2026-27 Pre-Budget Submission

Improving access to high-quality specialist care

CPMC
Council of Presidents of Medical Colleges

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Executive Summary

From the Chair, Council of Presidents of Medical Colleges

Improving health outcomes for people living in rural, regional, and remote Australia is a priority for the Commonwealth Government. Through initiatives such as the Specialist Training Program (STP), the Support for Rural Specialists in Australia (SRSA) program, and the Flexible Approach to Training in Expanded Settings (FATES) program, the Commonwealth has demonstrated leadership in advancing the National Medical Workforce Strategy's goal of a high-quality, well-distributed medical workforce.

Australia's health system is rightly regarded as one of the strongest in the world. Yet for too many people, particularly those living outside major cities, access to specialist care is increasingly difficult. Long waiting times, limited local availability and workforce shortages mean that where a person lives has become a decisive factor in whether they can receive timely, high-quality specialist care. This inequity is unacceptable and avoidable.

The underlying challenge is structural. Specialist care is unevenly distributed because specialist training is unevenly distributed. Where doctors train strongly influences where they practise, yet most specialist training continues to occur in metropolitan settings. While existing Commonwealth programs supporting rural specialist training, retention and innovation are delivering positive results, their impact is constrained by scale, fragmentation, and misalignment with workforce planning.

The Council of Presidents of Medical Colleges (CPMC) is the peak body for Australia's specialist medical colleges. Our purpose is to uphold and advance the standards of medical practice by influencing the development of a skilled medical workforce through training and education and the quality and safety of patient care.

Colleges are central to any sustainable solution to improving access to specialist care outside major cities. This Pre-Budget Submission sets out a small number of targeted, evidence-based investments designed to address the structural causes of specialist workforce maldistribution and improve access to high quality care where it is most needed.

On behalf of the 16 specialist medical colleges, CPMC proposes **an additional $45.6 million per year in ongoing Commonwealth funding, plus $980,000 in one-off funding**, to deliver a coordinated package of reforms that will strengthen specialist training, retention and workforce planning nationally, improving access to high-quality care where it is most needed. The proposed investments are to:

- **Train specialists where patients need care by scaling what works**

  An investment to develop and expand the Flexible Approach to Training in Expanded Settings program through an increase of $9 million per year, consistent with Grattan Institute recommendations. This investment would allow proven training innovation to be scaled and implemented nationally. This would be complemented by a one off $980,000 investment to scope and design multi-specialist rural and regional specialist training hubs.

- **Fund the specialists patients are waiting for**
  An increase of $35.4 million per year to the Specialist Training Program, consistent with the Grattan Institute recommendations to increase funding of training programs and expand specialist training capacity in priority specialties and locations outside major cities.

- **Retain the specialists rural communities rely on**
  An increase in funding for the Support for Rural Specialists in Australia program of $1.2 million per year, protecting access to care by retaining experienced specialists in rural and remote communities.

- **Plan nationally to deliver access locally**
  Establishment of a joint national specialist workforce planning mechanism to align funding, training capacity and workforce need, reducing duplication and implementation risk.

Together, these investments focus on fixing system design rather than managing the consequences of workforce shortages. They build on existing Commonwealth programs that are already delivering results, but lack the scale and coordination needed to shift access at a national level.

These solutions will improve access to specialist care closer to home for people in rural and regional areas, reduce avoidable hospitalisations due to delays as well as patient transfers, strengthen value for money from existing training investment, and support a more sustainable and predictable specialist workforce over the long term.

CPMC and its member colleges stand ready to work with the Commonwealth to deliver these reforms and ensure that access to high-quality specialist care no longer depends on postcode.

Associate Professor Kerin Fielding
Chair, CPMC

Introduction

The Council of Presidents of Medical Colleges (CPMC) is the peak body representing the specialist medical colleges of Australia. CPMC brings together the expertise of the leaders of the 16 accredited medical colleges, which oversee the training, accreditation, and continuing professional development for Australia's specialist medical workforce that underpins access to high-quality specialist care.

This Pre-Budget Submission focuses on **improving access to specialist care, particularly for those living in rural and regional communities**. Throughout this document, the term "specialists" refers to non-GP medical specialists.

Health outcomes are closely tied to the availability of a well-supported specialist workforce with colleges playing a critical role by training and supporting these specialists. -supported specialist workforce with colleges playing a critical role by training and supporting these specialists.

There is strong and consistent evidence that **where doctors train strongly influences where they practise**. Doctors of rural origin and those who undertake substantial training in rural and regional settings are significantly more likely to remain in those community's long term.

The Commonwealth Government has demonstrated sustained commitment to improving health outcomes outside major cities through the National Medical Workforce Strategy and targeted investments such as the Specialist Training Program, the Support for Rural Specialists in Australia program and the Flexible Approach to Training in Expanded Settings program. However, the current training arrangements, funding settings and workforce planning processes limit the ability to apply a "train-and-retain" approach at scale outside metropolitan centres.

Addressing these challenges requires coordinated action and sustained investment across training capacity, workforce retention, and national planning. Isolated or short-term measures will not deliver the system-wide change required to improve access to specialist care.

This submission builds on existing programs by proposing a small number of integrated, evidence-based solutions to strengthen specialist training and retention in rural and regional Australia, better align workforce planning with community need, and maximise the Commonwealth's investment to improve access to high-quality specialist care over the long term. Funding these solutions will deliver a stable, well-supported pipeline of specialists trained where they are needed the most.

The specialist access problem

Access to specialist care outside major cities is limited

Australia's health system is recognised as one of the strongest globally, supported by a highly skilled health workforce; yet access to specialist care is failing too many of us. As outlined in the Grattan Institute report, *Special treatment: Improving Australians' access to specialist care*, each year around **two million people delay or forgo specialist care**, driven by long wait times, limited local availability of specialists and cost barriers. This access challenge is most acute for disadvantaged populations, particularly people living in rural, regional, and remote areas.[1]

As a result, where a person lives has become a defining factor in their ability to access timely specialist care. This inequity gap is unacceptable and avoidable. Everyone should be able to access timely, appropriate specialist care regardless of where they live.

Limited access leads to poorer health outcomes and higher costs

Limited access has real and measurable consequences. People living in regional, rural, and remote areas experience **significantly higher rates of potentially preventable hospitalisations and premature death** than those in metropolitan areas. These disparities worsen with increasing remoteness with potentially preventable hospitalisations with 30% higher in outer regional areas and 70% higher in remote communities compared with major cities. Age-standardised death rates are approximately 10% higher in outer regional and 2communities Nearly a[2]care.[3]

At the same time, people outside major cities carry a **disproportionately high burden of chronic and complex disease yet** often face extensive delays or must travel significant distances to access specialist services. For many patients, this means travelling hundreds of kilometres or temporarily relocating, imposing significant financial, social and health costs.[Error! Bookmark not defined.]

First Nations people report additional access barriers due to availability and distance travelled, affordability, cultural appropriateness, and previous experiences of racism in health care environments for themselves, family, or community members.[4]

To compound this, there is a systemic shortfall in health expenditure across hospital, primary care, aged care, disability, and ancillary services in non-urban areas. Despite clear and measurable need, people living in non-urban areas receive substantially less health spending per person than those in metropolitan areas, with recent analysis showing an annual funding shortfall of $8.35 billion, equivalent to around $1,090 less per capita.[5]

Australia is facing a specialist workforce distribution crisis

Demand for specialist care is rising due to an ageing population, increasing prevalence of chronic disease and rising service expectations. However, **specialist supply is not keeping pace**, and the workforce remains **overwhelmingly concentrated in metropolitan areas**, with more than **80% of specialists practising in cities**. This maldistribution continues to limit access to specialist care for people living outside major cities.

The Australian Medical Association's 2025 *Rural Health Issues Survey* highlights chronic understaffing, inadequate facilities, and limited specialist outreach services as persistent barriers to specialist care in rural areas.[6]

Current training and planning settings reinforce metropolitan concentration

A substantial proportion of medical students express an intention to work outside major cities, yet only a small minority of specialist trainees ultimately do so in practice.

There is strong and consistent evidence demonstrating that **where doctors train strongly influences where they practise**. Doctors of rural origin and those who undertake substantial rural training are significantly more likely to practise in rural and regional areas long term.[7,8] The Medical Deans Australia and New Zealand survey of final year students showed that among the 2024 graduating cohort, just under 40% of domestic medical graduates indicated a preference for future practice outside capital cities, this increased to over 62% for students from a rural background.[9] Doctors who grew up in rural areas are 2-3 times more likely to practice in rural areas throughout their careers, and this rises to 5 times more likely for those who complete post-graduate and vocational training in rural areas.[10]

Recruiting rural-background students and providing local training is a key strategy in building the rural workforce, however most specialist training continues to occur in metropolitan hospitals.

Rural and regional health services face persistent shortages of accredited training positions and supervisors which limits their ability to function as centres of training excellence. Without sufficient scale, coordination and long-term planning, exposure to rural specialist practice remains limited and training pathways fragmented, reducing the likelihood that specialists will train and practise outside major cities.

At the same time, **specialist workforce planning is fragmented**. Decisions about funding, training numbers, trainee selection, accreditation, and employment are made by different authorities through largely uncoordinated processes. While the development of a national workforce strategy is a step, **a strategy alone will not deliver change** unless it is supported nationally by ongoing, coordinated decision-making involving governments, specialist medical colleges, universities, and employers.

Effective programs exist, but they are too small and disconnected

The Commonwealth already invests in programs that support specialist training, retention, and innovation outside metropolitan areas. These programs are effective, but their impact is constrained by scale, fragmentation, and static funding settings.

Demand for rural training and professional support continues to grow, **yet funding supports only a fraction of eligible specialists and training opportunities**. Successful innovations are not consistently shared or embedded across the system, slowing progress. Without sustained investment and system-level planning that aligns funding, training capacity and workforce distribution, these programs will continue to deliver benefits at the margins while the underlying access gap persists.

Australia does not have a shortage of solutions. It has a shortage of scale, coordination, and sustained investment. Without targeted Commonwealth action, access to specialist care will continue to depend on postcode, with avoidable consequences for patients, communities, and the health system.

Recommendations / Solutions

Addressing these challenges does not require creating new systems or starting from first principles. What is required now is a targeted, coordinated set of investments to scale effective approaches, align training with workforce need, and ensure that planning decisions translate into real improvements in access to specialist care.

The following recommendations represent the minimum set of actions needed. Together, they focus on increasing training capacity in priority locations, retaining the rural specialist workforce, embedding innovation at scale, and strengthening national coordination so that investment delivers sustained improvements in access for patients, particularly outside major cities.

INVESTMENT	FUNDING REQUEST	WHAT THIS FIXES	WHAT GOVERNMENT GETS
Scale specialist training innovation to improve access *(Develop and expand FATES)*	Increase of $9 million per year	Proven training innovations remain siloed and small-scale	National rollout of effective training models that expand access in underserved settings
Train specialists where patients need care *(Rural & regional multi-speciality training hubs)*	$980,000 (one-off)	Specialist training remains metropolitan-centred, limiting long-term rural supply	An implementation-ready national model to train and retain specialists in rural and regional communities
Fund the specialists patients are waiting for *(Expand Specialist Training Program)*	Increase of $35.4 million per year	Too few funded training places, particularly outside major cities	More specialists trained in priority locations and specialties, improving future access and reducing reliance on short-term fixes
Retain the specialists rural communities rely on *(Increase SRSA funding)*	Increase of $1.2 million per year	Workforce loss due to professional isolation and lack of access to essential training	Improved retention of rural specialists, protecting local services and continuity of care
Plan nationally to deliver access locally *(Joint national workforce planning)*	Within existing resources / modest establishment cost	Fragmented decision-making undermines workforce distribution	Coordinated planning that aligns funding, training capacity and workforce need

Solution 1: Train specialists where patients need care by scaling and implementing what works

To improve access to specialist care outside major cities, **medical colleges must be supported to change where and how specialist training occurs**. Colleges are responsible for designing training programs and accrediting training sites, yet current funding settings limit their ability to expand training into non-metropolitan settings at scale.

The two solutions outlined below propose targeted investment to enable medical colleges to shift specialist training closer to where patients live. The first focuses on scaling the Flexible Approach to Training in Expanded Settings (FATES) program to support the national implementation of innovative training models, addressing *how* specialist training is delivered. The second supports a study of structural reform to training delivery by 'flipping' training from metropolitan-based models to multi-specialty rural and regional training hubs, addressing *where* specialist training occurs.

a. UNLOCK SYSTEM-WIDE IMPACT BY SCALING SPECIALIST TRAINING INNOVATION

Expand and establish a national FATES Implementation, Learning and Innovation Program: Additional $9M investment per year

Since 2021, the Commonwealth has invested $29.5 million through the Flexible Approach to Training in Expanded Settings (FATES) program, supporting 30 projects across 12 specialist medical colleges.[11] These projects have demonstrated that specialist training can be delivered effectively in regional, rural and other non-traditional settings and have supported medical colleges to design and trial flexible and innovative training models.

FATES projects have generated a strong evidence base, including:

- flexible and distributed training pathways
- expanded training in regional, rural and remote communities
- community-based and private practice training settings
- culturally safe training approaches for Aboriginal and Torres Strait Islander trainees
- tele-enabled supervision models that support training outside major cities.[11]

The challenge is not a lack of successful ideas. The challenge is that **what works remains small and siloed** within individual colleges. Without scale and coordination, innovation remains fragmented, duplication persists, and the Commonwealth is not yet realising the full return on its investment. The Grattan Institute recommended that this program funding should be increased by $9 million.[1]

At present, learnings from FATES projects largely remain within individual colleges. This limits their impact, to consolidate lessons learned, share successful models, or translate project level

innovation into system-wide improvement. As a result, opportunities for collective progress are being missed, duplication persists across colleges and slows progress in expanding specialist training in areas where patients face the greatest barriers to access. Harnessing this knowledge in a coordinated way is essential to embedding successful models, accelerating system-wide improvement, and ensuring that future investments build on what is already known to work.

This solution proposes targeted investment to implement and expand flexible training models and move FATES from a research and pilot phase to a scaled implementation model. It would enable medical colleges to integrate flexible, regionally based training models into core training pathways, supporting a sustainable specialist workforce closer to where rural and regional people live. These projects would be able to be embedded rapidly and would complement and be a component of the longer-term multi-specialist rural and regional hubs described below.

Additional FATES funding of $9 million is required per year to develop, expand and integrate flexible training models, consistent with recommendations from the Grattan Institute. Doubling the current funding envelope would additionally allow proven training models to be scaled and shared **nationally through a national FATES Implementation, Learning and Innovation Program.**

A **national FATES Implementation, Learning and Innovation Program** as part of the governance of the FATES program, would enable successful models to be allocated, rapidly shared, adopted and embedded across colleges through structured collaboration. As the only national body representing all specialist medical colleges, CPMC is uniquely placed to coordinate this work. It already brings together senior education and training leaders across colleges and has the infrastructure required to manage cross-college collaboration efficiently, reduce duplication, administer the grant, and ensure that insights from Commonwealth-funded projects translate into system-wide improvements.

EXPECTED OUTCOMES

This investment will:

- accelerate the expansion of specialist training capacity outside major cities
- maximise the return on existing Commonwealth training investment
- strengthen rural and First Nations training pathways
- improve access to high-quality specialist care closer to where rural and regional people live
- reduce reliance on short-term workforce fixes such as high-cost locums.

b. DESIGN AND ENABLE MULTI-SPECIALTY RURAL AND REGIONAL TRAINING HUBS

One-off grant of $0.98M to scope and design rural and regional multi-specialty training hubs

While scaling innovation is essential, long-term access gains also require a **step change in how and where specialist training is delivered**. Australia currently lacks a nationally coordinated model for delivering multi-specialty specialist training at scale in rural and regional settings. What is required are training models that are predominantly centred rurally and regionally rather than being metro centric.

Training activity is uneven, supervision capacity varies by location and specialty, and decisions about where training occurs are not consistently aligned with workforce need. As a result, many regional hospitals are unable to function as centres of specialist training excellence, reinforcing the concentration of training in metropolitan areas.

A one-off Commonwealth investment of $980,000 is required to undertake a scoping study to design rural and regional multi-specialty training hubs.

This work would translate long-standing evidence, policy commitments, and successful pilot activity into a structured national approach capable of supporting sustained reform. Rather than relying on short, fragmented rotations, hubs would enable longitudinal or extended training pathways that allow registrars to remain in a rural or regional location for most, or all, of their training through to fellowship.

Australian and international evidence consistently shows that “train to retain” models built around continuity of location, where trainees spend more than 12 months in the same rural community, supported by sustained supervision and full professional integration, are significantly more effective in producing a sustainable rural specialist workforce than short-term rural exposure alone.[10] These extended training models allow the trainees to become trusted, embedded members of the workforce, which is why these models produce far stronger rural retention outcomes.[10,12,13]

A scoping study would determine the optimal combination of specialties that can be effectively delivered in rural and regional hospitals, balancing workforce needs, population health requirements, and opportunities for cross-specialty synergy.

The study would:

- identify priority locations and specialties where rural specialist training can be expanded sustainably
- assess current training capacity, supervision, and key constraints to scale

- develop scalable, multi-specialty hub options for a nationally coordinated model that enables specialists to complete the majority of their training in rural and regional settings
- clarify the roles of the Commonwealth, states and territories, specialist medical colleges, universities, local health services, and Rural and Regional Training Hubs in establishing and sustaining the hubs

Because the training programs within the hub would be designed specifically to meet rural and regional service needs, they would align rotations, supervision, and skill development with the realities of rural practice.

PROPOSAL DETAILS

It is expected the study would take 12 – 18 months. The scoping study would involve the following:

ACTIVITY	DESCRIPTION
BASELINE INFORMATION	
Mapping current state	Map the present regional, rural, and remote training footprint of each college, including a description of their processes for supporting these, the associated costs, and any enablers of and barriers to the sustainability of their efforts.
Map current college and government processes	Map how regional, rural, and remote training allocations are currently determined, including opportunities to strengthen decision-making through improved data sharing and more granular demand data by specialty and subspecialty.
MODEL DESIGN	
Scalable models	Examine scalable training hub models, including: • Distributed and 'flipped' training pathways • Shared supervision arrangements and tele-supervision • Integration across hospital, outpatient, and community settings • Tailored approaches to meet local community needs.
Feasibility of establishing multi-specialty rural and regional training hubs	Estimate infrastructure, workforce, and support requirements, including supervision requirements, procedural facilities, teaching and simulation spaces, accommodation, and trainee support.

ACTIVITY	DESCRIPTION
IMPLEMENTATION, GOVERNANCE AND ACCOUNTABILITY	
Roles of stakeholders	Clarify roles and responsibilities of the Commonwealth, states, colleges, universities, local health services, and Rural and Regional Training Hubs in implementing and sustaining hubs.
First Nations training requirements	Ensure that First Nations training requirements are addressed at all stages of the scoping study. This would include equity considerations, including culturally safe training environments, First Nations engagement, and opportunities to expand training in Aboriginal Community Controlled Health Organisations.

EXPECTED OUTCOMES

Coordinating the training of multiple specialties within centres of rural and regional excellence will:

- expand multi-specialist training capacity outside metropolitan areas
- allow doctors in training to remain in a rural location throughout their pathway to full fellowship
- create a stable, sustainable training pipeline
- strengthen long-term rural specialist retention by keeping trainees in rural and regional settings for longer and increasing the likelihood they remain after fellowship.
- maximise the impact of existing and future Commonwealth training investment
- develop a more connected and collaborative specialist training ecosystem
- improve access to specialist care.

This blueprint would be implemented through the expanded FATES investment outlined above, ensuring that design and delivery are tightly aligned and that successful models can be scaled nationally.

Solution 2: Fund the specialists rural and regional patients are waiting for

INCREASE THE SPECIALIST TRAINING PROGRAM (STP) FUNDING BY $35.4M PER YEAR

Australia cannot improve access to specialist care without increasing the number of specialists trained in rural and regional areas. While demand for care continues to rise, the training system is not producing specialists in the places where patients need them.

Around **one-third of final-year medical students say they intend to work outside major cities**, yet **only 14% of specialist trainees do**.[9] This gap is not about willingness; it is about where training opportunities exist.

The Grattan Institute has identified insufficient postgraduate training in rural areas as a key driver of ongoing workforce shortages and poor access to care. The Grattan Institute report concludes that expanding rural specialist training is essential, because doctors who train in rural settings are far more likely to practise there long-term.[1]

The STP is the Commonwealth's primary mechanism for supporting non-GP specialist training - funding training beyond metropolitan public hospitals into regional, rural, remote, and private settings. The Commonwealth funds approximately 7% of all specialist training places via the STP[14] that states and territories do not otherwise cover. This amount is **too small and too constrained** to respond to workforce need at scale. The overall investment by the Commonwealth in the STP over 2022 to 2025 is approximately $708.6 million (an average of $177 million per year), providing funding for 1,080 FTE non-GP specialist trainees per year.[15] The Grattan Institute recommends increasing Teaching, Training and Research funding by 20%.[1] Consistent with this recommendation, we propose an increase to the STP of $35.4 million per year. The shortage of government-funded training positions is the major driver of workforce undersupply. As a result, access gaps persist, particularly outside major cities, and governments and health services remain reliant on short-term measures such as locums, outreach services, and international recruitment.

To strengthen the national training pipeline, consistent with Grattan Institute recommendations, **the Specialist Training Program funding should be increased by $35.4 million per year.** This investment would enable a significant expansion of specialist training in priority specialties and locations, particularly in regional and rural Australia.

Expanding the STP at this scale would directly improve patient access by increasing the number of specialists trained closer to where people live. It would also provide the government with a stronger lever to shape future workforce distribution, rather than continuing to manage shortages after they emerge.

To be effective, this funding increase should be aligned with national workforce planning and supported by deliberate efforts to grow the training capacity outside metropolitan centres. Without sufficient scale, program redesign alone will not deliver meaningful redistribution.

EXPECTED OUTCOMES

Increasing STP funding by $35.4 million per year will:

- significantly expand specialist training in regional and rural Australia
- improve access to specialist care for patients outside major cities
- reduce long-term reliance on costly short-term workforce solutions
- support a more sustainable and predictable specialist workforce.

Solution 3: Retain the specialists rural communities rely on

INCREASE THE SUPPORT FOR RURAL SPECIALISTS IN AUSTRALIA PROGRAM FUNDING BY $1.2M PER YEAR

For many regional, rural, and remote communities, access to specialist care depends on a small number of highly skilled clinicians who practise with limited local support. When those specialists leave, services are reduced or lost altogether, forcing patients to travel long distances or wait longer for care.

The Support for Rural Specialists in Australia (SRSA) program, funded under the Specialist Training Program and administered by CPMC directly addresses this risk. SRSA is not a discretionary professional development program, it seeks to reduce professional isolation and strengthen the retention of non-GP medical specialists in rural and regional areas.

The program provides funding by subsidising travel and training costs which enables rural specialists to access high-quality, context-specific training that is often unavailable locally, gaining advanced skills that are immediately applicable within their regional health services as well as remain connected to professional networks.

The success of the program is evident, recent data has shown:

- increased confidence and willingness to remain in rural practice with **85.5% of participants highly likely to remain in a regional, rural, or remote area.**
- improvements in clinical capability in high-risk, low-support environments with **over 96% of applicants indicating that the program has improved their skills and competencies required to work in rural and remote areas.**
- better care for patients closer to home, with **over 99% saying the program enhanced the quality of the services they provide to their communities.**

Rapidly growing demand for the program and rising costs have significantly outpaced the static available funding, resulting in the majority of eligible applicants being unable to access support.

Since FY2023, the number of applicants has doubled, and is projected to reach nearly 700 specialists in FY2026. Despite this, annual funding has remained fixed at $800,000, meaning that **most eligible specialists are turned away.**

At current funding levels, SRSA can support only a small fraction of the rural specialists who seek assistance. The SRSA provides around 110 specialists per year with an average grant of $6,000 to attend out-of-region training. With demand projected to reach nearly 700 applicants by 2026, rising CPD costs, and stagnant funding of $800,000, roughly 82% of applicants are expected to miss out.

To meet projected demand and ensure equitable access to the proven benefits of SRSA, **annual funding for the SRSA program should be increased by $1.2 million**, bringing total funding to $2 million per year.

This would allow the program to support approximately **50% of eligible applicants**, significantly strengthening workforce stability in areas where access to specialist care is already fragile.

This is a modest investment with an immediate and measurable impact. Retaining an experienced rural specialist avoids the far higher costs associated with locums, service closures, patient transfers, and emergency care, while preserving continuity and quality of care for local communities.

EXPECTED OUTCOMES

Increasing SRSA funding to $2 million per year will:

- support around **350 rural, regional, and remote specialists annually**
- improve retention of specialists in high-need locations
- strengthen local service capability and continuity of care
- Improve clinical outcomes in isolated communities and reduce rural health inequities
- reduce reliance on short-term, high-cost workforce fixes such as locums
- improve access to high-quality specialist care closer to home.

Solution 4: Plan the workforce nationally to deliver access to specialists locally

ESTABLISH A JOINT NATIONAL WORKFORCE PLANNING MECHANISM

Specialist workforce planning decisions are mostly made through separate, uncoordinated processes by individual governments, specialist medical colleges, universities, communities, and employers. There is no formal, ongoing national workforce planning mechanism that brings key stakeholders together to jointly plan trainee numbers, training locations, or priority specialties across the country. To date, specialist workforce planning has largely occurred at the state and territory level with only ad hoc input from specialist medical colleges.

When these decisions are made in isolation, the result is:

- decisions are often driven by short-term pressures rather than long-term need
- training capacity is concentrated in metropolitan hospitals
- mismatches persist between workforce supply and community demand leading to shortages emerging in certain specialties and regions
- access gaps for patients persist or worsen.

The Commonwealth's development of a national health workforce strategy requires a structured mechanism that brings together those who fund, train, select, and employ specialists to ensure workforce planning will meet the future needs of all Australians. It must be underpinned by an ongoing, coordinated planning process that meaningfully involves the key stakeholders in its development, implementation, and regular review processes to ensure it remains responsive to workforce needs over time.

To improve access to specialist care, particularly outside major cities, workforce planning must move to a single nationally coordinated planning mechanism.

A joint national specialist workforce planning mechanism is needed, led by the Commonwealth and involving state and territory governments, specialist medical colleges, universities, communities and other key stakeholders. This mechanism would support regular and structured planning to align funding decisions, training capacity and workforce need.

Without this coordination, there is a real risk that government investment will not translate into improved access for patients resulting in:

- **misalignment between funding and training pathways.** Funding may be allocated to training positions that cannot be supported or accredited, and trainees may be selected for programs without available employment pathways
- **rural and regional objectives failing.** Colleges play a central role in accrediting rural training sites and shaping training models. Government investment in infrastructure,

supervision and other supports is needed to support rural training. Without the expertise of specialists with practical knowledge of training requirements, rural pipelines are unlikely to be viable or sustainable.

- **implementation risks to the National Workforce Strategy.** A plan developed without those responsible and accountable for delivery is harder to implement, monitor and adapt. These risks lead to inefficiency, wasted investment and continued reliance on short-term workforce fixes.

A coordinated national workforce planning mechanism allows emerging shortages to be identified early, training capacity to be adjusted before gaps become entrenched, and rural and regional pathways to be strengthened in a deliberate and sustainable way. This reduces implementation risk and increases confidence that investment will deliver real-world access improvements.

A genuinely collaborative approach treats Australia's specialist workforce as a single national system rather than a collection of jurisdiction-based silos. This improves alignment between supply and demand, reduces duplication, and supports a stable specialist workforce capable of delivering equitable access to high-quality care across the country.

EXPECTED OUTCOMES

A joint national workforce planning mechanism will:

- outline the specialist workforce need and distribution across Australia
- align training funding with workforce need across Australia
- strengthen rural and regional specialist pipelines
- reduce inefficiency and implementation risk
- improve patient access to specialist care across Australia.

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