	0	205
University of Wollongong	NSW	291	0	69
University of New South Wales	NSW	1183	0	199
The University of Sydney	NSW	895	0	227
University of Tasmania	TAS	475	0	93

¹³⁸ CSPs are not tied to a specific state. Higher education providers have flexibility to deliver CSPs across approved locations. Some providers deliver interstate medical programs.

¹³⁹ Flinders University commences 36 students into its Northern Territory Medical Program each year. These places are not CSPs, but pay no fees in return for a return of service obligation to work in the NT after graduation.

2024 medical places	Home state ¹³⁸	Maximum designated CSPs	Domestic full-fee paying commencement limit	Domestic completions limit
Western Sydney University	NSW	501	0	101
The University of Notre Dame Australia	WA	632	52 ¹⁴⁰	212
Bond University ¹⁴¹	QLD	0	N/A	N/A
Macquarie University ¹³⁹	NSW	0	N/A	N/A

¹⁴⁰ The University of Notre Dame Australia is permitted to exceed its domestic full fee paying commencement limit by 10%

¹⁴¹ Bond and Macquarie Universities operate full-fee paying medical schools. The government does not control the number of places or completions at these providers.