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Workforce Working Group Action Plan

Supporting Queensland doctors, creating better health

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The AMA Queensland Workforce Working Group was established by the AMA Queensland Council to provide advice and make recommendations to attract and retain Queensland's medical workforce. The group met from early to mid 2025 to identify the challenges and opportunities available across the crucial domains of Queensland's health workforce, including:

- **The health system as a whole, including cultural issues** – the ecosystem in which doctors work must be fit-for-purpose to meet the needs of patients and doctors into the future
- **The role of a doctor** – how it was, how it is now and what it needs to become to continue delivering the healthcare patients deserve
- **The medical training pipeline** – where we attract and grow the next generation
- **General practice** – the backbone of our health system, providing world-class preventive and early intervention health services for the entire community, from the cradle to the grave
- **Public hospitals** – that provide Queenslanders with life-saving tertiary services and essential training grounds for our medical graduates
- **Private hospitals** – that ensure patients and doctors have healthcare and workplace choice and encourage innovation.

The group developed a series of profession-led recommendations across these workforce domains for implementation by government and health organisations throughout Queensland and Australia. Patients deserve a health system that keeps them well now and into the future and these recommendations are essential to securing it. There is no time to lose.

Health system

Queensland's health system has held a world-leading reputation for generations. Providing a combination of primary, tertiary and quaternary care across varied settings including general practice and public and private facilities, it is increasingly complex and presents ongoing challenges for patients and clinicians in delivering seamless, continuous care. This is especially pronounced outside metropolitan areas where inequities in access and outcomes highlight the need to improve geographic parity in where we give and receive care.

Our health system is also the environment in which we train our future health professionals and leaders. But it is polluted by a toxic culture which is making those working in it sick. The workplace culture in many of our hospitals has failed to evolve with changing employment needs and expectations. Too often doctors report unacceptable incidents of bullying, harassment, discrimination, incivility and hostility by colleagues or executives and occupational violence by patients, their families and friends.

To address these urgent, medium and longer term issues, we must move towards a networked approach to Queensland's health system – one that improves integration, coordination and collaboration across regions. This approach must support equitable distribution of services and workforce, increase flexibility in how and where care is delivered and enable professional mobility and development across all parts of the state.

Recognising this urgent need for broad health system reform, the working group developed the following recommendations to address system issues for patients and improve workplace culture, the latter of which was regarded as the leading cause of burnout and doctor attrition rates.

Restructure of funding models to incentivise patient outcomes and efficiency

- Funding models must be oriented around patient outcomes and efficiency rather than time-based or diagnostic coding metrics. This must ensure funding incentivises preventive care, chronic disease management and multidisciplinary teams in addition to acute care
- The state and federal governments must review the effectiveness of pooled and block funding in regional and rural Queensland and ensure the system is sufficiently flexible to meet the needs of those communities
- Consideration should be given to reforming the Medicare Benefit Schedule (MBS) to reduce existing incentives for subspecialisation over generalism
- In addition, AMA Queensland urges reconsideration of wholescale reform of Medicare to realise system-wide efficiencies and greater accountability for patient outcomes regardless of funding source. This includes devolution to state government or centralisation with the Commonwealth to eliminate unnecessary duplication and cost-shifting between the MBS and state-funded services.

Reduce hospital demand

- Urgent review and implementation of non-hospital services funding so patients can receive the right care and support they need. This includes for residential aged care facilities (RACFs), National Disability Insurance Scheme (NDIS) services, Aboriginal Community Controlled Health Organisations (ACCHOs), Mental Health, Alcohol and Other Drugs services and community support and alternative care arrangements to discharge maintenance care patients, particularly for vulnerable groups and mental health
- Increased investment for virtual care and hospital alternatives where clinically appropriate and cost-effective in comparison to inpatient care
- Increased funding for general practice to:
  - provide care after hours
  - employ practice nurses to undertake triage, follow-up patients post-hospital discharge and help provide care for clinic patients in RACFs.
- Implement remaining Ramping Roundtable Action Plan recommendations
- Implement recommendations from AMA Queensland Surgical Wait List Roundtable.

Health workplace culture

- Urgent reform to implement evidence-based change management practices that will improve medical workplaces and doctor wellbeing. Traditional ideas about medicine as a vocation are no longer meeting the workplace needs of modern medical practitioners just as the disconnection between hospital executives and frontline clinicians has grown to dysfunctional levels. Many health services are no longer safe or productive workplaces and reform is urgently needed to protect those working or receiving treatment in them
- Increased use of formal human resource mechanisms to ensure all aspects of employment, including rostering, promotions, trainee rotations, leave and continuing professional development/research opportunities and trainee allocations are transparent, merit-based and rebuild trust in the workplace. These mechanisms must rebalance current power and structural differences among different staff across all medical settings

- Promotion of the value of diversity in the workplace, including adopting a proactive approach to the employment of doctors from diverse backgrounds and inclusion in workforce data collection. This must come with adequate industrial and other employment protections for vulnerable doctors, particularly international medical graduates, doctors in training and non-accredited registrars. A stronger focus on equity and diversity has the potential to create the more inclusive and capable workforce our community needs into the future
- Regular reviews of workplace issues and changing demographics to ensure employment frameworks and structure remain fit-for-purpose (e.g. to ensure flexible work arrangements don't lag behind trends towards increasing part-time employment rates or significant demographic changes within specialty fields or workplace settings)
- Improvements to the regulatory environment, including Ahpra and Medical Board of Australia processes, to ensure it does not act as a barrier to improving workplace culture and wellbeing. Doctors feel intimidated to speak up at work against poor cultural practices for fear of retribution via existing complaints processes and weaponisation of mandatory reporting obligations. Patient safety must be paramount but systems must have embedded protections to ward against their abuse by bad faith actors.

Role of a doctor

Medicine has undergone a rapid rate of change over the last 20 years. New technologies, medications and treatments become available at increasing rates. The rate of change is only increasing, with AI and genomic therapies likely to represent the next paradigm shift in modern medicine. Despite the change in what doctors do every day, how it is done has remained obstinately similar to how doctors worked in years gone by. We cannot incorporate the benefits of evolving technologies, without also changing core elements of how we work and how we train future generations of medical specialists.

Advances in medical therapy have occurred in tandem with a radically changing attitude among recent medical graduates, and current medical students, towards the vocation and work-life balance. The combination of these effects means that the role of a doctor must change as well. The speed at which this change must happen is accelerated by chronic medical workforce shortages, especially in the bush.

The working group developed the following recommendations to help identify what the core role of a doctor is and should be and what activities are currently performed that could be done differently, by someone else in collaboration or independently, or not at all. There will be resistance from some parts of the medical profession to these recommendations but, if it is to survive, the profession and doctors must lead this change. Others, including governments, stand ready to make the changes with or without them.

- Funding of AMA Queensland's proposed **PhD research project** including job analysis to determine core duties of doctors and work/job redesign, including:
  - re-evaluation of the administrative workflow in medicine
  - options to encourage work product and patient outcomes over time-based billing (fee-for-service over fee-for-time).

- Commitment to the **Getting Rid of Stupid Stuff** (GROSS) initiative and reducing red tape
  - Doctors of all levels, from interns to VMOs, report significant inefficiencies and waste across all hospital settings. Much is due to duplication, unnecessary and/or outdated bureaucratic processes and work methods and poor or non-existent systems integration
  - GROSS focuses on aspects of doctors' work that could be removed or altered with minimal or no cost to realise immediate benefits and savings to the health system. Relieving doctors of such unnecessary and frustrating tasks would also greatly contribute to job satisfaction and lead to improved workplace culture and doctor wellbeing
  - Doctors must be equipped to work to their full scope of practice. This results in the most efficient and effective services for patients provided health services employ the necessary support staff and resources required. Expanding scope for other health practitioners has been shown to be less safe and more costly than equipping doctors to do the very tasks for which they have trained.
- Technological investments that **improve clinician workflows, not administrator workflows**
  - Expansion of technologies that are supported by clinicians on the ground across tertiary and primary care (e.g. the **Ward Call app**) in all Queensland Health hospitals
  - Standardisation of electronic services for better integration, access and efficiency across the state
  - Improved speed of assessment, and implementation of emerging technologies, such as AI and Large Language Models, with a focus on freeing up frontline clinician time. Doctors must be enabled to spend more time with their patients and less with a computer monitor.
- **Prioritise direct care** to patients, their loved ones and family. Clinicians need adequate time with patients and loved ones to discuss and provide high quality care. Direct care of patients is core to the doctor's role and must be supported in their tasks and duties
- **Middle-grade workforce reform**
  - Remodelling of practices, systems and processes to reduce tasks of the middle-grade workforce, particularly administrative tasks
  - Sensible, evidence-based and safe top of scope practice to reduce burden on middle-grade/registrar workforce
  - Establishment of a Career Medical Officer role for experienced, non-specialist doctors.
- **Revived focus on generalist, flexible, broad-skilled specialists**
  - Providing incentives to encourage trainees to choose generalist careers/maintain a broad base of skills as they progress through their careers e.g. anaesthetists that can do trauma, paediatrics and maternity
  - Launching a positive education campaign about the benefits of generalism for the profession and the public
  - Incorporating a generalist skill competency as a prerequisite or high-scoring attribute for specialty training
  - Broadening the scope of practice acceptable for fellowship completion
  - Expanding specialists' roles in hospitals
  - Reforming medico-legal, prevocational and college structures to reduce barriers to generalist practice.
- **Balance extended hours with business hours care**
  Patient safety must be safeguarded and while AMA Queensland supports extended hours for hospitals, a sensible approach needs to be taken to ensure clinicians are delivering care at times that are optimal and safe.

Medical training pipeline

For the past century, Queensland's medical training system has produced a calibre of professionalism unrivalled across the globe. Patients have reaped the health benefits through the provision of best practice treatments delivered by highly trained doctors across a broad range of specialties and career stages. But this is now at risk.

Our medical training pipeline is no longer fit for purpose and is harming both our future medical leaders and the patients they treat. We are no longer producing the number and types of doctors our community needs and health provision and outcomes are going backwards. Australian Government data shows the number of hospital non-specialists increased 17.6% from 2019 to 2023 but specialists-in-training only increased 4.3% over the same period.[1]

Maldistribution has become undersupply in too many specialties and growing numbers of hospital and health services have not had essential specialists for years. Doctors themselves are suffering burnout and reducing their hours or quitting altogether just to survive.

From the perspective of many early career doctors, securing the essential medical training they need is unnecessarily complicated and uncertain. This creates avoidable stress and often sets them up for poor wellbeing that lasts the rest of their careers. AMA Queensland's 2024 Resident Hospital and Health Check showed just 37% of early career doctors were satisfied with the quality of formal teaching and training they receive.[2]

[1] Australian Government, Department of Health, Disability and Ageing, 'Summary Statistics, Medical Profession' (22 April 2024) available at: **https://hwd.health.gov.au/resources/data/summary-mdcl.html**.

[2] AMA Queensland, '2024 Resident Hospital Health Check' (2024) available at: **https://www.ama.com.au/qld/campaigns/resident-hospital-health-check**.

The medical training pipeline must change to match the health demands of our workforce and community. The working group identified the following key recommendations for short-medium term implementation to reshape it for the future.

- Establishment of a **national independent health workforce planning agency** to determine needs-based workforce planning and coordinate training capacity assessment. Medical colleges would remain safety and accreditation supervisors but training numbers must be determined by the national body to rebuild trust in the system. The agency would be responsible for matters such as:
  - undertaking future community **needs projections** to determine training numbers rather than current 'registrar' workforce desires
  - running an **education campaign** to inform medical students and junior doctors of in-need specialties and locations and benefits of choosing those identified
  - considered, sensible increases in **medical school places** that maintain high quality clinical education and supervision while addressing specialty/ geographic maldistribution
  - **tying training numbers to in-need specialties**, based on disease prevalence
    - This is needed urgently as future training is already being limited by the number of specialists who can facilitate more training. Doctors report current training numbers in any given specialty appear to follow the numbers that completed that particular training program the year prior, without any relationship to community health needs or future training and supervision requirements. We must produce enough consultants to treat patients and enable training of the next specialist cohort
  - Increasing the total number of specialist training placements while redistributing current training placements to address under- and over-supply of specific specialities
    - Training numbers must also be tied to clinical full time equivalent (FTE) and not head count or Medicare provider numbers which are inaccurate measures of available doctors due to flexible and part-time arrangements, other responsibilities like administration, teaching, research and similar non-clinical roles and activities and the fact doctors often hold multiple provider numbers.

- Allocating **Specialist Training Program (STP) funding** to incentivise increased training in high-need specialties, including consideration of a **statewide trainee delegation system** and an **optional rural bonding program**
  - enabling sensible fast-track training for interns and doctors in training who are identified for in-need specialties
  - incentives to encourage trainees to choose in-demand specialties using both financial and non-financial incentives
  - consideration of removal of required PGY1 and PGY2 terms for trainees
  - **needs-driven accreditation** of training places based on comprehensive data and consistent modelling methodologies. Health system resources, including non-medical staff, must have requisite increases to match in-need specialties and specialists
  - **colleges must set realistic expectations** for the various settings and contexts in which specialists work and the expected or reasonable patient loads per specialist. This must be undertaken with input from other central stakeholders and based on disease prevalence statistics over population data.
  - **competitive application processes for fully funded trainee positions** to encourage improvement and innovation in training methods, including:
    - public-private training networks
    - greater university involvement
    - expansion of successful networked training and supervision models
    - non-college pathways such as Queensland Health funding non-accredited trainees and qualifications similar to the Membership of the Royal College of Surgeons program in the United Kingdom for resident medical officers
    - transparent and accountable trainee allocation process. Doctors in training report a complete lack of trust in the allocation of training places and hold a near-universal view that the process appears biased. This discourages trainee flexibility and the ability of health services to fill workforce gaps
    - requirements that embed diversity and equity into trainee selection.
- **Coordinating government agencies across the health system**, including health departments, Ahpra and training regulators to ensure cooperation and that existing government systems, processes and frameworks (e.g. credentialling arrangements) don't inadvertently block expansion of training positions. There must also be stakeholder buy-in which can only be achieved by agencies acting and being seen to be acting in good faith.

Primary medicine degree reform

- Improve the curriculum and content of primary medicine degrees to ensure:
  - interns graduate work-ready
  - students can be employed in health settings with:
    - defined clinical roles and responsibilities
    - as a complement to the existing workforce (not substitutes)
    - appropriate apprenticeship remuneration
    - appropriate support and supervision
  - students with a background in other health fields (e.g. pharmacy, physiotherapy, nursing), are supported to continue working in that setting while studying medicine.
- More Commonwealth Supported Places (CSPs) and scholarships, including state-government funded, across all of Queensland but particularly for Queensland students from regional, rural, remote, First Nations and diverse backgrounds and with an interest in identified in-need specialties. AMA Queensland notes previous government estimates have shown an additional 400 CSPs are needed in our state
- Provision of accommodation for medical students and doctors in training undertaking training in regional and rural areas
- Provision of accommodation for doctors in training living in regional, rural and remote locations to undertake training terms in metropolitan areas to achieve specialist qualifications.

Supervision improvements

- Reform of Medical Board guidelines to require protected supervisor FTE for training and education. This must be built into accreditation standards for all national training programs and be backed by requisite investment
- Improve consistency of senior medical officer (SMO) educator skills and FTE
- Setting of supervision ratios for different trainees. This will have cost implications for health services and should have sufficient flexibility to be tailored to the unique staff employed at a given service (e.g. supervision ratios will be higher for different trainee and supervisor mixes at different facilities)
- Improved use of private and community health settings for medical training, particularly where public funds are used for patient care (such as Surgery Connect)
- Diversify supervisors where appropriate (e.g. university and junior doctor educators)
- Funding and support for the adoption of innovative technology for training, including virtual reality and remote supervision.

General practice

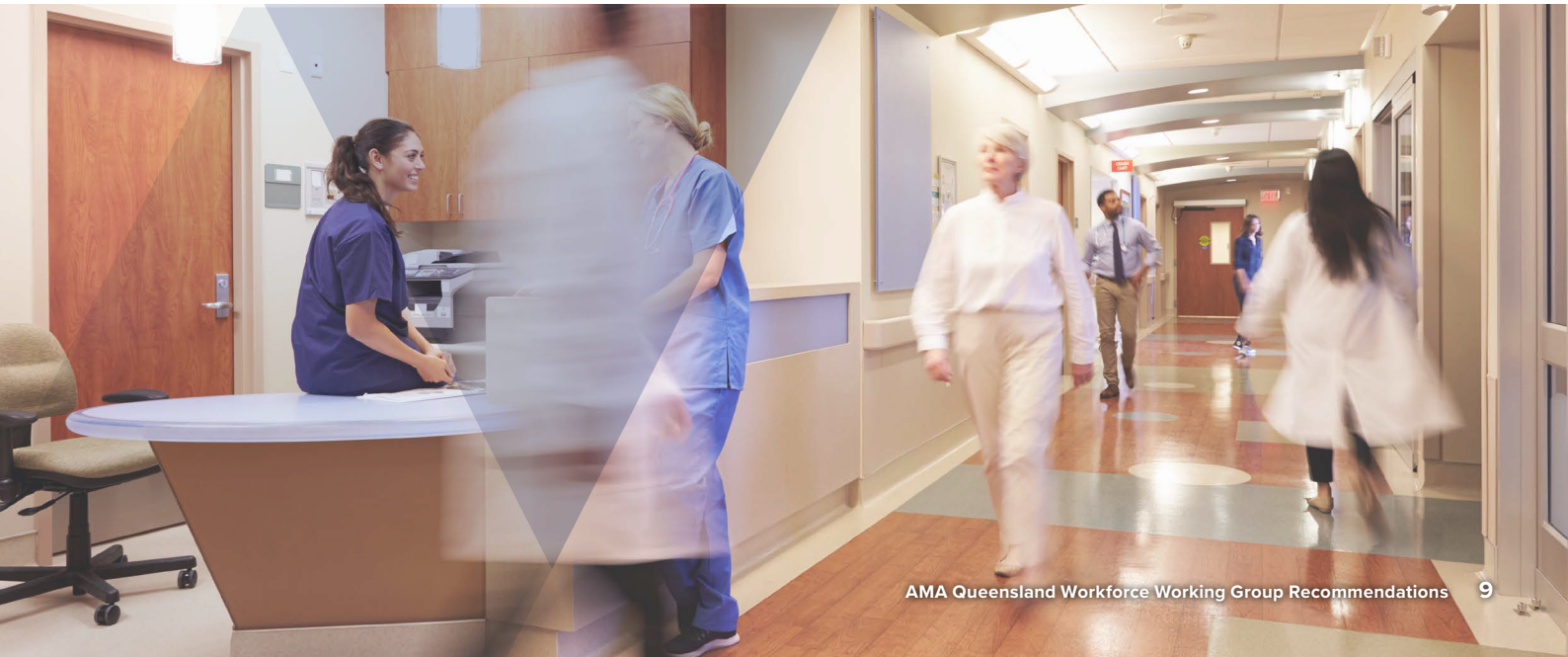
We cannot reduce pressure on our busy public hospitals if we don't keep people healthy and well as they grow and age. General practice is the cornerstone of preventive health and primary care, saving lives and health costs by providing cost-effective, early intervention and treatment when it is needed most. It is also one of the most rewarding careers in medicine, with general practitioners (GPs) caring for patients and their families throughout the life course, from the cradle to the grave.

Despite this, general practice is not immune from the current workforce crisis. Training numbers have dramatically fallen as the discipline competes for graduates against specialties offering higher pay and greater prestige as generalist disciplines fall out of favour. Governments at state and Commonwealth levels have recognised the need to invest in primary care, including funding greater training places and modest viability improvements through the MBS. But much more needs to be done.

The following recommendations were developed by the working group to further the work already started to increase our GP workforce.

Training and employment conditions

- Expand medical school and internship-postgraduate year 2 (PGY2) exposure to general practice
- Ensure public funding parity between GP and specialist training to make GP trainee placements attractive for practices
- Implement transferrable entitlements for GP trainees to align with hospital-based trainees, including maternity/family, sick and professional development leave and payout of long service leave early for those transitioning to accredited GP training
- Review regulations to allow non-employee and employee GP business models
- Commit to recurrent funding of the GP trainee incentive scheme in Budget allocations.



- **Modernise Medicare**
  - Implement **AMA's Modernise Medicare plan**
  - Immediate increase and ongoing annual indexation of MBS to ensure patients can access and afford GP care as readily as they can public hospital-based services
  - Amend MBS items to reward clinical efficiency and quality care rather than time-based billing, including to incentivise multidisciplinary team case conferences
  - Advocate for increased funding for longer GP consultations. There is evidence that prolonged Level D consultations (40+ minutes) are associated with reduced ED visits outside of metropolitan areas. Similar evidence has been found for multidisciplinary case conferences
  - Increased payments under the Workforce Incentive Program (WIPs) for practices to employ practice nurses and allied health professionals to provide care such as chronic disease management and triage
  - Funding and other supports for practices to upgrade IT and practice software to improve workflows
  - Ensure GP registrars have comparable remuneration to their hospital-based counterparts.
- **Integration of primary and community care with public hospitals** to create upskilling opportunities, procedural training/support and clearer referral pathways to realise efficiencies and improved patient outcomes
  - Establishment of senior GP representation within hospital and health services to embed two-way primary-tertiary communication. This will improve clinical handovers and discharge planning and ensure holistic consideration of:
    - how patients access the right tertiary care at the right time
    - downstream impacts for patients post-discharge, especially if they require significant after care, including readmission or outpatient access.
  - Expansion of the patient care facilitators (PCF) pilots
  - Greater funding for ACCHOs
  - Funding via the National Health Reform Agreement (NHRA) for integrated state-Commonwealth information technology systems for hospital to aged care, NDIS, community care and primary care services.
- **Preventive health** investment, including MBS items and community-based programs
- Engage with colleges to determine **baseline GP per capita ratios** to monitor growth and shortages.

Public hospitals

It's in our busy public hospitals that our workforce crisis is perhaps most obvious, seen in increasing emergency and planned surgery wait times, long work hours and unsustainable on call rosters. This is causing poor patient outcomes and doctor burnout, with some regional practitioners likening conditions to those in developing nations.

Our metropolitan teaching hospitals aren't faring much better, with patients still waiting far longer than recommended times and trainees missing out on quality training and supervision. The working group's recommendations focused on several important areas of our public hospitals for both patient care, doctor training and workforce sustainability. Action should be taken on these immediately to halt the decline in public hospital performance across the state.

- **Service provision tied to required specialists for a community's disease prevalence** for all specialties
  - Those **figures must drive recruitment targets** for regional centres with significant populations for key surgical specialties (e.g. urology for locations like Mackay with a population of approx. 185k[3])
  - **Tailor unit staffing** to location
  - **Incentives targeted at in-need specialties and locations** with mix of financial and conditions, particularly continuing professional development opportunities and facilitation for regionally based clinicians to maintain skills, upskill and take up research opportunities. This measure has clear cost implications for government but the crisis in our regional and rural areas demands significant investment. Doctors report non-metropolitan patients are suffering worse outcomes than their metropolitan cousins simply through a lack of access to timely care. This is indefensible. It is also causing moral injury to health workers and can no longer be tolerated
  - Cautious use of **networked or fly-in fly-out models in the short-medium term**
    - Clinicians must be incentivised to participate and not coerced into such models by use of suspected retribution or other punishments for refusal. Government must make a genuine commitment to long-term, permanent specialist workforce recruitment and retention, rather than rely on short-term networked models. This means Queensland Health must first ensure regional, rural and underserved HHSs are attractive and safe places to work such that doctors feel confident to work in them. Senior clinicians also need to lead the way to create a genuine networked model and avoid two-tiered structures where senior specialists are excluded from rural service but junior specialists cannot avoid it.
  - Deliberate, strategic planning to **reduce reliance on locums and IMGs**
  - Transparent and accountable consultant recruitment process. Like doctors in training, consultants also report a complete lack of trust in Queensland Health processes and view them as biased and not based on merit.
- **Ways of working**
  - Implementation of **strength-based employment streams**
    - Clinical stream: higher patient load; less teaching and supervision responsibilities
    - Teaching stream: lower patient load; more teaching and supervision responsibilities.
  - **Redesign workflow to use optimal skillset**
    - Reform multidisciplinary, doctor-led, team-based care via value-based healthcare
    - Consideration of indicative (not mandatory) doctor staffing based on community need/disease prevalence

[3] https://www.mackay.health.qld.gov.au/__data/assets/pdf_file/0028/345970/annual-report-2022-2023.pdf

- Increase pharmacist presence for medication histories at admission (not day after)
- Expanded inpatient allied health access, including extended hours of operation beyond 8am-5pm where care can still be delivered safely and to best practice standards
- Improved availability of support staff so doctors have more time for clinical tasks that make the best use of their full scope of practice
- Expansion of community paramedicine, virtual and hospital in the home models.

- Key performance indicators (KPIs) for all doctors to **measure performance against clinical output, patient outcomes and system improvements** (e.g. faculty meetings, college involvement, union or peak body representation) including performance incentives
- HHS executive KPIs structured to complement clinician KPIs for improved efficiency and patient outcomes
- **Tailored accreditation standards** to suit the services offered and specialists employed at different hospitals
- Fund **PhD job analysis** to map modern public hospital workforce, particularly increases in non-specialist hospital-based doctors over the last decade.

- Implementation of the **Australian Salaried Medical Officers' Federal Queensland (ASMOFQ) Medical Officers' Certified Agreement No 7 (MOCA7)** log of claims
- **Technology**
  - **Frontline-focussed digital technologies**: technologies implemented for frontline staff must improve frontline clinician efficiency rather than satisfy administrative requirements
  - **Medical scribes/non-doctors/artificial intelligence** for data entry and other **administrative** tasks to enable doctors to focus on clinical care
  - Prudent expansion of **telehealth, 24/7 clinical supports, outreach and networked services**.

Private hospitals

Queensland's health system is dependent on a strong private hospital sector. Workforce attraction and retention is greater where senior clinicians can undertake a combination of private and public work. Where they cannot, public hospitals usually struggle to retain the consultant staffing required to operate core services, demonstrated most clearly in the failure of public maternity units such as Gladstone's following the closure of the local private service.

Private hospital sector reform has never been more urgent. We are seeing private hospitals entering voluntary administration followed by liquidation as the model becomes increasingly unviable. Patients are being denied continuity of care and doctors a stable and diverse career in which to develop skills, innovate and thrive. This accelerates the downward spiral as more patients question the value of private health insurance in a cost of living crisis with rising premiums – premiums that then rise even further to cover the lost revenue of patients who drop their cover.

Recommendations to bolster the private hospital workforce were identified by the working group as set out below. It should be noted that these are directed at the private workforce only. Large scale reform of the private health sector to achieve ongoing financial viability is outside the scope of the recommendations.

- Promote and support **visiting medical officer models** in all hospitals but particularly in regional services
- Set **limits for public hospital doctors' on call requirements** so practitioners can pursue and fulfil private practice obligations and reduce fatigue and burnout

- **Surgery Connect** contracts should be encumbered, so that the specialists receiving the benefit of public funds are also contributing to public hospital workforce needs, such as participating in an on-call roster.[4] This is especially crucial in areas of workforce shortage. Where public patients are treated in private facilities, these contracts must also ensure a training benefit (i.e. SMOs are authorised to take their registrars with them to the private facility)
- Improved **public-private integration** to support private clinicians to manage more complex patients and work to the top of their scope, including:
  - funding support for multidisciplinary teams
  - nursing staff work arrangements (e.g. after-hours support, nurse specials)
  - peri-operative support
  - intensive care unit/high dependence unit support
  - post-op complication admitting rights
  - permitting **private billings in public hospitals** for public specialists in locations where there is no private facility
    - Flexible billing services for private specialists within public hospitals enables choice for medical practitioners and patients. Special consideration must be allowed for private specialists in rural and regional areas.

[4] Royal Australasian College of Surgeons, 'Guiding Principles for Outsourcing Elective Surgery Waiting Lists in Australia' (May 2025) available at: **https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/manuals-guidelines/2025-05-23_GDL-3181_Guiding_Principles_for_Outsourcing_Elective_Surgery_Waiting_Lists_in_Australia.pdf?rev=5c01dc8608b844eca5fd0218f6428167&hash=F5D1A9034601F3E089A7D038AC480700**

- Incentives to encourage **training in private facilities**, throughout the entire training pipeline. This cost should be shared by the state and federal governments given private health is largely an Australian government responsibility but accessed by state governments through arrangements like Surgery Connect
- Remuneration/incentives for **private clinicians to participate in system-based improvements**
- Advocate for **private insurance to cover preventive care and chronic disease management**
- Implementation of recommendations from the **AMA's Private Health 2025-26 Pre-budget Submission**, particularly the establishment of an independent health systems authority with sufficient statutory power and expertise to develop, implement and monitor compliance with standardised contractual terms and resolve disputes.

Conclusion

The recommendations set out in this action plan provide a profession-led road map to bolster our medical workforce to meet the health needs of our community. AMA Queensland acknowledges the simultaneous efforts being made by government and other health organisations to this end, however, any solutions adopted must be fully supported by the medical profession. That means securing buy-in across all specialty groups and especially from doctors who maintain a frontline clinical FTE. Measures imposed on, rather than crafted in collaboration with, clinicians will not succeed.

The solutions in this action plan are doctor-led with the full support of Queensland's peak medical body. AMA Queensland looks forward to working with Queensland Health, private hospital providers, GP and specialist clinic owners and other stakeholders to implement them and secure a sustainable medical workforce for us all.

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