Keep the people you have: leading health systems through the workforce squeeze

What Health Service Leaders across Australia, New Zealand and the Asia Pacific told us in Cairns about retention, planning from need, belonging, integrated care and AI, and what health services can do next.

ACHSM Asia Pacific Health Leadership Congress · Cairns Convention Centre, 28 to 30 October 2026

EXECUTIVE SUMMARY

Thirteen sessions, one consistent message: health systems cannot digitise or restructure their way out of a workforce problem. The services making progress asked their people what was wrong and built fairer, more transparent systems around the answers. Speakers also reminded us that funding cycles are far shorter than the timeframes over which disease burden and community health need evolve, and that planning, innovation and policy need to bridge that gap.

It was a privilege to be part of a community that came together so openly to talk about where the health system is heading, the challenges we face today and those still ahead. This paper groups what we heard into five themes, grounded in the outcomes and evidence shared on stage.

1. **Retention is a design choice**
   Listening, fair allocation and longitudinal rural pathways
2. **Plan from need, not from history**
   Population based planning and intellectual authority
3. **Belonging is a workforce strategy**
   Connection, generations and the positive duty
4. **Integration where it matters**
   Partnerships, First Nations leadership and data sharing
5. **AI is changing scope of practice**
   Trust, governance and how Clinicians learn

THE NUMBERS THAT FRAMED THE CONGRESS

49% → 88%
Junior Doctor retention at a Territory Tertiary Hospital over two years, after asking Doctors why they were leaving[1]

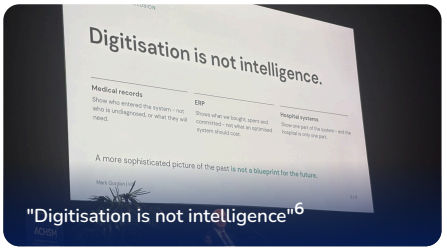
47.1% vs 2%
Doctors who became regional Senior Medical Officers after more than a year of rural mid career work, versus under six months[2]

11 million
Projected global shortfall of Health Workers by 2030[3]

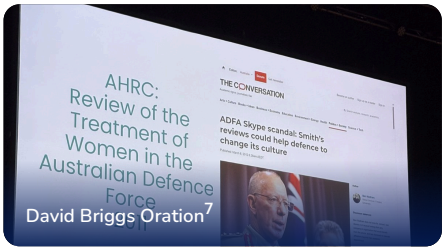
62 million
Healthdirect Australia interactions with the community in FY25, as Consumers increasingly ask AI first[4]

FROM THE PLENARY HALL


Digital health panel, Plenary 4[5]



"Digitisation is not intelligence"[6]



David Briggs Oration[7]

THEME ONE

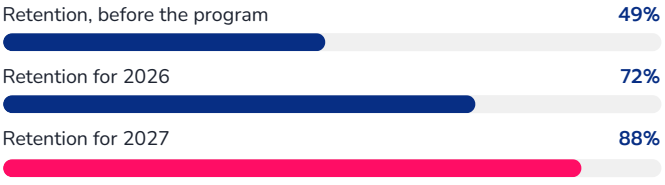
1 Retention is a design choice

The Federal Health Minister opened the congress by naming the shortage of Health Workers as one of the biggest challenges facing the system.[8] Globally the projected shortfall is 11 million by 2030.[3] Locally, a large regional Queensland service reported one in six job ads going unfilled and a vacancy rate that rose from 7.2% in 2019 to 12%.[9] The services turning this around did not wait for supply to improve. They redesigned how Doctors are allocated, supported and kept.

Case study: ask your Doctors, then fix what they tell you

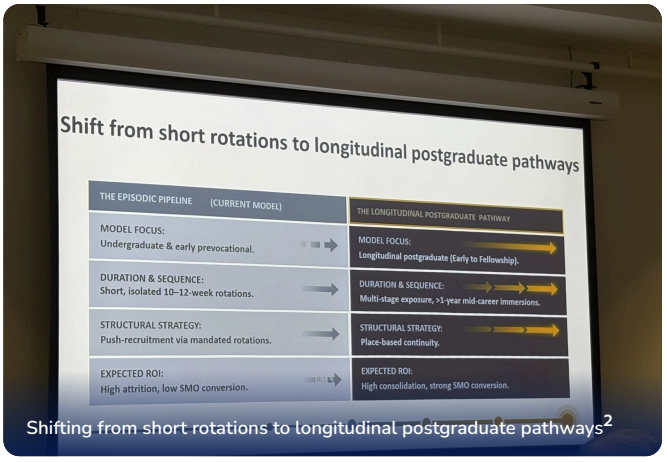
A Territory Tertiary Hospital was losing about half its Interns and Residents every year and filling a 20% vacancy rate with Locums costing more than double a contracted Doctor.[1] Trainees loved the work and the lifestyle but could not see how their careers would progress. The response:

- Restructured allocations around GP and rural generalist pathways: 50% of Trainees wanted these careers, against 18% nationally
- Mapped every term to college prerequisites, published allocation rules and waitlists, and prioritised Territory trained Doctors
- Protected a daily urgent pages only teaching hour, approved leave in the first round and offered part time options
- Recruited ahead of known mid year attrition, and closed the loop: "this is what you told us, this is what we did"



Applicants rose 20% for 2026 and a further 34% for 2027, with an estimated $4 million saved in Locum salaries and no full term vacancies forecast.[1]

> "Ask your Doctors. They will usually know the problems, and they often know the solutions as well."
>
> Medical Administration Registrar, Territory Tertiary Hospital



Shifting from short rotations to longitudinal postgraduate pathways[2]

Continuity, not short rotations, builds the rural senior workforce

Twelve years of payroll records for 1,259 Medical Officers in two Queensland rural health services showed a dose response pattern.[2] Only 6.4% of Doctors employed at a single career stage became Senior Medical Officers there, rising to 18.8% with early plus later career exposure. After more than a year of rural mid career employment, 47.1% converted, against about 2% for stays under six months. National data points the same way: 78.4% of Doctors who spent over 40% of postgraduate training rurally went on to work rurally, versus 10.4% of those with 10% or less.[10]

> "Those interruptions can mean that those Doctors don't stay and work with us as SMOs."
>
> Executive Director, Medical Training Pathways, Queensland

What Leaders can do now[1,2]

Ask | Allocate fairly | Anchor locally | Track

Run structured "why are you leaving" conversations, publish transparent allocation rules, base rural training locally with placements longer than a year, and track your own payroll data by career stage to measure conversion to senior roles.

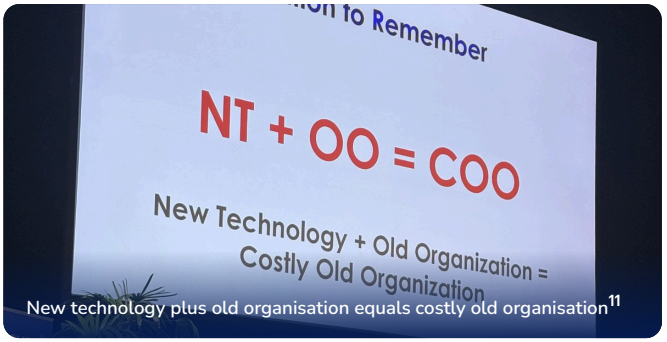
THEME TWO

2 Plan from need, not from history

The opening international keynote argued that health systems everywhere plan from what they already have: beds, staff and last year's budget plus inflation. More money, restructures and digital programs keep failing for that reason.[6] The alternative he proposed is a "mission control" approach, a term borrowed from military command and drawing on his own service as a former British Army Officer: start with the epidemiology of your own population, design clinically optimised pathways, then derive the activity, workforce, beds and capital needed, and test it all openly. Managers are being asked to make 10 to 20 year decisions inside 12 month budget cycles.[6]

> "Activity is too often confused with achievement, expenditure with investment, and organisational change with improvement."
>
> International Keynote Speaker, Health System Intelligence

His closing challenge: reclaim intellectual authority from external Advisers and Funders by telling them, with evidence, what your population needs. "Historical utilisation is not healthcare need."[6]



New technology plus old organisation equals costly old organisation[11]

Leadership capability is part of the plan

The College President urged Leaders to treat their own development as protected time, not something deferred for the next urgent meeting, and announced two new ACHSM programs for early and mid career Managers.[8] The same point came from the digital stream: technology layered onto an unchanged organisation simply produces a more expensive version of the old one.[11]

> "Leadership is about not having all the answers."
>
> College President, ACHSM

THEME THREE

3 Belonging is a workforce strategy

A leading social researcher described social isolation as the number one public health issue in contemporary Australia, citing research that 51% of adults are socially isolated or lonely, and about 28% of households now contain one person.[12] For staff who relocate or rotate for work, belonging is a retention factor, not a nice to have.

> "We don't really know who we are until we know where we belong."
>
> Social Researcher and Author, Plenary Keynote

Five generations now work side by side, including a Nurse Educator over 90 in one Queensland service. Its intergenerational training, built on mixed age teams, mentoring, shared language, flexibility and choice, and explaining why, was rated 4.85 out of 5.[9,13]

1,200
Members in the SA Health Young Professionals Group, run on a $16,000 annual conference budget, with over 95% recommending its events[14]

46th → 8th
Australia's global gender gap ranking, 2016 to 2026, after the positive duty reforms[7,15]

The David Briggs Oration reminded Leaders that since December 2022 every employer has a positive duty to prevent sexual harassment and discrimination, shifting organisations from responding to complaints to preventing harm. Boards should expect reporting on prevention, not just individual cases.[7,16]

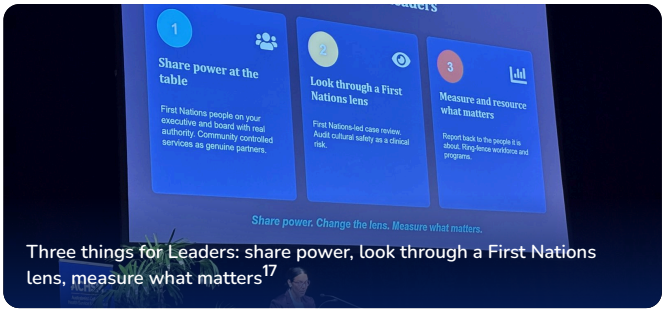
> "It isn't time that inevitably leads to change. It is action, and it is people taking the actions, that causes the change."
>
> David Briggs Orator, Former Sex Discrimination Commissioner

THEME FOUR

4 Integration where it matters

The integrated care panel argued that integration has stalled for 20 years because of short government cycles, fragmented funding, 12 month contracts and poor information exchange.[17] Their advice was to drop the "utopian" view and target integration where patient volume and pain points are highest, to write collaboration into commissioning contracts, and to shift decision making to First Nations leadership for services First Nations communities use. Only 4 of 15 Closing the Gap socio economic targets are on track.[18]

> "Without interoperability, without quality data, without sharing agreements in place, we just can't get really good integration, either at a system level or at an individual care level."
>
> CEO, Northern Queensland Primary Health Network



Three things for Leaders: share power, look through a First Nations lens, measure what matters[17]

Partnerships that survive turnover

A partnering roundtable described five levels of partnership, from transactional to ecosystem. Delegates estimated about half of proposed mergers never happen, usually because trust breaks down, while successful ones consolidate payroll, email and core systems in the first 18 months. One virtual paediatric partnership moved local Paediatricians from a 1 in 2 to a 1 in 5 on call roster.[19]

> "Healthcare leadership at the moment is like trying to assemble a 3D puzzle where the pieces change size all the time, and the picture on the box seems to change every election cycle."
>
> Executive Director, Performance Improvement, KordaMentha

THEME FIVE

5 AI is changing scope of practice

The international digital health keynote framed AI as a scope of practice change, similar to Nurses moving to top of licence 15 to 20 years ago. AI is already embedded in operations and moving into clinical decision support.[11] In Asia Pacific, 46% of organisations started AI adoption programs in the past 12 months and 81% report using generative AI.[20]

> "In the end, this is not a technology question. This is people, process and technology. The technology is going to be the easy part."
>
> President and CEO, HIMSS

The panel that followed warned that generative tools are being used by Consumers and Clinicians outside any governance. Healthdirect Australia handled 4.1 million calls and 62 million interactions in FY25, and its CEO warned that unless health meets Consumers on AI now, the system risks being seen as an obstacle rather than an authority.[4,5]



Plenary 4: Disrupt or be disrupted[5]

Protect how Junior Clinicians learn

Panellists urged Leaders to govern AI by type, monitor it continuously, and train staff on bias and automation bias, the documented tendency to follow wrong computer advice.[5,21] As AI automates notes and synthesis, deliberate supervision and feedback matter more, not less.

> "We have to remember all these professions are apprenticeships and we learn through osmosis."
>
> Health Informatics Professor, University of Sydney

FROM INSIGHT TO ACTION

How Med App helps health services act on these themes

Most of the retention wins we heard about in Cairns were built by hand, with spreadsheets, emails and determined people. Med App turns them into systems. Used by 65+ hospitals across Australia, New Zealand, Ireland and the UK, it works alongside the EMR, rostering and HR systems rather than replacing them.

THEME	WHAT WE HEARD	MED APP CAPABILITY	EVIDENCE
1 Retention	Doctors stay when allocation is transparent, preferences are heard and rural time is continuous rather than episodic.	Preferences and Allocations: in app preference collection, rules for prerequisite terms, local priority and waitlists, and AI assisted allocation; pulse surveys to close the "you said, we did" loop.	**Up to 5 weeks saved on allocation; 34% improvement in Junior Clinician return rates**
2 Planning from need	Workforce plans built on establishment numbers miss who is ready, where they want to work and what they need.	Allocation, preference and competency data that shows supply and readiness by site and career stage; inbuilt reporting and benchmarking across 65+ hospitals.	**One click accreditation reporting; ~0.3 FTE saved on accreditation prep**
3 Belonging and culture	New and rotating staff need to be welcomed, included and clear on expectations, including the positive duty.	Journeys: automated onboarding and orientation tracks by role and location, with acknowledgements and approvals; Announcements for short updates; wellbeing tools and EAP access.	**88% completion of mandatory orientation and policy acknowledgement**
4 Integration	Staff moving between sites and partners need the same local information and agreed pathways.	Network wide broadcast across sites; MedGuidance for shared local protocols and referral pathways on mobile, offline; contacts and rosters in one app.	**Up to 6× faster protocol access at the point of care**
5 AI and scope of practice	Scope is shifting, AI guidance changes constantly and Junior Clinicians still learn as apprentices.	AMC accredited Workplace Based Assessment and multi source feedback with supervisor sign off across sites; Journeys and Announcements to push updated guidance and required acknowledgements.	**15 to 23 minutes saved per assessment; 80% read rate vs ~5.3% for email**

See it running in your health service

A 30 minute live tour maps Med App to your retention, onboarding and training priorities.

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med.app

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Synthesised from ACHSM 2026 session notes, transcripts and photographs captured by MedApps. Quotes attributed by role. Figures are as presented by Speakers unless a published source is cited, and have not been independently audited.