Meeting Report:
Health Workforce Australia ~ National Training Plan Consultation Workshops

Health Workforce Australia (HWA) was established in 2009 under mandate of the Council of Australian Governments (COAG). HWA is charged with the responsibility to ensure Australia has a sustainable and sufficient medical workforce into the future. Replacing the Australian Medical Workforce Advisory Committee (AMWAC), HWA has a $1.4 billion dollar budget and a short term program to establish reforms to all organisational and governance systems pertaining to Hospital and Health Workforce Reform. The intended reforms have far reaching implications for the surgical workforce, surgical training programs and surgical leadership. The Australian Health Ministers’ Conference (AHMC) has commissioned HWA to develop the National Training Plan (NTP) and report to AHMC by the end of 2011.

National Training Plan
The goal of the NTP is to have self-sufficiency in the supply of medical personnel by 2025 within a global labour market.

The College was invited to attend two workshops. Workshop one was entitled: Surgical and Interventional Services. Prof Bruce Barraclough (FRACS) Dean of Education attended the workshop held in Melbourne on June 15 representing the College. Workshop two was entitled Geographic Distribution – Regional, Rural & Remote Workshop. Mr Ivan Thompson (FRACS) attended the workshop held in Perth on June 20 also representing the College.

The suggested purpose of the workshops was to obtain significant stakeholder input into the development of the proposed alternative scenarios to ensure that the scenarios represent clinical and health system real world views. The scenarios were a baseline or “no change” and a small number of alternative planning scenarios. Scenarios were to be used to examine possible reforms, constraints or other changes. These scenarios are detailed in the attached Health Workforce Australia documents National Training Plan - Overview and National Training Plan - Methodology Paper.

A confidentiality agreement was signed by stakeholder delegates to ensure the release of figures presented within the workshop were not published outside of the proceedings. Thus the actual figures presented within the workshops will not be shown in this report.

Surgical and Interventional Services Workshop

Baseline and Projections
The NTP representatives noted that there currently is no single national database to work from. The data currently employed are from the Australian Institute of Health and Welfare (AIHW).

A health workforce baseline which utilised current numbers to model projections to 2025 was presented to the stakeholders. The projection figures presented were considered to be “about right” for surgery in order to service the Australian community. No consideration was given to the aging workforce, feminisation of the workforce and work-life balance.
Achieving self-sufficiency by reducing reliance on International Medical Graduates (IMGs) is one of the goals outline by the NTP. Achieving self-sufficiency in nursing was of great concern and anticipated to be difficult to achieve by 2025.

Limitations, gaps and wants
The delegates were asked to consider and suggest methods, inputs, assumptions, data sources, data gaps, limitations of current projections, etc. in relation to supply and demand. These discussions were held in order to improve the reliability of the projection modellings and also to consider a number of “what if’s” which may not yet have been identified by NTP.

The need to recognise increasing demand, due to an aging population and the wants as well as needs of aging baby boomers were discussed. New and innovative treatments and technology were also considered.

Discussion around the likelihood of developments in further specialisation and sub-specialisation with increasing knowledge and ability to successfully treat even older and sicker patients and improved diagnostics were considered.

There is a need to factor in the Generation X and Generation Y issues. These may include an increase in workforce supply in order to facilitate work-life balance as well as feminisation of the surgical workforce.

Currently there are already limitations in supply of operating facilities and available time which impact upon waiting lists. This however, is not a workforce issue but a facility supply problem which needs to be addressed.

Tsunami of medical graduates
The consequences of the significant increase in undergraduate university medical training places since 2006 and subsequent graduation of medical doctors were discussed. These doctors will be graduating between 2011-2015.

Their expectations and the community expectations are that there will be similar training opportunities upon graduation as there have been to date. Traditionally, approximately 50% of medical graduates become specialists and this expectation is not likely to change even if there is not the absolute need for this number of new specialists. This may become a sensitive political issue as the expectation is that the surgical training posts in the public system are unlikely to be able to be increased beyond about another 10%. This then leads to a need to either develop a new model for training in the private sector or dramatically increase the surgical training program. Currently, 60% of elective surgery is private sector.

Mal-distribution of surgical services
The delegates discussed issues pertaining to mal-distribution as one of the “what if’s.” This discussion raised a number of issues which require further investigation which are as follows:

- How to attract surgeons to smaller towns and regional centres?

The answers to these questions generally indicated that— Critical mass of patients, colleagues, support structures and resources, a full team and an ability to address the high acuity problems were all important. Further local schooling opportunities for children
and spouse employment opportunities were also a factor needing to be considered in addressing mal-distribution.

- **Subspecialisation is seen as a problem. Can they be replaced by generalists?**

Subspecialisation is here to stay, worldwide and there is nothing Australia can do to change this trend. The increase in knowledge and capability that drives subspecialisation is not about to go into reverse.

Some generalists will continue to be produced but there are few incentives to be a generalist as often that role is seen as less fulfilling and the generalist often receives less status, recognition, and recompense.

- **Can length of surgical training be reduced, particularly if there was to be a focus on “generalists”?**

In the time frame being looked at there may well be an excess of medical graduates. With increasing knowledge, even with the use of innovative educational methods, training time is unlikely to go down and may continue to go up. If working hours are reduced the years of training may need to be increased.

- **What about substitution? eg nurse colonoscopists, physician’s assistants, etc.**

It was proposed that nurses and other medical professionals could be trained for specific roles however there were many issues still to be addressed for this to happen.

**Surgical Team**

The need to address the whole surgical team was emphasised. That is, if a town wants a 24 hour 7-day a week orthopaedic service, then the community will need at least three orthopaedic surgeons. This extends to having the right support from assistants, operating room nurses, high dependency or intensive care wards, radiology services with CT and MRI capability, physiotherapists, rehabilitation specialists and occupational therapists, as well as the specialised operating rooms and disposables.

**Summary**

A number of limitations were identified in the projections presented by the NTP representatives. The robust and informative discussions held by the stakeholders provided a clear picture that further work is required on the national model. The NTP representatives were very keen to work collaboratively with the College in order to produce a more reliable set of projections.

**Geographic Distribution – Regional, Rural & Remote Workshop**

**Data Integrity**

The issue of data integrity was foremost in the discussion. Over the past decades successive governments have relied on figures which suggest that there was an oversupply of medical professionals in Australia. In 1994 Professor Peter Baume was commissioned by the Federal Government to survey the “oversupply” issue. A serious and growing shortage in surgeon numbers was identified.
There is a pressing need to get the data right. This was emphasized by delegates from the various professions and acknowledge by the National Training Plan (NTP) representatives.

The College assured the NTP representatives that they were willing to share data and that the College data is likely to be more reliable than the nationally obtained data being used in the scenario modelling and projections. The College was willing to check for discrepancies and work collegially to improve the data integrity.

The College currently provides approved data to the Medical Training Review Panel (MTRP). MTRP data is one of a number of resources used for the NTP modelling.

**Planning should be local.**
The methodology behind the workforce planning and projection modelling was discussed.

Regional, rural and remote issues are unique to the geographic locations through Australia. These issues include and are not exclusive to the local industry (agriculture, mining etc), socio-economic status, diverse cultural issues and indigenous peoples, population density and proximity of geographic area to major regional centres. What is required in a metropolitan geographic area with the number of surgeons per capita and skill sets does not translate to the regional, rural and remote areas. A highly specialised surgeon practicing exclusively in a chosen subspecialty is not necessarily going to be effective in a remote community where the cases presented are diverse and varied in nature.

It was agreed by the delegates and NTP representatives that a regional level review and not a National or a State wide review of the current practices should take place. The task of review should be executed by those effectively managing the area and empower them to continue to do so into the future. Clear evidence of effective practices should be built upon within the local area. These effective practices are known by the local managers. A “Canberra based bureaucrat” cannot decide what is suitable in a location such as the Kimberley for example. A National picture could not truly be representative of what happens on the ground with regard to regional, rural and remote areas. The data required for scenario planning and projection modelling would need to be locally collected. A needs analysis of the demands and supply requirements to service the regional, rural and remote area would need to be tailored to the area’s needs.

In light of the agreed approach of local management of local issues and not national management, the planned discussions on national scenario and projection modelling were disbanded. Time instead was spent discussing what was required at the grass roots level. A summary of the discussions held are as follows.

**Population and workforce distribution**
The need to increase the overall numbers of medical professionals in each of the regional, rural and remote areas throughout Australia was discussed. This increase is seen as essential. Medical professionals servicing these communities are over stretched, facing burn out, aging and preparing for retirement and/or relocation. The population distribution is not centralised. Australia is a vast country. Larger centres typically have a population of 20,000 to 25,000 people. Communities are otherwise spread out across geographic areas.

How to better address this distribution was discussed. The need to avoid a “one horse town” where a single surgeon is overseeing the surgical cover of a location is essential. This
scenario was identified to have inherent issues with continuation of coverage to the community without reprieve from ongoing on-call. Practising in isolation presents potential safety issues particular with ongoing on-call, limited and/or no collegial interaction, peer support or peer audit opportunities. Further, opportunities for holidays are seldom with burn out being a reality. Difficulties exist in supplying manpower to sustain regional, rural and remote areas. There is a need to have three surgeons per specialty to provide a viable surgical service to a community. Possible solutions were raised. These included having three towns in a geographic area which each have a surgeon to provide coverage over the area. Therefore the surgeons based in one town are able to assist in covering a further two towns in a geographic area thereby providing effective collegial support.

A reality check was also discussed between what the gaps are and what is able to be delivered from a resources perspective in the short, medium and long term.

Skills training
Surgical training needs were discussed. Surgical coverage needs to be provided by an adequately skilled surgeon. A surgeon’s skills should be tailored to better suit the unique geographic region of intended practice. Exposure to a range of surgical situations crossing multiple surgical specialties will better prepare a surgeon entering a community such as Kalgoorlie. This was considered to be termed “generally trained” or “generalist training”. Therefore post fellowship training in certain skill sets needs to be formalised and tailored to the surgeon matching the skills set required for practice in a unique geographic location.

E-solutions
The potential to expand the reliance upon e-diagnosis was discussed. Currently remote proceduralists have access to electronic dermatological diagnosis by a skilled dermatologist. This has helped in reducing skin cancer related morbidities in isolated communities. Introducing e-solutions into regional rural and remote locations may assist with overcoming the lack of specially trained medical personnel. Possible expansion into radiological services was discussed.

Socio-economic issues
Socio-economic issues including incentives, lack of spouse support in the community and family support were discussed.

Traditionally surgeons married medically trained partners such as other surgeons, nurses, physiotherapists etc. This provided the flexibility to both participate in local hospitals and clinics in a mutually agreeable location. Nowadays the careers of the surgeons’ partner are more diverse such lawyers, engineers, architects etc. These career aspirations typically require a metropolitan location for career advancement. Opportunities for career advancement in regional, rural and remote locations are limited.

Incentives and reasons discussed included lack of support in the hospital, and also issues to support the family. Naturally parents want the best education for their child. Private schools are traditionally viewed as the best possible source of education. Private schooling opportunities are limited to metropolitan locations. The family unit typically relocates with the child leaving the regional, rural or remote location in order to pursue private school. Possible solutions were discussed. Incentives for moving into a regional, rural or remote centre should be considered. Opportunities for the spouse for employment within the
community should be actively pursued. Long term placements are no longer attractive opportunities. One option was for hospitals to provide realistic placements such as 5 to 10 year tenures thereby taking into consideration a likelihood of a family unit moving for career and/or educational pursuits.

Summary
The decision to disband applying a national scenario model to what are unique and individualised issues of the regional, rural and remote locations was welcomed by all in attendance. The issues facing the regional, rural and remote locations have been known for decades. The urgency of these issues continues to intensify.

The workshop discussions were informative and productive interchange of possible solutions. The feedback provided by the stakeholders was I believe heard and hopefully heeded. The College will endeavour to continue to dialogue with Health Workforce Australia.