ANZCA
FPM

President and CEO
Australian and New Zealand
College of Anaesthetists

6 January 2021

Ms Kathryn Yuile
Acting Assistant Secretary
Health Workforce Reform Branch
Health Workforce Division
Department of Health
GPO Box 9848
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Via email: Kathryn.yuile@health.gov.au

Dear Ms Yuile

National Medical Workforce Strategy 2021-2031

The Australian and New Zealand College of Anaesthetists (ANZCA), including the Faculty of Pain Medicine (FPM), is one of the largest medical colleges in Australia. The college is responsible for the training, examination and specialist accreditation of anaesthetists and specialist pain medicine physicians and for setting the best standards of clinical practice that contribute to a high quality health system.

ANZCA appreciates the opportunity to provide feedback on the draft National Medical Workforce Strategy 2021-2031. We commend the Department of Health and the Medical Workforce Reform Advisory Committee on the development of the strategy and acknowledge the efforts to engage with stakeholders in its development. Representatives of the college attended strategy consultation forums in Melbourne, Sydney and Ballarat, in addition to participating in other face to face meetings and teleconferences with the Department.

The college is supportive of the development of the National Medical Workforce Strategy to ensure that the community continues to enjoy the benefits of a high quality health workforce and that our doctors are well supported in professionally stimulating careers. Overall, the draft strategy is an ambitious, considered document and while it will take some time for many of the proposed actions to demonstrate tangible benefits, it is important that the first steps to effect these long-term changes are taken now.

As noted in the draft strategy, the COVID-19 pandemic has highlighted that things can change rapidly. On the one hand, the pandemic demonstrated that at the core of our health system is a skilled, flexible and resilient workforce and that all stakeholders are able to work together effectively and decisively in extreme circumstances. On the other hand, COVID-19 highlights the difficulties inherent in long-term workforce planning, with potential impacts on many of the assumptions made in the strategy. For example:

- The recent average annual population growth rate of 1.6 per cent may slow significantly given this was largely driven by immigration which has temporarily ceased.
- In addition, the financial and other insecurities created by COVID-19 may further reduce Australia's already low birth-rate.

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- The proportion of the population aged over 65 is likely to accelerate in the absence of an influx of younger, working-age immigrants.
- Regional centres have experienced significant growth as people working from home have moved away from larger cities, attracted by more affordable housing and improved lifestyles and the flexibility now afforded by many employers for work from home arrangements.

Whether these trends continue or rapidly return to pre-pandemic levels is unknown at this time, however they do highlight the need for flexibility and responsiveness to change to be an overarching consideration of the strategy and its associated action plan.

In the attached table, we provide some more specific feedback on the draft National Medical Workforce Strategy. It is pleasing to note that ANZCA is already tackling many of the actions detailed under the plan through initiatives such as our Indigenous Health Strategy, Indigenous Health Learning Outcomes Project Group, Regional and Rural Workforce Strategy, Gender Equity Working Group, Diversity and Inclusiveness Working Group, Wellbeing Special Interest Group and Trainees Wellbeing Project Group,.

We look forward to continuing to work with the Department and other stakeholders to ensure all Australians have access to safe, high-quality anaesthesia and pain medicine services.

Yours sincerely

Dr Vanessa Beavis
President, ANZCA

Nigel Fidgeon
Chief Executive Officer

Attachment 1: ANZCA feedback on the draft National Medical Workforce Strategy

Priority Area One: Collaborate on planning and design

Page	Item	Comment
30	Action 1 Establish a joint medical workforce planning and governance body.	The college supports the establishment of this body with the understanding that the specialist medical colleges will be represented and subject to the delegated authority of the body. We note that ANZCA does not set training numbers.
31	Action 3 Develop and implement a National Medical Workforce Data Strategy.	Naturally the college supports collaboration with the Commonwealth on developing evidence-based, long-term medical workforce planning and recognises that this requires the collection of comprehensive and high quality data. We note however that the data being requested from specialist medical colleges to support the proposed pipeline modelling is extensive and in some cases may not be currently collected. This request needs to be balanced against costs to the colleges and data already supplied to the Department annually through the National Medical Training Advisory Network/ Medical Workforce Reform Advisory Committee. Any duplication of data requests needs to be minimized to reduce the resource requirement to respond to multiple requests.

Priority Area Two: Rebalance supply and distribution

Page	Item	Comment
33	Since 2013, the annual rate of increase of employed doctors was 3.6%, compared to population growth of 1.6%.	This does not necessarily imply an oversupply of doctors. Other factors must be considered including the ageing population, changing consumer expectations, a demand for healthcare services growing faster than the population, changes in hours worked by doctors and so on.
35	Other specialties that are not yet in undersupply but appear less popular with medical students include occupational and environmental medicine, rehabilitation medicine, pain medicine, sexual health medicine and public health medicine.	Note pain medicine is a post-fellowship specialist qualification, hence medical students would choose a different primary specialty.
36	Other specialties showing signs of being in oversupply include cardiothoracic surgeons and anaesthetists, while others are more nuanced and difficult to measure. There is growing interest amongst medical students in taking up a career	The college does not control trainee numbers, hence initiatives such as Queensland Health's Medi-Nav which provides prospective trainees with information including the number of applicants versus the number of trainees selected will help prevocational doctors make more informed choices. The current oversupply indicators highlight that supply is

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	in anaesthesia - from 8.1 per cent in 2015 to 11 per cent in 2019.	only one part of the equation and as highlighted, ANZCA do not control the number of trainees. Conversely, demand is another consideration which is difficult to always accurately measure. As an example, surgical procedure measurements don't take into account increasing use of interventional radiology. Radiological procedures which require anaesthesia is, as yet an unrecognized "demand". A further example is that of clot retrievals for stroke, which is a recent invention that has excellent clinical outcomes from a patient and public health perspective, but has not been considered as part of demand projections to date. ANZCA strongly suggest that any use of forward projections of workforce requirements takes into consideration emerging clinical interventions/changes in practice that may impact on specialty and sub specialty workforce requirements into the future.
40	Actions in this Strategy encourage junior doctors to gain greater positive exposure to clinical practice in rural and remote settings, in turn improving the way clinical practice in rural and remote areas is viewed and experienced.	The college strongly supports increasing positive rural exposure during training and has been working on a number of actions to support this under our regional and rural workforce strategy including: • Supporting rural training sites to achieve accreditation for longer periods (for example from 26 to 52 weeks) enabling trainees to complete longer clinical rotations in rural areas. • Significantly increasing the number of regional and rural training posts supported by the Commonwealth's Specialist Training Program. • Assisted by funding from the Commonwealth's Specialist Training Program, developing new education and support initiatives for trainees in rural areas. • Promoting positive rural careers and lifestyles through regular features in ANZCA communications.
44	Action 6 Grow the Aboriginal and Torres Strait Islander workforce.	The college strongly supports this action and it a focus of our Indigenous Health Action Plan and will also be an important part of our Reconciliation Action Plan under development in 2021.

Priority 3: Reforming the training pathways

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48	To ensure they have access to the full range of training required, these rural registrars should have preferential access to any training that can only be undertaken in a metropolitan hospital.	The college does not believe that trainees in regional areas should have preferential access to required training in metropolitan hospitals. All trainees, regardless of where they are training, should have appropriate access to required rotations necessary to progress and complete their full scope of training. As a specialty college, whilst ANZCA sets the standards, the rotations required to ensure training requirements are met is an employment decision made at a local level that ANZCA has no role in determining.

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		Trainees should not in any way be disadvantaged by undertraining a rural training pathway.
56	Action 11 Medical training to occur primarily in rural Australia, wherever possible.	While ANZCA strongly supports increasing training opportunities in rural Australia, the college does not support the proposition that all training be conducted in rural Australia wherever possible, this is just not feasible. Given that 70 per cent of the population live in metropolitan areas, requiring all medical training to occur in rural areas where possible seems a disproportionate and inappropriate response to the workforce maldistribution issue. For specialties such as anaesthesia and surgery, it is neither possible nor desirable to complete all training outside of a large metropolitan teaching hospital. In addition to being necessary to complete specialised study units such as neuroanaesthesia, undertaking some training in large teaching hospitals ensures trainees receive a well-rounded training experience and possess a wide scope of practice upon fellowship. Previous initiatives suggest that schemes that force people to train and work in rural Australia when they do not wish to, does not provide a sustainable solution to the maldistribution issue.

Priority Area Four: Building the generalist capability of the medical workforce

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66	The rebate increased to $38.20 by 2019–20, representing a 3.1% increase across those five years.	This increase in the GP MBS rebate equates to around 0.6 per cent per annum, meaning that when inflation is taken into account, the salaries of GPs who bulk-bill the majority of their patients have been going backwards unless they see more patients in the same time. This is likely to act as a strong incentive to pursue a different medical specialty.
70	New fellows to demonstrate competence across full scope of practice.	ANZCA currently produces well-rounded new fellows with competence across a broad scope of practice. As noted, this is only possible through completing some training rotations at large metropolitan teaching hospitals. It should be noted that Sub specialty training is post fellowship training. Without rotations to large metropolitan hospitals it is unlikely the trainees will have exposure to clinical settings that are a mandate of the training program.
70	Action 20 Implement and leverage innovation from the National Rural Generalist	It is recognised that there are some areas that cannot support specialist anaesthesia services and in these areas the college supports general practitioners with

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	Pathway.	advanced training to perform some anaesthesia services within their scope of practice. The highest level of expertise in delivering safe and high quality clinical care is provided by specialist anaesthetists. In the interests of delivering best patient outcomes, this expertise should be utilised wherever practicable. This also needs to be balanced with the need for equity of access to quality patient care where specialist care may not be accessible. It also needs to be recognised that whilst a GP with advanced training can, at times provide a safe level of care, this should not be the default option for rural or remote regions. The college supports the implementation of the National Rural Generalist Pathway on the proviso that: • Rural generalists with advanced skills training in anaesthesia work in those areas that cannot support specialist anaesthesia services. • ANZCA continues to be responsible for defining the standards of anaesthesia practice that rural generalists with advanced skills training in anaesthesia must meet. • Health services understand that rural generalists with advanced skills training in anaesthesia have a clearly defined scope of practice and ensure that there are appropriate protocols in place for cases that are not within this scope.

Priority Area Five: A medical workforce that is supported to thrive and train and work flexibly

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77	Action 22 Review COVID-19 from the lens of embedding more support and flexibility within the medical workforce.	The college supports this aim and the flexibility and responsiveness to change of the anaesthesia and specialist pain medicine physician workforce was amply demonstrated in fellows', trainees' and specialist international medical graduates' response to COVID-19.
77	Action 23 Increase flexible working arrangements to reflect the changing needs of the medical workforce.	The college strongly supports this and it is an action of our Gender Equity Action Plan.