Transcript of the National Medical Workforce Strategy presentation

Chair (Megan Crawford): I'll introduce now. Associate professor Susan Wearne. So, before I commence, I'd like to acknowledge the traditional custodians of the land, which we all are respectively meeting. For myself in Brisbane, that's the Turrbal and Yuggera people, and I'd like to pay my respects to elder's past, present and emerging. So again, thanks everyone for joining us. We're nearly up to 50 participants. We were hoping and we had about 110 registered, so we'll see how we go in terms of numbers. So, I have asked you all to go on mute. I will just reiterate that if you're new to Webex functionality as we are, we will hopefully be able to provide some support and step you through it. Down the bottom is a bit of a navigation panel to mute yourself, to turn your video off and to share your screen. There's a little hand raising function down the bottom so please use that function to raise your hand if you have a question that you would like to ask. I understand that Webex will order the hand raising, so we will be able to tell who put their hand up first and provide some access to questions in an in an orderly manner. There is also a little emoticon down there, and there is a chat function as well, so hopefully you'll be able to get used to that by either having your participant panel up or your chat panel up. It's pretty similar to TEAMS as we know it.

So, getting into our presentation proper I'd like to introduce Associate Professor Susan Wearne this afternoon and we are going to hear about the National Medical Workforce Strategy, which was published by the Australian Government Department of Health in January this year. Susan is the Senior Medical Adviser in the Health Workforce Division in the Australian Government, Department of Health and she is the clinical Associate Professor at the Australian National University and works as a sessional General Practitioner in Canberra. Susan has trained in the UK and then worked for Flinders University in Alice Springs. She combined clinical practice at the Aboriginal Medical Service in Alice Springs and later for the Royal Flying Doctor Service at Ayers Rock Medical Centre with Health Profession Education and Research. Her work with the Remote Vocational Training scheme sparked her interest in using technology to facilitate training, and we've had a good couple of years of using technology with respect to medical education and training in the last recent experience through COVID and through Associate Professor Wearne's PhD on remote supervision during GP training and her general practice work textbook is now in its fourth edition. Is that correct? Susan yes, fantastic and Susan has been the medical lead on the National Medical Workforce Strategy and is chairing the Committee during the implementation phase. So, a number of you will be very familiar with the National Medical Workforce Strategy and the recommendations that have come out of the Strategy. So now we'll actually go through the Strategy, and I think Susan will take over and share her screen and we will work through the presentation. At the end we'll have opportunity for questions and just reminder we have capped it to an hour session. Hopefully we will be able to keep honest on our timings. Thanks very much, Susan.

A/Prof Susan Wearne: Thanks Megan, thank you for the introduction and I'd like to acknowledge that I am currently on Ngunnawal land in Canberra, and I'd like to acknowledge elder's past, present and emerging and also friends past, present and emerging in that there's many people on the screen who I have known for many years. Nice to see also some fresh faces and also some who've been intimately involved in this work and could probably do this presentation. And put a Queensland perspective as well. So, thank you and I'll share my screen.

So, the National Medical Workforce Strategy has, as Megan said, has been published and has been endorsed by every state and territory and was really a very much collaborative approach in what are the issues within our workforce, of the things that we could do, what should we do and how are we going to work together to improve our medical workforce? Why did we need a National Strategy? There were lots of reasons for it. There's no single source of medical

workforce data, nor national approaches to working out what the data means. We have decreased numbers of doctors applying for General Practice. We have more and more people who graduate from medical school and actually choose to be a sub-specialist, not a generalist. We've got maldistribution of our workforce – more and more people choosing to work in the cities rather than rural and remote areas where the workforce may be needed. We've also got an undersupply in some disciplines and an oversupply in others. We're also aware of trainee well-being issues, the need to increase the number of Aboriginal and Torres Strait Islander doctors and to make the workforce and their training experience a safe and supported experience for them. And then we've got the need for changing the different models of care, how we could actually work; rather than each in our own silo, how can we get better leverage by using all professions to their strengths and their full scope? And then we've heard feedback from trainees that their training pathway is disjointed and it's really difficult and those are the people that get on to training, and then there's a larger group who are still struggling to get on to training. Everything does work much better when you're not on your own and you're sharing with the team and that's what we've got to do within the workforce strategy, using the data and evidence to make sure that the medical workforce sustainably meets the changing needs of Australian communities. And even during the process of developing this Strategy, those needs have changed and when we started we had an oversupply of doctors, currently I know many of you will be in managerial positions in hospitals, trying to just staff rosters is a real challenge. So things have changed, but the absolute need to use the data to make really good decisions is key to this strategy working.

So, I'm going to go through each of the actions in more detail, but there are three cross cutting themes in the Strategy that we need to work through. One, I've already mentioned of growing the Aboriginal and Torres Strait Islander workforce and improving cultural safety, so that's for them to feel culturally safe and for each patient coming into our health system to feel culturally safe. So that's a big piece of work. But there's also like much of the Strategy, we're not starting from scratch. There are lots of different people have been working on the similar topics for a long time and have got experience that we can use. So, we're working with people who are already doing things with the Aboriginal and Torres Strait Islander workforce and how we can improve that. Looking at and supporting better models of care and improving doctor wellbeing are ones that we are beginning to work through within the Department and again who else is doing what. So, I'm going to go through each of the priority areas in a bit more detail. Priorities being collaborating on data, then rebalancing the training system, reforming training pathways, building the generalist capability of the workforce and then building a flexible and responsive medical workforce. So, at the meeting that Megan was mentioning that Professor McNeil is coming to tomorrow, looking at how across jurisdictions, colleges, universities, postgraduate medical councils, how we can all use the information that we have to actually better plan how many of each sort of doctor we're going to need as best as we can predict it. It's not going to be an exact science, but currently nobody has a national picture of good data to be able to work out those training needs, and that particularly showed up during COVID where we were getting questions in the Commonwealth, saying, well, how many trainees do we have from colleges. Sometimes jurisdictions weren't sure about how many people were in training positions, so we really need to build a better picture so that rather than each of us making a decision in our own silo and seeing what we can see, that we expand it to what is a national picture, while still respecting people's need to make decisions on their local area as well. So, it's just going to be that balance of what you need locally, what could work there? But actually, if you make that decision there, how's that going to impact the rest of the system? So, when we think about rebalancing supply and distribution it really is looking at those undersupplied specialties. General practice comes to mind, psychiatry comes to mind, and then decrease the number of trainees in oversupplied specialties. The ones that we're predicting to be an oversupply, anaesthetics, emergency medicine, and possibly cardiology and orthopaedics.

One of the big things regarding that oversupplied specialty is the work that we're doing on a service registrar model. Service registrars is probably the least liked phrase that we've come up with in this whole Strategy, but really describes the doctors who are working in a middle grade sort of reasonably responsible role within a hospital, key to that hospital providing 24-hour care, still needs some supervision not yet fully fledged and ready to be on their own. Currently we're training putting a lot of people into training positions to run that sort of service, but they're not going to be needed to have jobs at the end of it. So, how can we boost that sort of middle grade? So not just the not the juniors but in the middle grade, so that not everybody who's operating at that scope of practice is necessarily going to be needed at the specialist fully fledged level. So, that's quite a change to the way that the medical workforce has operated with our assumption that if you start as a junior, you will progress through your training and everybody will become a fellow. Where is the reality of the workforce profile that we need is that we do need many more people in that middle grade than we do at the senior level. We do want to reduce the barriers and increasing the incentives for doctors to work in training rural and remote communities. And one that we kept putting in but haven't yet started work on but I think is becoming an even bigger issue is how we use locums. Always going to need locums; if somebody suddenly unwell, you need to fill a roster, but there are hospitals that are reliant on locums. There are junior doctors who opted to take on locum work because it pays well, they can work for a couple of months a year then take a bit of time out. Now that may be appropriate for some people, but is it appropriate for the large numbers that are doing that? What's their long-term future, and is it the best use of our healthcare dollar? Is there a way that we can make those jobs where locums have become the sort of mainstay of a system, can we use that funding rather than excess on locums, can we use it in a better way?

Lastly, on this one is aligning the migration and distribution regulation. Currently we have regulations within Commonwealth, there are different ones within the states. If I was coming in as an International Medical Graduate which I did, it would be very confusing to know, well one person says one thing, another person says another thing. Our current work that we've got on these priorities is yes, we've got the Medical Workforce Reform Advisory Committee meeting tomorrow. looking at who is going to be best placed to make any decisions that are or recommendations to government on, say, the number of training places, where they should be. How do we use the information that we have about how many doctors we need in Australia to then make recommendations regarding the number of places at the beginning of the supply chain of university places. So that's a key discussion having that group, and it was one of the things that kept coming up in consultations was the need for that group and MWRAC currently gives advice but governments and colleges are not as required to, and there never will be an absolute requirement to follow it, but we need to strengthen the ability to make those recommendations otherwise, we'll continue with the system that we have of one person making one decision because it's absolutely appropriate for their context, but that has ramifications for the rest of the system. So, we need that overarching body to do that governance work and we are planning the data and we have got the service registrar work well underway.

So just showing you what we can do with the improved data. This is actually just general practice and consultations billed to Medicare. It shows I think, quite interesting data for QLD. In 2021, the General Practice services per capita went up significantly well they went up, I don't know whether it was numerically significantly, but they've continued to increase in all MMM's except MM7, where there's been a decrease, so just looking at that begs the question, what's happened? Why? Maybe there's been a change in the service model and more General Practice services are provided through Queensland Health and not billed through Medicare so we're missing seeing it. So, that's the power of the data that we're beginning to get, but it's only so powerful because, as yet, we still haven't got the data sharing agreements between jurisdictions and Commonwealth.

I know it is State of Origin time and even as a pommy I am aware that that's of some reasonable significance, so just showing some New South Wales data. This is showing what we can do from the General Practice data information we have regarding the number of deliveries in New South Wales, but it is woefully inadequate because we haven't got the hospital data showing actually how many babies were born in hospitals and under the care of obstetricians and midwives. So, if you were trying to use this information for workforce planning, you can't.

So, what do we need to do with our training pathways? I thought it was a bit of time for travel so here's Lombard Street in San Fran Cisco, in California which I think is a good symbol of how some of our training pathways work which is that they're very crowded, there is hardly any room for people to get it, they're wiggly and this one in fact is a one way street whereas I think some of our training pathways are more than one way. But it is very city centric and what we would like to move to is the lower picture where it is a beautiful straight open road, this is actually Broken Hill, where you can see where you're going and it's really easy to drive along. That's what we'd like the training pathways to be. So, we need to, as much as we can, increase training in rural and remote areas. There is a plan, but once we have better data, we can actually set the numbers and distribution of training places nationally that there would be better coordination and visible training pathways. I know Queensland has a system of providing information to junior doctors, for say, how long is it going to take you to train in this discipline, or what do you need to do to get onto it? So, what are the requirements to make it more obvious to doctors when their making choices about their careers and again coming back to culturally safe training.

So, issues around selection – can we focus more on the attributes for the specialty rather than the hierarchy of sort of PhD's? Great to have one, but not if it's not required for the discipline that you're wanting to train for. It would be fantastic to have a coordinated trying time frame nationally for recruitment because a number of times you might recruit somebody to a regional Hospital and think yes, I've snagged my anaesthetic registrar only for them to actually get a city post in a different state and you've lost your workforce. That is going to be a long time off, but I'd love to get to that. And selection, we think should also and is part of the Strategy actually consider where that work needs to be done, and that if you're somebody that's applying and it's not, you don't want to go where that specialty is needed, well, maybe you need to rethink. That brings up the issue of rural and remote training and accreditation, and that's work that would involve the AMC and each of the colleges. Thinking through not how does somewhere like Rockhampton do exactly the same as what's in Royal Brisbane, but actually, what are the alternative opportunities for training in Rockhampton that you can learn about or somewhere further West where you can then say this is what is on offer in the rural remote training option that you can't get in the city. So rather than it just being a city centric lens, thinking of the opportunities for rural and remote training.

Lastly, assessment. COVID did show that it is possible to be assessed remotely, and sorry that I failed on some of my assessment today and getting the computer to work. But you know, you now know what to score me on computer skills and similarly we can use the same in work-based assessments and tally supervision online teaching. You can't do everything that way, but it does open a huge opportunity for people to be better supported when they're in rural and remote places using IT.

Building the GP and generalist capability of the medical workforce as time has gone on has become more and more important. Encouraging people who are generalists, say generalists, cardiologists, please do you know, Yes, you want to be good at your electrophysiology, but you can also see people who've had heart attacks and got hypertension. If we continue to train down that sub-specialist route, we will never starve rural and remote because the sub-specialists will not have the clinical mass to make it worthwhile working in such areas and won't have the skills

to take on that work that's much needed. Similarly, we need to increase the number of people choosing General Practice. I still can't think of doing any other discipline. I love it. It's absolutely fascinating and still challenges me. Last few weeks of seeing somebody with something that I'd learned how to spell it in medical school, but I've never seen it. So, we need to talk up and the options for General Practice and that needs to occur throughout medical training, in medical school, how it's spoken about, better opportunities to learn within General Practice in the early and junior doctor years and then implementing better decision support so that when I did have that result that I'd never seen I didn't actually have to have a night with the books. I dream of " Siri, tell me what to do with"... We are way off from that, but probably we shouldn't need to be, but that can then mean that generalists are much better supported than and don't necessarily need to refer on everything that you don't understand at the time, but that you've got access to that just in time information.

Last priority is building a responsive and flexible workforce. I think we have much of (number 22) reviewing the impact of changes introduced during COVID for longer term implementation. Many of you are doing that, I know our medical deans have done that and reported on it. The AMC has, college presidents have and really need to embed those within our systems. Not sure it's got there yet for all exams or for even selection. You know I still sort of wonder about not only the sort of exhaustion sustainability, but the environmental sustainability of our selection systems where people fly over the country to get chosen, is that really still needed? The flexible working arrangements and with more people wanting to have a life outside medicine, both male and female graduates. Also, portability of entitlements is a big one where people sort of feel trapped within one system because if they move they're going to lose their maternity leave or their long service leave. Looking also at the potentially unsafe employment models. But that flexibility is for nonlinear career progression. Folks like me who's actually my career has been determined by where my partner's job was. How can you move from one place to another and actually build the skills so that you might start training, say, in College of Physicians, I'm not sure that's really for me, but maybe I'll get a diploma in something that I can then take on and do something else or the Emergency Physicians have now got their diploma level of skill so that I could maybe be a Rural Generalist with that diploma or other specialties. So, we have to make better use of past skills rather than the assumption that you have to start from scratch if you're starting in a new training scheme.

So, the next steps for us – we are continuing the implementation planning. There's a lot in that. And very happy to have feedback to our e-mail address there. But I've come to the end of what I plan to talk about, and so I'm going to stop sharing screen and I'm happy to take questions.

Chair (Megan Crawford): Thanks so much Susan. We are just waiting for the hands to go up in the participant bar. So, whilst we do that, I might pose one question which is, you know, an often question I probably pose and it's about data and the access to the specialist data within the heaDS UPP data tools. So, at the moment you've given us a lovely profile of the General practitioner workforce and some of the activity during COVID, just a question about extension of the heaDS UPP data set and in time frames and access to specialist other specialist data through that data set tool.

A/Prof Susan Wearne: I want it yesterday. It's planned. I don't have a date set.
Megan Crawford: Thank you. I don't actually I can't see hands up unless I am not seeing them, but I think I did see Jenny Johnson's hand go up.

Speaker 1: Yes, thank you Jenny Johnson from the Australian College of Rural and Remote Medicine. Hello, Susan, just wondering if there's any indication that with the new government, the New Labour Government there will be any change in priorities, any change in strategic

direction or plans to implement this Strategy, if you've had any indication around any of those issues, thank you.

A/Prof Susan Wearne: Thanks Jenny and I should have prefaced it by saying that this is all subject to, well hopefully not all, because actually each state and territory has signed up to it, Colleges have signed up to it, and the AMA has, so we're hoping that that is enough to persuade the new Minister, but yes, absolutely the priorities may well change.

Chair (Megan Crawford): Thank you, I think Bruce Willett was next.

Speaker 2: So gday, Susan, sorry for those who don't know Bruce Willis from the RACGP, so I guess there are two questions. One is the catchments previously were there were 820 something that they've been reduced. Is that correct? The number of them, the bigger ones.

A/Prof Susan Wearne: So, I was showing on that slide the data per Modified Monash Classification. That's one way of cutting the data. GP catchments is a more granular level of data, and we still are using those. Yeah, it's just a different thing that I chose to show today. That's all.

Speaker 2: That's all so they're still at that roughly 800 hundred and it was 19 or something. And sorry, just a second question, I guess. I love your analogy of the straight road because I've been using something very similar myself and I think what I would like for General Practice is for it to be the clear route that people take and particularly Rural General Practice, and if you do something else then that seemed like a diversion from that clear road of how you should be proceeding. So, the trouble, I guess, and I think from a college point of view, it's really necessary to forge stronger relationships with the uni's to do that. The problem that we're going to have is we lose people in the hospitals, and that's really been a key issue all along. What do you think is the solution to that, the issue of losing people to General Practice in general and rural general practice in particular in those hospital years? Thank you.

A/Prof Susan Wearne: Interestingly, there was a paper Belinda O'Sullivan published comparing the wigglyness, that's not the term she used on the paper, but basically you know, the complexity of getting into different training programs and General Practice was the smoothest road. I think one of my pushes has been that more early junior doctor places in General Practice and that certainly ties in with the planned changes to be brought in by the Australian Medical Council for a two-year transition to practice. So, if you've got two years, then part of that two years I think should be in General Practice and like you know, I keep quoting that the old PGPPP, that even those who chose not to become a general practitioner had a different viewpoint of the complexity and breadth of scope of practice and the challenges of the practice and were better orthopaedic surgeons, once they knew what the situation was. So, I keep arguing for it, and I will keep arguing for it. Thank you.

Chair (Megan Crawford): Thank you, we have Vanaja Sabesan next.

Speaker 3: Yeah, thanks Megan and thanks Susan for a great presentation and I have read this Strategy a few times as well and look I'm the Medical Director for Queensland Paediatric Training Network, so we manage all the paediatric basic training and to a degree central paediatric advanced training as well as antenatal, perinatal advanced training and also, I'm very involved with Royal Australasian College of Physicians in terms of selection and assessment and so on. It's quite interesting to see that we are talking about rural and regional workforce, and at the network level we've been trying to address that to a degree, but other problems in terms of having those training positions in those outside the major city. There are numerous training positions in the major hospitals, but limited numbers in outside, so we may get so many trainees

from regional/remote area into the training program, but at the end of the day we need to place them to train them, so that's one of our limitations. Every time there's a service registrar comes always there in the regional hospital, not in the major hospitals that I haven't heard any service registrars in major hospitals. So, I guess that's the challenges we face. And then what happened to those service registrars? Do we have a pathway so that service registrars will end up being a hospital generalist or some other pathway? We need to have a clear pathway for them as well if we are going to encourage and expand that pool and they need to be supervised and supported and the other point I want to raise and we talk about flexible training, but it's really hard to get part time jobs for our trainees and it's been a constant struggle for me within our network trying to convince the HHS to give part time jobs, so I guess these are the challenges. I think it's excellent ideas we all have but trying to implement that at the ground level it's going to be a challenge for us.

A/Prof Susan Wearne: Yes, I hear it and I think with the service registrars, we've actually been looking at the numbers of doctors who are in that group, so at PGY, sort of three plus and there are quite a lot of them who don't intend to train, and so it's an interesting dilemma that most of the people on this call are the ones who've wanted to complete training, had the ability to complete training. But the people who are maybe in the service registrar's group, they're probably doing child pick up now. So, there is this group for whom we have the opportunity to create meaningful, well supervised professional work, but they don't necessarily want to get to that level. Or maybe not at the moment, and I think that's what we're trying to work with colleges as well to say, well, look if somebody's been a service registrar, been in that situation for a long time and then circumstances change and they are then able to devote more time to their, career – can they then go back into training so that you then have three or four years of I'm just going to work part time in a relatively less stressful job. It's appreciated, it's worthwhile, it's in the area that I'm interested in. And then when life settles down, you know, no longer caring for elderly parents or whatever and you can move for training, then people do that so, but it is a bit of a cultural shift. But if we keep the system we have of relying on training to provide that middle grade workforce, we will persist with the issue of an excess 2000 Emergency doctors, 2000 Anaesthetists who say I'm qualified where's the job now? Those are the ones we can see in the data because it's very difficult to set up private practices and Anaesthetist. You can't actually sort of have a supplier induced demand, I think you need an anaesthetic today, Mrs. Smith, you know you actually need the whole structure. Whereas in cardiology or orthopaedics you can create that work. And so, we're seeing I'm seeing patients I've seen somebody recently who's paid couple of $100 to see a cardiologist for exactly the same thing that I can do as a GP. Maybe my rooms aren't quite as posh, but you know the content of the work was the same, so that's why we need this alternative workforce and maybe you know my dream, I can dream you have to others have to implement, that's a trap for me. If there are so many who need to want to do Paediatrics and are can the service registrars be in the city and the training registrars be in rural so that they train in rural because that's where they're going to be needing to do the work later on.

Chair (Megan Crawford): Thanks so much, Susan. And thanks everyone who has their hands up. We have a list so thanks for your patience. The next person that we are going to go to is Jen Rossiter.

Speaker 4: Susan, a question for you particularly around you know, with the political landscape changing, et cetera. You know Ministers are sort of asking for quick wins at the moment if we were going to look at some more immediate change around our workforces, is there anything that stands out from the work that you've done that you would push forward as something to consider in this very early stage of changeover?

A/Prof Susan Wearne: I think analysis of the funding going to locums. And I think another option is a clearer pathway for those doctors who are working within the hospital system, waiting to get on to training programs that they're never going to get on to and options for that group to do whatever is needed to then consider if General Practice is the right career for them. Bruce knows, I've spent many years training people who for whom General Practice was the last thing that they ever wanted to do. I think we need to make sure people would be happy with that broad scope, but if we have a large number of people waiting in the hospital system, or maybe they're doing their PhD – I don't want to take people out of, because hospitals are short – but maybe they're part way through a PhD because they think a PhD is going to get them onto the ophthalmology training program when the reality is, it's not. If there's already that number so clear and supported opportunities for people who could switch plus locums.

Speaker 4: And some sort of brokering service that actually helps them switch?

A/Prof Susan Wearne: Yes, yeah, yeah. And say OK, you've been an orthopaedic registrar for five years. You think you'd like to switch to general practice? You're gonna need some paediatric time, you're gonna need some of some women's Health, we'll help you with. We'll give you those terms, or we'll make you supernumerary in those positions so that you really learn what you need to do, then you do some general practice, we'll keep hold of your super and your leave allowances so that if you come back to us you're not starting from scratch and that sort of thing.

Speaker 4: Great thank you. Thank you.

Chair (Megan Crawford): Our next question is from Erin McMenimum.

Speaker 5: Hello, thanks very much for that presentation. I am coming from the Dermatology QLD faculty and I think actually many of the specialty colleges with competitive selection programs would applaud your ideas about removing CV buffing, removing people hanging around for four or five years, trying to get on unsuccessfully and I think that supported redirection would be a good idea. I just wondered if from the data you have and do you have any advice for us about how to do that? And what qualities do you look for in someone's second or third round of medical school that you say you're great? Come on and to the others, you have a one of those difficult chats where you say you're really not that great, don't bother doing your masters or a PhD you should find another path because they're really hard chats to have. So, these people just sort of tend to get left hanging around waiting.

A/Prof Susan Wearne: Thank you, I think for me it would be specialty specific plus patient specific. So, I will talk about ophthalmology because my husband's ophthalmologist in Alice Springs some people coming through who've done PhD's, but their hand eye coordination had never been tested. So, something that you know that is clearly, you know you've seen me trying to operate a computer screen you're glad I'm not doing your ophthalmology operating so in dermatology you know actually looking at different skin lesions. I still find it really, really difficult, again, wouldn't be my strong suit, so what are the discipline specific things that you can choose? And then what are the patient feedback ones. In general practice we are now using, has been used for years, Doctor-Patient Skills Questionnaire. With colleague feedback, there are validated tools about what you like to work as a person, so you could use those and also as an alternative, or maybe as an adjunct to the currently the sort of academic. You know your ability to publish a paper, that shows your ability to really persist in one thing, but what do the people who've worked with you say about you?

Speaker 5: Thanks, that's good and I just had one other comment. We suffer from workforce shortages in dermatology in rural and we've got some strategies in place. But also, I find an

increasing problem is the number of our graduates we lose to cosmetic medicine, and it strikes me as you know, a lot of other specialties are suffering the same problem because we're graduating people but half their weeks cosmetics and disclaimer I don't do any cosmetics and I'm half time public, but I think a lot of people that are looking for specialties where they think they can do that and earn a lot of money. That is the elephant in the room, and it's not just being negative about those graduates, but if they're looking to specialty where they think they can earn 1 to 2 million a year, then we need to make things like rural GP more attractive. And I think we would all agree that GP's need to be paid more and I'm just probably part of your Strategy, but I think you'd have support from all colleges to try to take that to the government. And make that perhaps the help with the attractiveness of that pathway.

Chair (Megan Crawford): Thank you, thank you. Susan, I've just noted that Erin has put a comment in the chat saying it might be controversial, but if you thought about restricting Medicare allocation based on population needs to redistribute senior workforce, taking into consideration health inequality, so I'll leave that one there.

A/Prof Susan Wearne: Yes, and I see this Strategy as the last chance for the profession as a whole to actually address the issues. And if the profession doesn't start to address, you know, just those issues of I'll put cosmetic surgery above doing routine dermatology of the person who's got psoriasis in a rural area, then I think it will become government requirement to actually restrict. Because I pay the same taxes when I'm living in Alice as I do living in Canberra. That's probably me being controversial, and I don't know whether the new Minister would agree, but that's just my thoughts.

Chair (Megan Crawford): Thanks, Susan, and we've just had a follow-on chat from Neil about colleges that severely restrict access to training, are they going to be asked about opening up access to training as part of a rural workforce and access to specialty care?

A/Prof Susan Wearne: Yes they have been and we are doing.

Chair (Megan Crawford): Thank you. Being mindful, we have limited time left in our session. We've had some people very patiently waiting with their hands up. I might ask Shannon Widderick to pose her question, please.

Speaker 6: Hi, thank you carrying on I guess from all of the other controversial statements I'll throw another one out there. My name is Shannon, I'm the Senior Medical Education officer at Gladstone Hospital and I'm wondering with regard to the service registry model, was there any discussion or did you all have a look at ideas of bringing in other health care providers like physician associates or nurse practitioners into this area as a way of increasing skills mix and health workforce pool for folks in Australia.

A/Prof Susan Wearne: Yes, and that comes into the models of care work, and I think as we're all feeling the pinch with workforce at the moment, I think there will be more appetite for that. Currently our issue was that we had large numbers of doctors who were already trained and so that was the reason for looking at the service registrar group.

Chair (Megan Crawford): Thank you, Shannon and obviously from a state-based perspective there are some state focused initiatives that we are working towards, so that's a probably a conversation we can have outside of this forum. Richard, I noticed you had your hand up and put it down. Are you OK?

Speaker 7: Oh good, maybe look I participate in this at the national level from a Medical Deans

point of view. I suppose maybe just so that everyone and people know this, we live in a complex, overlapping fragmented healthcare system and try to get the medical workforce part of that right when no one's actually in charge at all, it is a challenge. I think that's one of the strengths of this piece of work. I think the diagnosis, as I've said before is pretty spot on, I think in respect of the issues. I think that where the work needs to really be done, not least in jurisdictions like Queensland, not where you know 40% of the large population live outside of major cities, is that how do we get it actually done? What's the prescription? And I think data is necessary, it's not the answer and we certainly can't wait around until the Commonwealth and state pull data and get a better bead on what are some really obvious problems and not least as we watch many parts of the state, and particularly in the more remote, the Canaries in the coal mine, essentially starting to fall over. And the state government of course, the provider of last resort when all else has fallen over you know there's a high cost to pay, so I think Queensland has a particular opportunity to get the various actors together, work with the Commonwealth and get some of the levers that do need to be pulled in the short run, you know, in what is really a complex system, I'll leave it at that. There's a lot that could be said, not least, the very nice point around Shannon about the so called non physician clinicians, PA's and other because we are wasting junior doctors and indeed service grade registrars on tasks that could really be more readily done by others. Thanks.

Chair (Megan Crawford): We have one final question and then we will be able to complete the session. So that's from Dr John Riley.

Speaker 8: Oh hi thank you for the presentation. It was really just to follow up. We've talked a little about general practice and generalism, but I was interested in whether there were any principles that you've taken out for generalists specialists, because the issue there is a little bit different sometimes than general practice, and often can be specialty specific, so I just wondered if there was anything more generic or suggestions with regard to the prescription that arise out of that.

A/Prof Susan Wearne: Thanks John. So, the ones that we've had is where some specialties are so subspecialty driven that if at all possible, people sort of chunk their training. They're sort of do maybe I'll go back to eyes; you know they do glaucoma, they do cataract, they do retina, and it's very rarely that they'll actually have a day where they're doing all of the disciplines. So, one option is again to encourage more later training actually, in rural, where the setup is more general. But I think for the colleges trying to make sure that somebody maintains their skill and builds that general profile throughout training rather than just that sequential training, which means that actually by the time you've graduated, it might be a couple of years since you've done one of the disciplines. So that's a big piece for those colleges to think about. The other is the timing of any subspecialty training, so it tends to be so with anaesthetics that you'll do your general training and then you might do a year or two of a subspecialty fellowship, which may be in Australia, it may be going over to Boston to learn about a new widget that we really need to know about in Australia. So, during that training, what are the systems that enable that person to maintain their Generalists' skills whilst they're also learning their subspecialty? And again, I've come across people who've then started, they've done their overseas fellowship, they've come back to Australia, they've been offered a job in a regional area because that's where they're able to get work, but it's been years since they've done general and it's suddenly they've got that leap of being the specialist and they're suddenly it, they're the end of the road at a time when they're actually feeling quite rusty on their generalist skills. So, I think having a sort of, I'd love a post, a sort of fellowships in rural and remote so that you get that generalist skills just at the end. And for the fellowship programs to include that you need to keep up your generalist skills as well as focusing on your subspecialty.

Chair (Megan Crawford): Thank you, thanks everyone. We're pretty much to time a little bit over. Thanks for bearing with us and with our first ever Webex presentation. A very huge thank you to Associate Professor Susan Wearne for making herself available to us this afternoon. Thank you to my team for coordinating in the background. They've done an exceptional job on getting it all together and thank you all to you who've given your time this afternoon and asked some really important questions to help us further understand the Strategy and how the process will work in QLD. So, we're just about to pop into the chat an e-mail address in case any of you have any follow up questions and we will certainly collate them and take them on with the magic of technology it's there. Thank you, Lily. So, everyone have a great afternoon and obviously if we have further developments, we might seek to have another session where we can continue to share our understanding of this process. So, thanks again everyone and have a good afternoon.