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AMA submission on the Draft National Medical Workforce Strategy

The AMA welcomes the opportunity to provide feedback on the Draft National Medical Workforce Strategy.

The AMA is broadly supportive of the five priority areas and most Actions outlined by the Draft Strategy. If executed well in concert with other major health reforms already underway, the Strategy provides a solid platform to achieve its vision to 'work together, using data and evidence, to ensure that the medical workforce sustainably meets the changing health needs of Australian communities'.

AMA support for, and comment on each specific Action is detailed in the tables below. Key aspects of the AMA's response to each Priority area include:

Priority 1. The AMA welcomes the proposed establishment of an independent joint medical workforce planning and governance body with authority to advise, direct, and make decisions in relation to the size and structure of the medical workforce, and development of a National Medical Workforce Data Strategy to underpin workforce planning into the future.

Priority 2. The AMA supports the development of new models of care focusing on building structured rural-metropolitan partnerships and networks that will facilitate improved patient care, reinforce clinical governance structures, and support rural doctors to maintain skills and knowledge, provide on call relief and reduce clinical isolation. This includes the development of rural specific employment contracts.

The Strategy should ensure that the creation of 'end to end' rural medical school programs are supported through the redistribution of existing CSPs with no offsetting increase in medical school of full fee-paying student numbers, and provide opportunities for medical students and prevocational doctors to gain experience in rural/remote workplaces by accrediting prevocational rural rotations and replacing the Junior Doctor Training and Innovation Fund with the AMA's Community Residency Program.

Priority 3. The AMA recommends the introduction of legislation to regulate full fee paying domestic and international medical student numbers, and for the Government to commit to no further increase in the total number of medical school places to address issues of oversupply. This should extend to establishing a mechanism to regulate the number and location of medical schools.

Priority 4. It is essential to ensure that the implementation of the Rural Generalist pathway continues, with the immediate focus on standardising credentialing.

Improved linkages between tertiary, regional and rural hospitals, Aboriginal health services, universities, medical colleges, and regional training providers are essential. The development of functional and reciprocal links between these institutions and the integration of prevocational and vocational training pathways within these networks must be a priority to ensure trainees undertaking generalist training have adequate access to relevant terms in larger urban hospitals. These links must also continue after training is completed to allow for skill refreshment and updating but also to preserve collegiate relationships and referral pathways.

Priority 5. Trainees in unaccredited training positions work in an unsafe environment with the potential to compromise clinical care. The Strategy should commit to fund and resource the appropriate agencies to undertake accreditation of all prevocational training positions to improve the quality of training and support for prevocational doctors not in a College training program.

The Strategy should also review funding levers to address renumeration of GP trainees and other generalist careers, and commit to the development of a 'single' employer model for GPs in Training. This should be designed in consultation with the profession, to deliver equitable remuneration and employment conditions for GPs in Training while also ensuring adequate support and funding for supervising practices (also relevant for Priority 2).