

AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION



Pre-Budget
Submission
2021-22

Australian Medical Students' Association
Pre-Budget Submission 2021-22

Australian Medical Students' Association
42 Macquarie St
Barton, ACT 2600
January 29th, 2021

The Hon Josh Frydenberg MP
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Dear The Honourable Josh Frydenberg,

CC The Hon Greg Hunt MP, Minister for Health
The Hon Alan Tudge MP, Minister for Education
The Hon Ken Wyatt AM MP, Minister for Indigenous Australians

The Australian Medical Students' Association (AMSA) thanks the Government for the opportunity to develop the following Pre-Budget Submission for consideration.

As the peak representative body of Australia's 17,000 medical students, and the nation's future medical workforce, AMSA has developed five health and education priorities for the 2021-2022 Federal Budget.

The recommendations are in the areas of:

1. Medical workforce
2. Mental health
3. Indigenous health
4. Climate change
5. Gender equity

Sincerely,



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President



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MEDICAL WORKFORCE

Recommendations:

1. Fund the establishment of a Joint Medical Workforce Planning and Governance body and National Medical Workforce Data Strategy.
2. Refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international, medical students.
3. Refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling addressing workforce need.
4. Align future Junior Doctor Training Program funding with medical student numbers, to ensure all Australian-trained medical students may access an internship position.
5. Allow Australian medical students to apply for and access OS-HELP funding to assist them to undertake medical placements domestically in rural areas.
6. Direct federal funding toward providing rural vocational training to medical graduates already in the rural medical pipeline to improve workforce retention.
7. Provide increased funding for specialist training options in rural and regional Australia via expansion of the Specialist Training Program.

1. WORKFORCE MALDISTRIBUTION

Current economic cost	Recommendation
Workforce maldistribution contributes to economic and healthcare burdens both in underserved Australian populations and the health workforce.	Fund the establishment of a Joint Medical Workforce Planning and Governance body and National Medical Workforce Data Strategy.

The Issue:

Australian workforce maldistribution across both geography and the over and under-supply of specialist doctors has significant economic and health implications. Training a doctor takes approximately 10-20 years from medical student to specialist, and the fiscal and

labour investment is enormous. Consequently, it is important that this personal and government investment leads to individual career progression and satisfaction, and clinician engagement across diverse areas of the health sector, including in the treatment and management of populations with traditionally inaccessible healthcare and poorer health outcomes. The projected over-supply in areas such as Emergency Medicine and Anaesthetics and undersupply in areas such as Psychiatry and Ophthalmology represent an inefficient use of resources, and increase disease burden in the Australian community. Sequelae include increased disease morbidity and mortality, reduced quality of life, preventable hospitalisations, and social and economic disengagement.

In inner regional and remote areas, avoidable death rates are approximately 20 per cent and 65 per cent higher than in metropolitan areas, respectively. Australian Institute of Health and Welfare states that the average cost of a hospitalisation is \$3100 - \$6100, and in 2015-16 there were 25 potentially preventable hospitalisations per 1,000 people in major cities compared with 60.9 in very remote areas of Australia.

The Solution:

The funding and establishing of a Joint Medical Workforce Planning and Governance body with the authority to advise, direct, or make decisions on the size and structure of the entirety of the medical workforce pipeline will allow medium to long-term planning and resource allocation to align workforce with demand. Concurrently, the funding of a National Medical Workforce Data Strategy will facilitate evidence-based decisions of workforce planning and enable evaluation of the efficacy of different rural training models in retaining a rural workforce.

2. MEDICAL SCHOOLS AND STUDENT NUMBERS

Current economic cost	Recommendation
<p>The rapid increase of medical schools in Australia from 15 in 2006 to 23 in 2021 is estimated to cause an oversupply of doctors of at least 4,494 by 2030. The cost of training a single doctor is estimated at \$58,318 per year and. Without completing an internship, medical graduates cannot be registered as doctors, representing an opportunity cost of between \$237,272 to \$408,226 depending on the length of the degree.</p>	<p>Refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international medical students.</p> <p>Refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling addressing workforce need.</p> <p>Align future Junior Doctor Training Program funding with medical student numbers.</p>

The Issue:

The rapid increase of medical schools in Australia from 15 in 2006 to 23 in 2021 is estimated to cause an oversupply of doctors of at least 4,494 by 2030. Australian medical graduates cannot register as doctors without the completion of an internship. Medical Deans have approximated the cost of training a single doctor per year to a conservative \$58,318 (with current degrees ranging from 4-7 years in length), thus, training medical students who will be unable to find an internship to become fully qualified doctors represents both an inefficient use of federal funds and a waste of personal investment.

The contemporary landscape of the medical training system means that new medical schools, regardless of whether they are placed rurally or in a metropolitan location, will not yield an increased rural medical workforce. Even after spending time rurally in medical school, the vast majority of doctors are forced to return to metropolitan regions to undertake training with a specialty college. As long as medical training pathways are unable to retain training doctors in rural areas, efforts to increase the interest of medical students in rural practice will largely remain fruitless. Further, the investment required to establish new medical training programs in rural areas duplicates the already successful Rural Clinical School scheme and represents a poorly targeted use of federal funding that may otherwise be directed at rural health services. Further, as aforementioned, it takes 10-20 years before a medical student becomes a fully qualified doctor. A far more targeted use of these funds is to train specialists rurally through the Specialty Training Program (STP), allowing qualified doctors to be brought into rural communities now, rather than hoping medical students will return to the region in 20-years.

The Solution:

In line with AMA and AMSA policy, we request that government refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international medical students. Further, to ensure the efficient use of health and education spending, we request that the government refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling addressing workforce need. Finally, AMSA commends the Federal Government's support of the Junior Doctor Training Program (JDTP) in recent years. We request that this program continue to be funded beyond 2022 to ensure that all Australian-trained medical students may access an internship position. Future JDTP funding should be aligned with medical student numbers.

3. OS-HELP LOANS

Current economic cost	Recommendation
Government allocated OS-HELP loan funding is not being utilised.	Allow Australian medical students to apply for and access OS-HELP funding to assist them to undertake medical placements domestically in rural areas.

With the presumed under-utilisation of OS-HELP funding in 2020-21, we request this program be expanded to include support for domestic training opportunities. This will reduce financial barriers to undertaking short periods of training domestically and engage students in areas of healthcare delivery in regions impacted by workforce maldistribution. Studies have shown that a positive rural experience in medical school is a positive predictor for undertaking a rural career. Including domestic applications within the OS-HELP loan program will therefore assist students to engage in rural medicine and foster interest in a rural career.

4. RURAL SPECIALTY MEDICAL TRAINING

Current economic cost	Recommendation
Rural and remote communities experience a higher disease burden than metropolitan areas and more difficulty accessing healthcare, leading to higher preventable hospitalisation rates which alone costs the government between \$3100 to \$6100 per hospitalisation.	<p>Direct federal funding toward providing rural vocational training to medical graduates already in the rural medical pipeline to improve workforce retention.</p> <p>Provide increased funding for specialist training options in rural and regional Australia via expansion of the Specialist Training Program.</p>

The Issue:

Australia's remote and rural population struggle to access health services, largely due to their geographical location. Rural Australians are more likely to defer access to general practitioners (GPs) due to cost, significant travel distances, and/or extended wait times. Subsequently, rural Australians face significantly poorer health outcomes in comparison to their metropolitan counterparts. Potentially Preventable Hospitalisations (PPHs) for remote and very remote communities are 39.5 and 60.9 per 1000 population, compared to 25.0 in major cities. A major contributor to this is the lack of medical specialists in remote and very remote communities. Major cities have 288.9 medical specialists per 10,000 population

compared to 192.3 per 10,000 population in remote and very remote communities. With reduced population density in these regions, specialist availability is limited.

The Solution:

The provision of vocational training pathways in rural areas is critical to retaining rural doctors and addressing workforce maldistribution. AMSA commends the government's commitment to continue funding the Specialty Training Program (STP) into 2021 and with flexibility in meeting training targets affected by COVID-19. Expanding STP funding across additional rural sites, particularly for under-serviced medical specialties, in combination with novel methods of supervision, will facilitate rural workforce retention in areas of need.

MENTAL HEALTH

Recommendations:

1. Provide \$5.7 billion to Better Access to continue funding for 20 Medicare-funded psychology sessions.
2. Provide \$1,380,000 for Mental Health First Aid Training for medical students over 2 years.

1. MENTAL HEALTH FOR ALL AUSTRALIANS

Current economic cost	Recommendation
The economic burden of mental health costs \$200-220 billion per year.	Provide AUD\$5.7 billion to Better Access to continue funding for 20 Medicare-funded psychology sessions.

The Issue:

The Productivity Commission's Mental Health Inquiry found that the economic burden of mental health costs \$200-220 billion per year. There is a clear need for addressing the burden of mental health given the enormous economic and social cost, which amounts to approximately one-tenth the size of Australia's entire economic production yearly.

The Solution:

In line with the Productivity Commission 2020 Mental Health Inquiry¹ and recommendations from the Australian Psychological Society², the number of psychology sessions required to achieve effective clinical outcomes varies from 20 sessions for low-intensity treatment needs, to up to 40 sessions for high-intensity treatment needs. Therefore, continuation of funding for 20 Medicare-funded psychology sessions is crucial in combating the health and economic burden of mental illness, and leading to better individual outcomes for millions of Australians.

¹ Productivity Commission 2020, Mental Health, Report no. 95, Canberra.

² The Future of Psychology in Australia: The Future of Psychology in Australia. (2019). Australian Psychological Society.

The Productivity Commission highlighted the economic benefits of investing in mental health care across multiple areas. An increase in labour force participation for consumers and carers will lead to a gain of up to \$31.9 billion annually in productivity. Further, a reduction in the cost of disability and premature death due to suffering from mental illness will save the economy \$150 billion annually. **Consequently, the mobilisation of \$5.7 billion to fund 20 sessions would represent a return on investment of up to \$31.9 dollars per dollar spent.**

2. MENTAL HEALTH FIRST AID TRAINING FOR MEDICAL STUDENTS

Current economic cost	Recommendation
<p>Medical students are an at-risk population for poor mental health and the economic investment in training a medical student is significant (\$58,318 per year). The opportunity cost of poor mental health on the health workforce due to attrition of medical students or loss of productivity is therefore immense.</p>	<p>Provide \$1,380,000 for Mental Health First Aid Training for medical students over 2-years commencing in 2022.</p>

The Issue:

Medical students and doctors are an at-risk population for poorer mental health outcomes, experiencing higher rates of psychological distress, mental health diagnoses and suicide than other professionals. Furthermore, medical students are more likely to be approached by colleagues, friends, or family in distressed or pre-distress states. Mental Health First Aid training is invaluable in facilitating early intervention by training students to identify and respond to crisis scenarios in themselves and others.

The Solution:

AMSA commends the government for the \$690,000 Mental Health First Aid (MHFA) funding for medical students in 2020-21 to complete the online component of MHFA training. We request the Federal Government provide a further \$1,380,000 over 2022-23 to ensure this invaluable training is to remain freely available to Australian-based medical students. We have requested an increase from the \$690,000 investment as MHFA training certificates last 3-years, while medical school is between 4 and 6 years. This will ensure MHFA training, and the associated skills, cover the entirety of medical school.

INDIGENOUS HEALTH

Recommendations:

1. Commit \$1,346,000 annually to subsidising Cultural Safety Training for one cohort of Australian medical students.
2. Commit a further \$2 million annually to support Indigenous medical students to complete their degrees.

1. CULTURALLY SAFE HEALTHCARE

Current economic cost	Recommendation
Disparities in Indigenous health outcomes cost the Northern Territory \$3.34 billion annually. Further, the healthcare cost of preventable hospital admissions alone for Indigenous peoples totals \$136 million to \$268 million annually.	Commit \$1,346,000 annually to subsidising Cultural Safety Training for one cohort of Australian medical students.

The Issue:

Aboriginal and Torres Strait Islander peoples almost universally experience poorer health outcomes than the non-Indigenous population, largely due to a lack of accessible and appropriate healthcare. This is against a background of historic and ongoing systemic racism, including a long history of neglect, exclusion and negligence from the medical community.

Amongst medical practitioners, a lack of understanding of First Nations values, principles and cultures hinders their capacity to deliver culturally safe and sensitive healthcare. This further ostracises First Nations peoples from healthcare settings, reduces help-seeking behaviours and results in poorer outcomes from health service engagement. These outcomes manifest in health inequity that come at an enormous cost to First Nations peoples and communities.

There is also a strong financial argument to be made for closing the gap. Research from the

Northern Territory has calculated disparities in Indigenous health outcomes to cost the Northern Territory \$3.34 billion annually.³ Further, during 2017-18 Indigenous Australians were three times as likely to have a potentially preventable hospitalisation as non-Indigenous Australians.⁴ This represents 44,040 annual potentially preventable admissions. Considering the average cost to the health sector of a hospital admission lies between \$3100 and \$6100, this totals \$136,524,000 to \$268,644,000 in annual government expenditure for preventable hospitalisations of Indigenous Australians.⁵

A Solution:

Several studies have suggested that the key to reducing Indigenous health disparities is health care workers developing partnerships, eliminating bias through self-reflection, and building relationships with Indigenous people. We ask that government commit \$1,346,000 annually to the provision of Cultural Safety Training for one cohort – 3,845 medical students – studying in Australia. Through an annual commitment from government, we may ensure that all medical students graduating in Australia will enter the workforce trained to provide culturally sensitive, informed and safe care. We request that this training be administered by National Aboriginal Community Controlled Health Organisations currently engaged in Cultural Safety Training, contributing to the funding of these services.

2. ABORIGINAL AND TORRES STRAIT ISLANDER MEDICAL STUDENT RETENTION

Current economic cost	Recommendation
\$2.16 to \$2.54 million of government investment lost annually to Indigenous medical student attrition.	Commit a further \$2 million annually to support Indigenous medical students to complete their degrees.

The Issue:

In 2020, about 600 doctors in Australia’s medical workforce identified as being Aboriginal and/or Torres Strait Islander peoples – about 0.5% of the workforce. To reach population parity, that number should be closer to 3,600. One key barrier to this is Indigenous medical student attrition. Indigenous medical student retention can be calculated as less than 70% by tracking medical student enrolment and graduation data over time.⁶ Further, growth in

³ Davey, R.X. (2017). The economic benefits of eliminating Indigenous health inequality in the Northern Territory. *Medical Journal of Australia*, 206(4), pp.186–186.

⁴ Disparities in potentially preventable hospitalisations across Australia: Exploring the data. (2020). Australian Institute of Health and Welfare.

⁵ Hospital Performance: Costs of acute admitted patients in public hospitals from 2011–12 to 2013–14. (2016). Australian Institute of Health and Welfare.

⁶ Medical Deans Australia and New Zealand. 2020. Student Statistics Reports. [online] Available at: <<https://medicaldeans.org.au/data/student-statistics-reports/>> [Accessed 05 January 2021].

recruitment is currently outpacing growth in retention by a factor of 1.175, emphasising that a shift in resources towards increasing retention is necessary. Consequently, of the 121 Indigenous medical students who commenced their studies in 2020, at least 36 will not complete their degree. With medical school Commonwealth Supported Places (CSPs) equating to a \$40,000-\$47,000 government investment per student per year, we estimate Indigenous medical student attrition to cost the government \$2.16 to \$2.54 million annually. This loss is projected to be higher due to the funds invested in Indigenous medical education scholarships and bursaries, and ABSTUDY. Course non-completion also places considerable financial burden on Indigenous medical students and their communities.

A Solution:

We ask for a further \$2 million to be invested into services to support Indigenous medical students to complete their degrees. Opportunities to direct this funding include investments in Indigenous Engagement and Support Units, and Indigenous medical student sponsorships and bursaries, with 86% of Indigenous medical graduates reporting financial hardship during their studies in AIDA's Healthy Futures report.⁷ Indigenous medical students are best positioned to guide the provision of services to better support their needs and we advocate for their consultation in this process.

⁷ Healthy Futures. (2005). Australian Indigenous Doctors' Association.

CLIMATE CHANGE

Recommendations:

1. **Commit to \$200 million to state governments to fund the installation of solar panels with batteries across 400 metropolitan and rural public hospitals and health services.**
2. **Commit \$2 million towards the establishment of a National Sustainable Development Unit (SDU) to coordinate reform of Australian healthcare environmental sustainability, and improve healthcare efficiency and cost-effectiveness.**

1. SOLAR HOSPITALS

Current economic cost	Recommendation
Air pollution from public hospital emissions alone is estimated to cost the government \$171-\$375 million in premature deaths annually. This figure doesn't account for non-mortality healthcare expenditure, including hospital admissions and medications, and non-healthcare expenditure, including public hospital electricity costs.	Commit \$200 million in payments to state governments to fund the installation of solar panels with batteries across 400 metropolitan and rural public hospitals and health services.

The Issue:

In Australia, healthcare is responsible for 7% of our carbon footprint, with public hospitals producing 34% of these emissions.⁸ Considering Australia's air pollution landscape, public hospitals may be estimated as the source of 1.55%. Local economic analysis has placed the financial burden of premature deaths in Australia due to air pollution between \$11.1 billion

⁸ Malik, A., Lenzen, M., McAlister, S. and McGain, F. (2018). The carbon footprint of Australian health care. The Lancet Planetary Health, 2(1), pp.27–35.

and \$24.3 billion annually.^{9,10,11} Given current rates of carbon emissions, the cost to government in premature deaths annually attributable to public hospital emissions alone is therefore \$171,717,000 - \$375,921,000. This figure doesn't account for millions¹² in non-mortality healthcare expenditure, including hospital admissions and medications, and non-healthcare expenditure, including public hospital electricity costs.

A Solution:

Solar energy produces only a fraction of the carbon emissions produced by coal, oil and gas. Further, in March of 2020 the Carbon Tracker Initiative analysis found investments in renewables to be cheaper than new investments in coal in all major markets today, including Australia. The report found that over half of all coal plants operating today cost more to run than building new renewables, and it could be cheaper to build renewables than run coal in all major markets by 2030.¹³ This is already evident across the Australian market, for example Blacktown Hospital in Western Sydney is predicted to save \$194,000 every year in electricity costs following the installation of solar panels last year.¹⁴

We request at least \$200 million be contributed to state governments specifically to fund the installation of solar panels with batteries across approximately 400 metropolitan and rural public hospitals and health services. This would represent 58% of all public hospitals in Australia and a significant step towards protecting Australia's health and economy.

⁹ Dean, A. and Green, D. (2017). Climate Change, Air Pollution and Health in Australia. UNSW Sydney Grand Challenges, p.5.

¹⁰ Begg S, Vos T, Barker B, Stevenson C, Stanley L and Lopez A (2007) The burden of disease and injury in Australia 2003. Cat. no. PHE 82. Australian Institute of Health and Welfare, Canberra. Available: <http://www.aihw.gov.au/publication-detail/?id=6442467990> [Accessed 25 June 2017]

¹¹ Access Economics. (2008). The Health of Nations: The Value of a Statistical Life. Report for the Office of the Australian Safety and Compensation Council. Available: http://www.safeworkaustralia.gov.au/sites/swa/about/publications/Documents/330/TheHealthOfNations_Value_StatisticalLife_2008_PDF.pdf [Accessed 21 Sept 2017].

¹² Air Pollution Economics: Health Costs of Air Pollution in the Greater Sydney Metropolitan Region. (2005). Department of Environment and Conservation NSW, p.63.

¹³ How to waste over half a trillion dollars: The economic implications of deflationary renewable energy for coal power investments. (2020). Carbon Tracker Initiative.

¹⁴ NSW Government. (2020). Solar savings for NSW hospitals. [online] Available at: <https://www.nsw.gov.au/news/solar-savings-for-nsw-hospitals#:~:text=Solar%20panels%20are%20being%20installed> [Accessed 26 Jan. 2021].

2. NATIONAL SUSTAINABLE DEVELOPMENT UNIT

Current economic cost	Recommendation
Victorian public hospital waste production alone costs an estimated \$21 million annually.	Commit \$2 million towards the establishment of a National Sustainable Development Unit (SDU) to coordinate reform of Australian healthcare environmental sustainability, and improve healthcare efficiency and cost-effectiveness.

The Issue:

When considering the issue of hospital waste management, the economic benefits of sustainability strategy are clear. Victoria's public hospital sector alone produces 52,000 tonnes of waste annually and spends an estimated \$21 million disposing of it.¹⁵ In Australia, hospital infectious waste costs approximately \$1/kg, which is tenfold that of non-infectious/general waste.¹⁶ This provides a strong financial argument for policy mandating the separation of wastes, yet there is currently no national oversight or body to guide and monitor these efforts. In hospitals around the world, efforts to reduce disposable plastic use alone have resulted in annual savings of upwards of \$760,000 per institution.¹⁷

The Solution:

The United Kingdom's Sustainable Development Unit (SDU) provides a successful example of the benefits of national coordination, commitment to targets, regular monitoring, and the provision of guidance to health providers on environmental sustainability. Since its foundation, the SDU has enabled cost reductions of £190 million (\$340+ million) annually across energy, waste, water and fuel spending. The SDU has also successfully reduced healthcare emissions by 18.5% and water use by 21% in 10 years.¹⁸

¹⁵ health.vic. (2021). Waste management in Victorian healthcare services. [online] Available at: <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/sustainability/waste>.

¹⁶ McGain, F. (2010). Hospital Waste. Control Publications, 92.

¹⁷ Blackwell, T. (2015). Showing surgeons "massive" cost of disposable supplies leads to big savings for hospitals. [online] National Post. Available at: <https://nationalpost.com/news/canada/showing-surgeons-massive-cost-of-disposable-supplies-leads-to-big-savings-for-hospitals/> [Accessed 20 Jan. 2021].

¹⁸ Sustainable Development Unit. Reducing the use of natural resources in health and social care 2018 report [Internet]. London: NHS England, Public Health England, 2018 [cited 2021 Jan 16]. Available from: <https://www.sduhealth.org.uk/policy-strategy/reporting/natural-resource-footprint-2018.aspx>

GENDER EQUITY

Recommendations:

1. **Increase the Medicare rebate for gender affirming therapies.**
2. **Subsidise the cost of Continuing Professional Development (CPD) modules specific to the treatment of trans and gender diverse people to incentivise participation in an under-engaged area of healthcare delivery.**

1. GENDER AFFIRMING THERAPY AND CPD

Current economic cost	Recommendation
Trans and gender diverse people are not being serviced adequately by the healthcare system, including for gender affirming therapies. Trans and gender diverse people are already at risk of poorer mental health outcomes and suicide, which comes at a significant cost to government. Exclusion from the health system only serves to increase disease burden and reduce help-seeking behaviour across multiple dimensions of health.	<p>Increase the GP Medicare rebate for gender affirming therapies to incentivise adoption of these therapies into normal practice.</p> <p>Subsidise the cost of CPD modules specific to the treatment of Trans and gender diverse individuals for GPs to complete.</p>

The Issue:

Gender-affirming therapy refers to surgeries or hormone therapies undertaken by trans and gender diverse (TGD) individuals to align their physical characteristics with their identity. Gender-affirming therapy is primarily managed by GPs, with input from endocrinology, paediatric endocrinology, sexual health, speech therapy, urology, gynaecology, general surgery, plastic surgery, endocrinologists and sexual health physicians as necessary or in more complex cases. A lack of access to gender affirming therapies leads to significant psychological distress, with Australian data demonstrating that over 50% of the TGD population have medically diagnosed depression and are at high risk of suicide. Barriers to

access include a lack of GP education and confidence in the delivery of gender-affirming therapy and a lack of incentive for GPs to engage in gender-affirming therapy in their normal practice due to unattractive rebates via Medicare.

The Solution:

Anecdotally, GPs report that the higher rebates available for skin cancer excision have led increased training and engagement in skin cancer medicine. AMSA recommends a similar approach whereby the government increases Medicare rebates for gender affirming therapies to incentivise engagement with TGD healthcare delivery.

Continuing Professional Development (CPD) is a requirement for General Practice (GP) registration. Often, the costs of CPD are borne by the practitioner. AMSA recommends the government subsidise consensus-backed CPD modules specific to treatment of TGD populations. Evidence from ACON has shown CPD training to result in significant improvements in GP confidence in delivering gender-affirming therapy to TGD individuals.