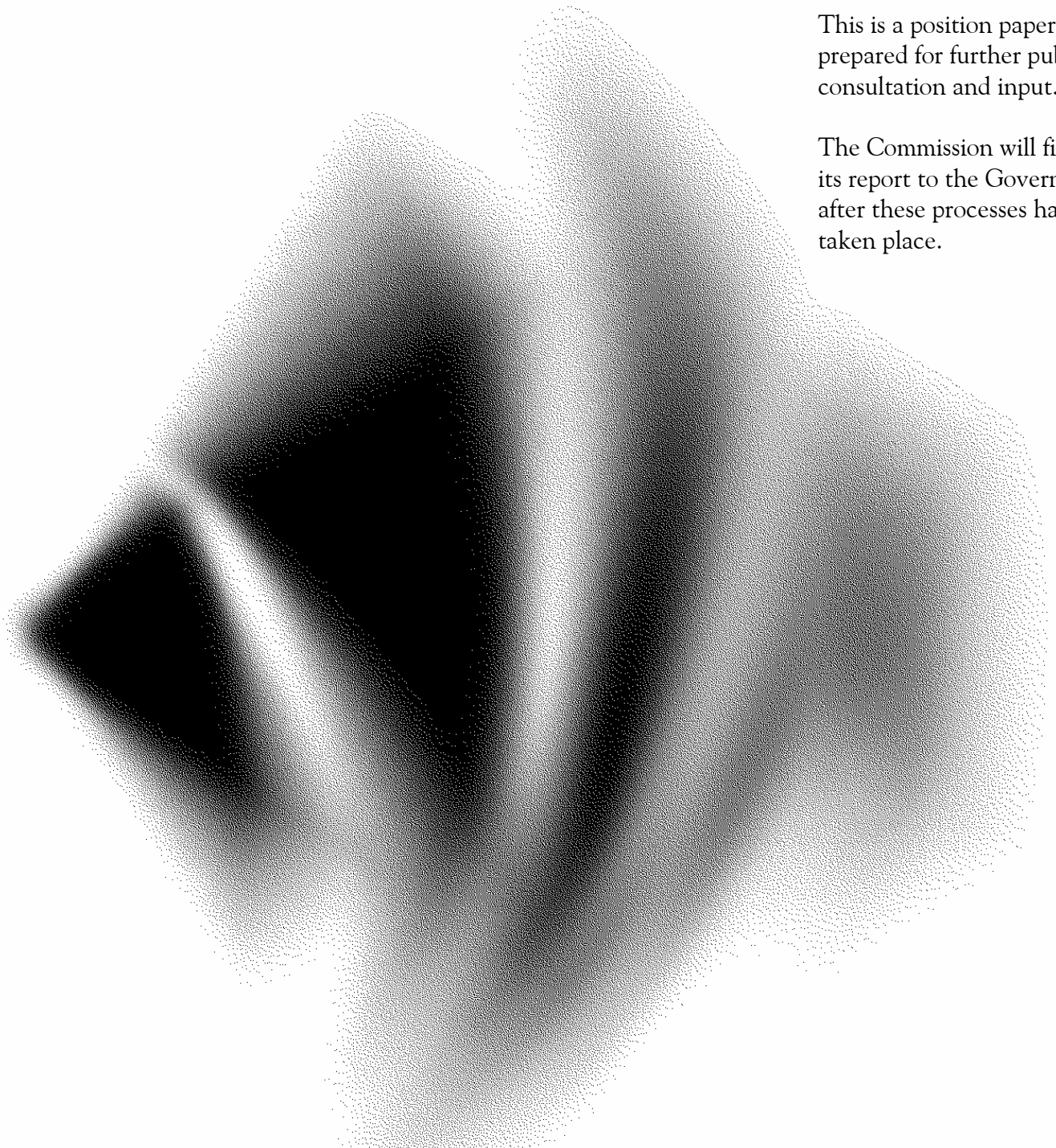
Australian Government
Productivity Commission

Australia's Health Workforce

Productivity Commission Position Paper



This is a position paper prepared for further public consultation and input.

The Commission will finalise its report to the Government after these processes have taken place.

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The Productivity Commission

The Productivity Commission, an independent agency, is the Australian Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Information on the Productivity Commission, its publications and its current work program can be found on the World Wide Web at www.pc.gov.au or by contacting Media and Publications on (03) 9653 2244.

Opportunity for further comment

You are invited to examine this Position Paper and to provide written submissions to the Commission. While you are welcome to comment on any aspects of the Position Paper, the Commission would appreciate a focus on its draft proposals.

Written submissions should reach the Commission by **Friday 11 November 2005**.

In addition, the Commission intends to hold a limited number of roundtables to obtain feedback on the draft proposals contained in this paper.

The Commission intends to present its final report to Government by the end of this year.

Terms of reference

PRODUCTIVITY COMMISSION ACT 1998

The Productivity Commission is requested to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals, and propose solutions to ensure the continued delivery of quality health care over the next 10 years. The study is to be undertaken in the context of the need for efficient and effective delivery of health services in an environment of demographic change, technological advances and rising health costs.

In undertaking the study, the Productivity Commission will have regard to the National Health Workforce Strategic Framework and other relevant bodies of research.

Background

Australian governments agree that the success with which health services are delivered across the nation is advanced through the commitment, care and professionalism of the Australian health workforce.

Accordingly, on 25 June 2004, the Council of Australian Governments (COAG) agreed to commission a paper on health workforce issues, including supply and demand pressures over the next 10 years. COAG also agreed that the paper should address the issue of general practitioners in or near hospitals on weekends and after hours.

For the purpose of this study, 'health workforce professional' includes the entire health workforce, from those trained in the vocational education and training (VET) sector to medical specialists. The education and training sector includes vocational, tertiary, post-tertiary and clinical education and training.

COAG Resolution

COAG agreed:

> "**HEALTH**
>
> COAG today discussed the issue of health and reiterated the importance of moving ahead on improving health services.

COAG agreed to commission a paper on health workforce issues, including supply and demand pressures over the next 10 years. The paper will take a broad, whole-of-government perspective, including health and education considerations, and will cover the full range of health workforce professionals. In considering these issues, the paper will look at the particular health workforce needs of rural areas.

It was also agreed that the paper will address the issue of general practitioners in or near hospitals on weekends and after hours.

This paper will be considered by COAG within 12 months."

Scope

In reporting on Australia's health workforce, the Productivity Commission should:

1. Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention, including:

(a) the effectiveness of relevant government programmes and linkages between health service planning and health workforce planning;

(b) the extent to which there is cohesion and there are common goals across organisations and sectors in relation to health workforce education and training, and appropriate accountability frameworks;

(c) the supply, attractiveness and effectiveness of workforce preparation through VET, undergraduate and postgraduate education and curriculum, including clinical training, and the impact of this preparation on workforce supply;

(d) workforce participation, including access to the professions, net returns to individuals, professional mobility, occupational re-entry, and skills portability and recognition;

(e) workforce satisfaction, including occupational attractiveness, workplace pressure, practices and hours of work; and

(f) the productivity of the health workforce and the scope for productivity enhancements.

2. Consider the structure and distribution of the health workforce and its consequential efficiency and effectiveness, including:

(a) workforce structure, skills mix and responsibilities, including evolving health workforce roles and redesign, and the flexibility, capacity, efficiency and effectiveness of the health workforce to address current and emerging health needs, including indigenous health;

(b) analysis of data on current expenditure and supply of clinical and non-clinical health workers, including the development of benchmarks against which to measure future workforce trends and expenditure; and

(c) the distribution of the health workforce, including the specific health workforce needs of rural, remote and outer metropolitan areas and across the public and private sectors.

3. Consider the factors affecting demand for services provided by health workforce professionals, including:

(a) distribution of the population and demographic trends, including that of indigenous Australians;

(b) likely future pattern of demand for services, including the impact of technology on diagnostic and health services; and

(c) relationship between local and international supply of the health workforce.

4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term, including:

(a) practical, financially-responsible sectoral (health, and education and training) and regulatory measures to improve recruitment, retention and skills-mix within the next ten years; and

(b) ongoing data needs to provide for future workforce planning, including measures to improve the transparency and reliability of data on health workforce expenditure and participation, and its composite parts.

In doing so, the paper should take into account existing Australian research and overseas developments that have demonstrated success in providing a flexible response to emerging trends.

5. Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.

6. Consult widely, including with peak industry, representative and community organisations, and relevant government agencies and public authorities.

7. The Commission is to produce an issues paper by 31 May 2005, provide a draft report, and produce a final report by 28 February 2006.

PETER COSTELLO

[received 15 March 2005]

Foreword

Australia's health care depends heavily on the commitment and skills of a health workforce of nearly half a million people and a large group of volunteers.

Many of the arrangements under which the workforce operates are under significant pressure, as are the health workers themselves. The headline indicator of these pressures is a workforce shortage across many professions, particularly in outer metropolitan, rural and remote areas. And these pressures are expected to intensify in the years to come. In response, Governments and other stakeholders have been initiating a range of changes, but further well designed and targeted reform is needed.

One of the challenges facing the Commission is that this isn't an inquiry into health care and its funding, and yet the efficiency and effectiveness of the health workforce is inextricably linked to that broader system, and to Australia's education and training regime. In addition, there are many detailed workforce-related initiatives that may well be helpful in improving outcomes in discrete areas of the health care system, but the Commission has neither the time nor the clinical expertise to assess them. The complexity and interdependency of health workforce arrangements presents its own challenge.

In undertaking this study, the Commission has focused on identifying potential areas for reform that will produce more sustainable and responsive health workforce arrangements. It has proposed a coherent set of improvements to the operation and interaction of the many institutions, processes, regulations and funding mechanisms so as to overcome some systemic impediments to more specific reform measures.

The Commission has been amply assisted through the many discussions with, and the nearly 180 detailed and thoughtful submissions from, participants. However, the very late lodgement of some key submissions has limited its capacity to fully consider them in preparing this Position Paper.

In releasing this Paper, we invite interested parties to identify any significant omissions or shortcomings in the evidence presented to us or in our analysis and lines of argument. Given the complexity of the issues being addressed, and the

strongly held views as reflected in the submissions, we look forward to a rigorous critique of the preliminary assessments contained in the Paper.

Finally, we acknowledge the significant contribution of our colleague, Helen Owens, to the early stages of this study.

Mike Woods (Commissioner) Robert Fitzgerald (Commissioner)

21 September 2005

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Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHWAC	Australian Health Workforce Advisory Committee
AHWOC	Australian Health Workforce Officials Committee
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
CoAG	Council of Australian Governments
DEST	Department of Education, Science and Training
DOHA	Department of Health and Ageing
GP	general practitioner
GPET	General Practice Education and Training
JWPG	Jurisdictional Workforce Planners Group
MBS	Medical Benefits Schedule
NHWSF	National Health Workforce Strategic Framework
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
VET	Vocational Education and Training

POSITION PAPER — SUMMARY

Key points

- There are considerable pressures on Australia's health workforce — as evidenced by shortages of supply in some professions, particularly (but not only) outside the major population centres, and a significant reliance on overseas trained professionals.
- In the future, ageing of the population will compound the impacts of other factors that will increase demand for health workforce services.
- Initiatives to boost the numbers of education and training places will be an important part of the response to both current shortages and increased future demand for health workers.
- But there is also scope and need to increase the productivity and effectiveness of the available health workforce and to reduce its maldistribution. Addressing a range of systemic impediments will enhance the capacity of the workforce to respond in an efficient and timely manner to the challenges of the future.
- Some of the Commission's proposals seek to overcome distortions and better align incentives for those using and providing health workforce services. Others seek to address the fragmentation, poor coordination, inflexibility and entrenched workplace behaviours in the current arrangements, through consolidating a number of entities and/or functions within more responsive, accountable and transparent national bodies or regimes.
  - Importantly, both types of changes have the objective of promoting an integrated approach across individual health professions to policy formulation and the delivery of services.
- Amongst other things, the Commission's proposed reforms are designed to:
  - facilitate major health workforce innovations on a national, systematic and timetabled basis through the introduction of an advisory health workforce improvement agency;
  - promote more responsive education and training arrangements, including through the creation of an independent council to assess new health workforce education and training models, and greater transparency and contestability of funding for clinical training;
  - lend further impetus to integrated workplace reform, as well as provide a basis for nationally uniform registration standards, through staged introduction of a single national accreditation regime and agency;
  - encourage complementary reform of registration arrangements, including improving the operation of mutual recognition as it applies to health workers; and
  - improve funding-related incentives for workforce change through transparent evaluation of requests to extend the coverage of the MBS to new services and professional groups by a more broadly-based and independent assessment body, and through progressive introduction of (discounted) MBS rebates for a wider range of delegated services.
- Those living in outer metropolitan, rural and remote areas and Indigenous communities, and others with special needs, would benefit from these system-wide initiatives.
  - However, further specific initiatives are required to ensure that the requirements of these groups are adequately met, and to understand better what approaches are most effective in improving health workforce outcomes in these areas.

Summary

Australia's health system has many strengths. Overall health outcomes compare quite favourably with those in other developed countries. Yet total spending on health care as a percentage of GDP and per capita is not overly high by advanced OECD country standards. Further, the system has responded to growing financial pressure and changing community health needs.

However, the sustainability of the system is under increasing pressure in various respects. There are poor health outcomes for particular groups in the community and difficulties in accessing services for some care needs and in some parts of Australia — including outer metropolitan, rural and remote areas. Workforce shortages are contributing to these problems.

Moreover, in coming years, an ageing population will add to the already strong demand and cost pressures arising from growth in income and consumer expectations and advances in medical technology. There are also likely to be significant changes in the types of care required.

Training more health workers, and drawing on suitably skilled overseas trained workers, will be part of the solution to current shortages and future demand growth. So too, will be initiatives to improve the health of the population and thereby moderate growth in demand for care services. In addition, measures which increase rates of retention and re-entry to the health workforce have an important role to play in boosting supply. In this respect, job satisfaction is an important issue.

But though important, such approaches will not be enough:

- The impacts of population ageing on labour supply will make it more costly to recruit sufficient numbers of new health workers to match growing demand.
- Recruitment of overseas trained health workers is also expected to become more difficult.
- Total health care expenditure, and the contribution by governments to it, will continue to increase as a proportion of GDP.

To cope with this potent set of demand, supply and financial pressures, Australia will also need to look at ways of improving the efficiency and effectiveness of its

health workforce and the responsiveness of that workforce to changing health care needs.

This research study, which was requested by the Australian Government in March 2005 in response to a decision by CoAG in mid-2004, provides an opportunity to review health workforce issues in this wider context. Essentially, the study examines: factors affecting the future supply of, and demand for, health workers; the efficiency with which the available workforce is deployed; and what health workforce measures might be taken to ensure the continued delivery of quality health care.

Many of the changes required to improve health workforce arrangements could only occur as part of broader health policy reform, including to the funding of health care in Australia. However, this is not the task currently before the Commission. Nor does the Commission profess expertise in relation to specific professional areas or matters of clinical judgment. It has not, therefore, come to a view on the merits of particular initiatives such as expanded roles for physiotherapists, pharmacists or enrolled nurses, or the respective contributions of generalist specialists, procedural generalists, paramedics or rural health workers in rural and remote areas.

The Commission has, instead, focused on both improving the incentives to which health workers respond and on creating more effective frameworks and processes within which specific workforce initiatives can be developed and implemented.

The study is occurring in parallel with a review by CoAG Senior Officials of ways to improve Australia's health care system. Both exercises are to be completed by December of this year, with the reporting date for this study brought forward by two months to enable such synchronisation.

The context for future workforce policy

The level of demand for health care

The level of 'underlying' demand for health care services cannot be readily determined. In part, this is because the signals which consumers respond to are heavily distorted — not least by the fact that governments meet the bulk of care costs.

Currently, aggregate annual expenditure on health care exceeds $70 billion and is growing rapidly. Over the last decade, annual real growth in spending has averaged 4.5 per cent, significantly higher than population growth of 1.2 per cent, and the ratio of health expenditure to GDP has increased from 8.2 per cent to 9.5 per cent.

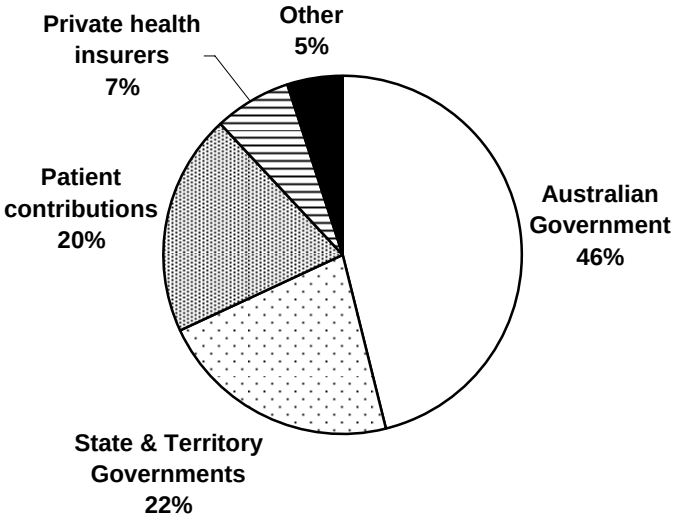
Although it is difficult to be precise, expenditure on health workforce services currently accounts for about two-thirds of total spending.

The role of governments in the health workforce

The health workforce is heavily shaped by government intervention.

- In seeking to promote equitable access to health care services and health workers, the Australian Government funds 46 per cent ($33 billion in 2002-03) and the States and Territories 22 per cent ($15 billion) of total health expenditure (see figure 1). For the States and Territories, health represents about one-quarter of their annual spending.

Figure 1 **Sources of funding for health care**



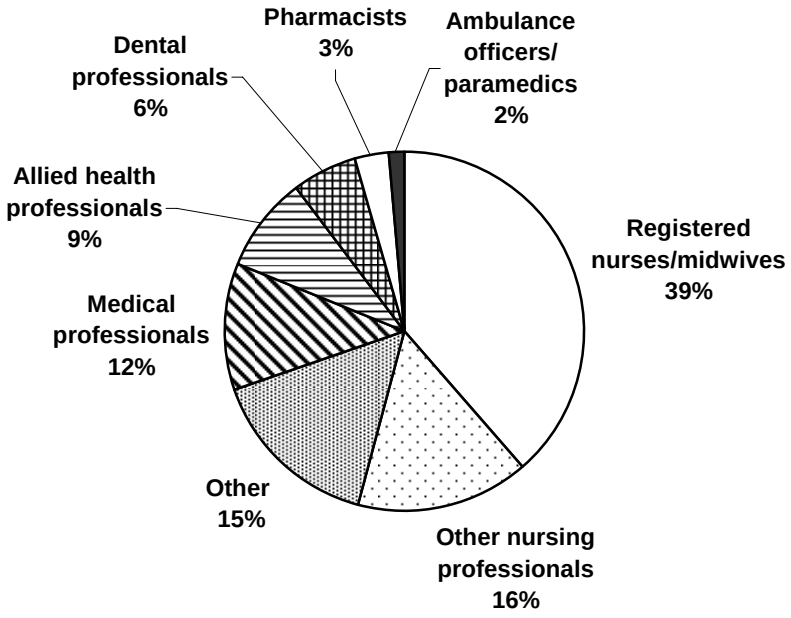
- To assist in their broader planning of health care and future workforce requirements, governments engage in various projections of numbers of health workers likely to be required in the future.
- For safety and quality reasons, health workforce services are closely regulated.
- And in common with other sectors of the workforce:
  - the cost of educating and training health workers is heavily subsidised by governments through the university and VET systems; and

– there is public sector involvement in determining the structure and content of some education and training courses for health workers.

The workforce in overview

There are around 450 000 paid health professionals in Australia, of whom just over 350 000 are employed in health service industries. More than 50 per cent of these professionals are nurses, with medical practitioners and allied health professionals (such as physiotherapists and podiatrists) accounting for a further 12 per cent and 9 per cent respectively (see figure 2). There is also a sizeable volunteer workforce.

Figure 2 **Health occupation shares**



Between 1996 and 2001 — the latest period for which data are available — the number of health professionals increased by over 11 per cent, nearly double the growth rate of the population. Over that period, the numbers of allied and complementary health workers grew by more than 25 per cent (see table 1).

However, in some areas of the health workforce, reductions in average hours worked per person have partly offset this growth in overall numbers. For example, between 1996 and 2003, average hours worked by medical practitioners declined from 48.1 to 44.4 hours a week. As in other parts of the economy, such declines in average working hours primarily reflect the ageing of the health workforce and growth in the number of those wishing to work on a part time basis. But in areas such as medicine and dentistry, an increase in the share of female practitioners —

who typically work fewer hours than their male counterparts — has also played a role. There is also a significant number of trained health workers who do not work in the sector.

Table 1 **Increases in the numbers of health workers**

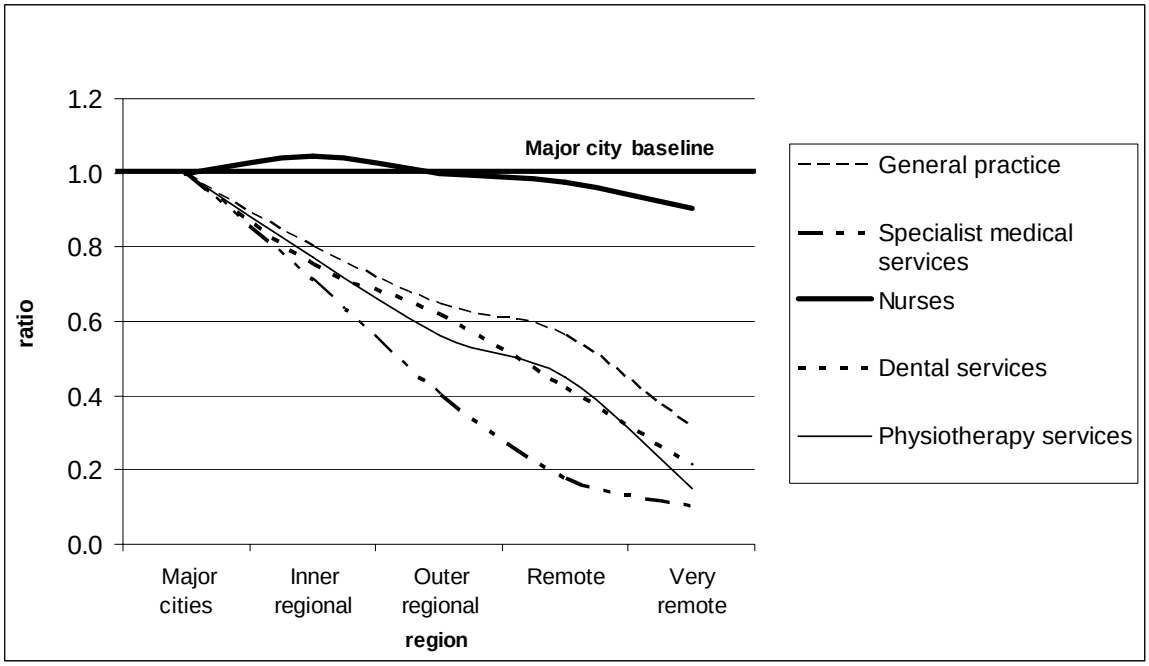
	Number of workers in 2001	*Proportion of health workforce*	*Percentage change between 1996 and 2001*
	'000	per cent	
Registered nurses/midwives	174	38.7	7.3
Enrolled nurses	19	4.3	2.7
Nursing assistants/ personal carers	51	11.2	18.8
Medical professionals	52	11.5	12.6
Dentists	8	1.9	7.9
Dental technicians/assistants	18	3.9	12.5
Pharmacists	14	3.0	13.0
Allied health workers	39	8.6	26.5
Complementary health workers	9	1.9	29.6
Medical imaging workers	8	1.8	25.0
Medical scientists	11	2.6	16.8
Ambulance officers/paramedics	7	1.5	12.5
Other	41	9.1	30.2
Total	450	100	11.4

Aside from the nursing occupations, a disproportionate share of health workers practise in the major cities and regional centres (see figure 3). Moreover, this disparity appears to have been increasing as a result of greater specialisation in some of the professions, and the larger patient base which this requires. As discussed below, access to health workers in rural and remote Australia, and in Indigenous communities, is a major concern, as it is in some outer metropolitan areas.

The health system has become increasingly reliant on medical practitioners trained in other countries. Overseas trained doctors now make up some 25 per cent of the overall medical workforce compared with 19 per cent a decade ago.

Although a variety of models of care have always been used to meet the diverse needs of patients, the mix and nature of those models has been changing. For example, scopes of practice have widened in some professional areas. Technological developments have enabled greater provision of 'arms length care' at home or in more remote areas. And there has been a growing focus on multi-disciplinary teams, particularly in relation to the provision of chronic care.

Figure 3 **Practitioner to population ratios relative to major city levels**



Current shortages

Identifying 'shortages' in workforce supply is not straightforward, especially given the difficulty of establishing underlying health care demand. Nonetheless, shortages in important parts of the health workforce have been widely documented (box 1).

Even for professions where overall workforce demand and supply are more in balance, shortages continue to be evident in outer metropolitan and rural and remote areas and in Indigenous communities. GPs, obstetricians/gynaecologists, pathologists and a variety of allied health professions are frequently mentioned in this context.

The pressures will increase

There have been many recent initiatives by governments, professional groups, education and training entities and local communities to address these shortages and to improve the efficiency and effectiveness of health workforce arrangements. And, as elaborated below, the health workforce system has demonstrated significant capacity for adjustment.

However, health workforce policy will not only need to address the current shortages, some of which may in fact be cyclical in nature. More importantly, it

must confront a range of longer term, and largely structural, demand and supply pressures and a range of institutional impediments which, if not addressed, will limit the responsiveness of the workforce to those pressures.

Box 1 **Widespread shortages of health workers**

In recent years, the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) have identified:

- sizeable shortfalls in some medical specialties such as thoracic medicine, and medical oncology and haematology. By way of example, for thoracic medicine, the restoration of a 'balance' between demand and supply was projected to require an 85 per cent increase in training places, equivalent to 3.5 per cent of the existing thoracic medicine workforce;
- smaller shortfalls in other specialties, including anaesthesia and radiology — for anaesthesia the 'required' increase in training places was projected to be 7 per cent, equivalent to 1.5 per cent of the existing workforce; and
- a shortfall of nurses of around 2.2 per cent by 2006, requiring an additional 4000 graduates (an increase of 40 per cent over projected graduate completions).

And the Department of Employment and Workplace Relations has identified shortages of dentists, pharmacists, and various allied health professionals, including occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists and sonographers.

Changes in the burden of disease

The health system and its workforce, a decade hence, will be dealing with a different mix of disease burdens. Various forecasts suggest, for example, that while there will be a significant decline in stroke victims, the health workforce will need to care for increasing numbers suffering Type II diabetes and dementia. In general, there will be a progressive orientation of care toward chronic conditions.

The health behaviours of the population are driving some of these changes, including an increase in the number of people who are overweight or obese. Many participants in this study have argued that a stronger emphasis on preventative health care is warranted, not only to improve the health status of Australians, but also as a means of containing the increase in demand for some care services.

Rising incomes and advances in technology

As incomes rise, people generally spend more on health care — and expect to be able to access a wider range of higher quality health services. Also, greater

availability of information on health care services (especially through the internet) will see consumers become more discerning, adding to their expectations.

Advances in technology will lead to the availability of new drugs and treatments, and to better quality care, thus providing the wherewithal for translating increased willingness to consume health care services into actual spending decisions. In its recently finalised study into the *Impacts of Advances in Medical Technology in Australia*, the Commission has estimated that over one third of the annual growth in Australia's real health care expenditure over the past decade or so has been attributable to technological change.

It is difficult to be precise about the likely impact of future technological advances on the demand for health workers. By expanding the range of treatment options, some advances will increase workforce demand. Others will reduce the number of workers required to provide a particular service, or the period for which care is provided. But what is clear is that most workforce-related technological change will require health workers to acquire new skills or provide care in different ways.

The compounding impact of ageing

By themselves, the impacts of income growth and technological change on demand for health care services might be reasonably manageable. That is, though growth in incomes stimulates demand, it also provides capacity to finance these higher expenditures.

However, in coming decades, ageing of the Australian population will add considerably to these other demand drivers. Older people typically require and consume more health services — spending on the over 65s is currently around four times more per person than on those under 65, and rises to six to nine times more for those over 85. Significantly, by 2045, more than one-quarter of Australians will be aged 65 years or more, double the present level. In its recent research report into the *Economic Implications of an Ageing Australia*, the Commission found that this changing age profile will significantly increase health expenditure, rather than simply delay the period late in life when health care needs are usually high (box 2).

Moreover, the increased incidence of chronic disease associated with population ageing will see more emphasis on team-based management of patients and the provision of care in residential aged care and community settings. The previously noted rise in non-age related chronic diseases associated with the greater prevalence of obesity and diabetes may reinforce this shift.

The supply of labour

The future costs of providing care and the way that care is provided will also be influenced by various pressures on the availability of health workers.

The average age of health workers is slowly increasing, with the rate of exits from many parts of the health workforce expected to rise in coming years. Service providers will be seeking to replace those workers, and to secure additional labour to meet accelerating demand, in an environment where growth in effective labour supply is expected to be slower than population growth.

Given the labour-intensive nature of many health services, there are likely to be sizeable wage-related cost pressures. While this will stimulate efforts to develop new models of care that economise on the use of health workers, in the face of strongly growing demand, more workers will be required.

Box 2 **Ageing and health expenditure**

Relative to income growth and technological change, population ageing has so far played a relatively minor role in the increase in per capita spending on health care in Australia.

However, in the future, it is expected to be a much stronger influence on expenditure levels, both in its own right and as it interacts with other pressures.

- As technology improves, more procedures can be performed safely on the elderly.
- Efforts to improve and extend the range of treatments tend to focus on areas where the disease burden is greatest and where the commercial payoffs will be highest — often conditions associated with ageing.

There is some debate about the significance of these impacts. Some argue that most health care costs will continue to be incurred in the last years of life, and that population ageing will therefore merely shift the timing of these high expenditures.

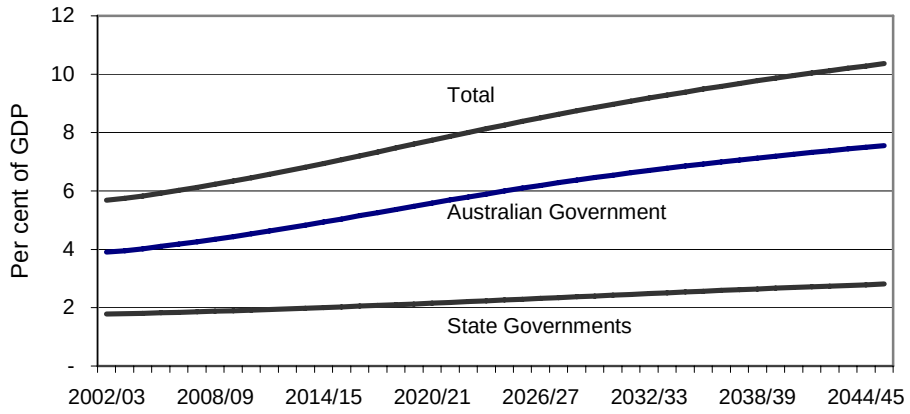
But after considering the available evidence, a recent report by the Commission on the economic implications of ageing concluded that:

- demand and technology are having a greater impact on per capita spending in the older age cohorts, suggesting that population ageing will compound the underlying growth in health expenditure arising from income growth and technology;
- foreseeable trends in disease prevalence and disability seem unlikely to alleviate the fiscal pressure associated with ageing; and
- available data support the view that costs rise with age rather than being largely concentrated at the end of life.

The fiscal upshot

In its recent report on the economic implications of ageing, the Commission projected that, under a 'business as usual' scenario, total health care expenditure could account for at least 16 cent of GDP by 2044-45. As governments between them currently fund two-thirds of all health costs, their fiscal burden would be at least 10 per cent of GDP (see figure 4).

Figure 4 **Projected future government spending on health care**



With many questioning the fiscal sustainability of such spending levels, the imperative to improve the efficiency and effectiveness of Australia's health care system is clear. Indeed, it is for this reason that boosting the numbers of education and training places for health workers to accommodate growing demand cannot be a *stand alone* response. That is, in helping to ensure that expenditure on health care remains fiscally sustainable, health workforce policy must also look for ways to improve the value that the community receives from spending on the workforce.

Impediments to a sustainable and responsive workforce

The complexity of health workforce arrangements

In common with the rest of the health care system and systems overseas, Australia's health workforce arrangements are extraordinarily complex and interdependent. Understanding how the various institutions, procedures, regulations and funding arrangements fit together, and what policies and programs apply in each area, is a major challenge in itself. For example:

- Both the Australian and State and Territory Governments are involved in all of the key parts of the health workforce system, and often at several levels.
- There are more than 20 bodies involved in accrediting health workforce education and training courses.
- There are over 90 boards that register health professionals.
- A host of professional bodies administer codes of conduct which complement formal regulation, or provide for self-regulation where statutory requirements do not apply.
- As well as funding for Medicare, public hospitals and the Pharmaceutical Benefits Scheme (PBS), both levels of government also fund a plethora of more specific programs designed to meet various health workforce objectives. Accompanying many of these programs are separate mechanisms to limit governments' budgetary exposure.

It would be very difficult to portray this complex system and its multitude of linkages in a single page flow chart. However, figures 6, 7 and 8 (see later) which depict just parts of the system, are illustrative.

The specialisation in functions across professions, jurisdictions and within governments that underpins these complex arrangements, will often have benefits. But it also renders effective policy formulation more difficult, particularly given the extensive interdependencies between different parts of the health workforce arrangements and growing overlaps in professional scopes of practice.

Reinforced by systemic factors

Reflecting this complexity and compounding its effects, are a range of systemic impediments to efficient, responsive and sustainable health workforce arrangements:

- *Fragmented roles and responsibilities:* The large number of entities involved in health workforce decision making, in conjunction with the division of responsibility across and within governments, results in conflicting objectives, cost and blame shifting and various other inefficiencies. It may also help to explain why health workforce policy has often been 'compartmentalised' by profession, even in circumstances when an integrated 'across-profession' approach is clearly called for.
- *Inadequate coordination mechanisms:* In such a fragmented system, effective coordination between governments, planners, educators, service providers, regulators and professional bodies will be difficult to achieve. Despite the need,

collaborative policy effort to improve coordination across the various parts of the system has often been lacking.

- *Inflexible and inconsistent regulation:* To ensure quality and safety, regulation will continue to be an integral part of the health workforce landscape. But current regulatory arrangements are often rigid and subject to considerable influence from the professional groups concerned. This is widely perceived as inhibiting changes to scopes of practice and the development of new competencies that could help to better meet changing health care needs. Moreover, inconsistencies in regulatory approaches across professions and jurisdictions again inhibit an integrated approach to policy development.
- *Perverse funding and payments incentives:* Current funding and payment arrangements for the services provided by health workers detract in various ways from efficient outcomes. For example, Medicare Benefits Schedule (MBS) rebates are largely restricted to services provided by medical practitioners. This may result in patients seeking treatment from a doctor, even when (unsubsidised) treatment from another health professional may be more appropriate. Also, the MBS provides only limited incentives for medical practitioners to delegate less complex service provision to suitably skilled, but more cost-effective, health professionals.
- *Entrenched workplace behaviours:* The health workforce, in common with many others, is heavily influenced by 'custom and practice'. While this often serves patients well, it can also increase resistance to changes to workplace practice, job design and education and training arrangements. Moreover, it can reinforce notions of 'high status' and 'low status' work areas, increasing the difficulties faced by service providers in areas such as Indigenous health, mental health, disability services and aged care in attracting and retaining sufficient numbers of appropriately trained staff to meet the needs of their clients.

Reform objectives

Contributing to overall health care goals

As part of a broader health care system, health workforce arrangements are a means to an end. Hence, options to remove or ameliorate impediments to improved workforce productivity and effectiveness must ultimately be assessed on the basis of their likely contribution to the achievement of the broader health care goals of promoting equitable access to high quality, safe, efficient, effective and financially sustainable health services.

To this end, the Commission has sought to identify mechanisms to promote health workforce arrangements which:

- maximise the contribution and efficiency of the available health workforce at any point in time, and help to reduce its mal-distribution; and
- are able to respond effectively, efficiently and in a timely manner to changing needs and pressures.

The broader system settings

To fully address some of the systemic impediments outlined above, changes to the broader health and education systems would be required.

In this respect, the current division between the Australian and State and Territory Governments of policy and funding responsibilities for health care and education and training is a major contributor to many of the coordination problems that arise in the health workforce area. In the words of the Australian Private Hospitals Association:

> Realistically, until an adequate resolution of this fragmentation [of roles and responsibilities] can be found, sustainable, long-term solutions to shortcomings in the health workforce are unlikely to be developed, let alone agreed.

Similarly, various aspects of broader health care funding and delivery mechanisms have pervasive, and not always desirable, impacts on the provision of services by health workers. The appropriate balance between fee-for-service and salaried medical practice, and the impact of policy and financial support for a private health system, are two of the broader issues that are particularly germane to workforce outcomes.

From this perspective, health workforce reform would best proceed as part of wider reforms to the health and education systems. Indeed, in its recent *Review of National Competition Policy Reforms*, the Productivity Commission proposed a 'holistic' review of Australia's overall health care arrangements.

However, this is not the task currently before the Commission. Moreover, the Commission is confident that considerable progress can be made within the narrower purview of this study, without compromising future broader reform initiatives, including any that emerge from the parallel review by CoAG Senior Officials.

Foundation stone — the National Health Workforce Strategic Framework (NHWSF)

The objectives which the Commission is working towards are for the most part consistent with the set of goals in the NHWSF, which was recently endorsed by Health Ministers (box 3). Hence, the Commission sees that framework as the complementary reference point for future detailed health workforce reforms. Were it to have wider endorsement at government level — for example, by CoAG — it could also be a vehicle for improving coordination across the different policy areas that impact on health workforce arrangements.

However, the Commission considers that the principle of 'national self sufficiency', as currently expressed in the NHWSF, is not an appropriate objective for health workforce policy. The health workforce is international and will increasingly be so, meaning that Australia should not restrict itself to employing only locally trained professionals. Hence, in its view, this particular principle should be more broadly couched — along the lines that, at a minimum, Australia should aim to produce sufficient numbers of health workers to meet future care needs, without unsustainable reliance on overseas trained professionals.

Box 3 **The National Health Workforce Strategic Framework**

The NHWSF — which was developed in consultation with a cross section of stakeholders and has been endorsed by Australian Health Ministers — sets out seven core principles to facilitate better health workforce outcomes. These principles focus on promoting/achieving:

- at a minimum, national self sufficiency in health workforce supply, while acknowledging Australia is part of a global market;
- a workforce distribution that 'optimises' access to health care and meets the health needs of all Australians;
- workplace environments in which people want to work;
- an appropriately skilled and competent workforce;
- the optimal use of available skills and workforce adaptability;
- a health workforce policy and planning regime that is informed by the 'best available evidence' and linked to the broader health care system; and
- collaborative pursuit of the objectives of the framework by all of the stakeholders.

The framework also outlines a non-exhaustive list of potential strategies for pursuing these principles, recognising that, in a changing workforce environment, the framework 'should evolve over time'.

Strategies for achieving workforce improvement

Initiatives to boost the numbers of education and training places will clearly be an important part of the policy package for both overcoming current workforce shortages and addressing increased demand for health workers in the future.

> Increased … investment in education and training is pivotal to achieving sustainability in the health workforce. Under the current policy parameters, substantial and growing workforce shortages persist. (Victorian Government)
>
> The provision of more publicly funded training is one of the ways of alleviating skills imbalances. It also buys time to develop more fundamental approaches to the mode of health service delivery. (South Australian Government)

Indeed, while it will be some time before the benefits of recent measures to increase places are realised, the additional health workers delivered by those extra places will then be available to provide services for many years to come.

However, notwithstanding the need for such increases in supply, there are limits on the capacity of governments to fund additional education and training places for health workers. Moreover, to fully overcome workforce shortages in rural and remote areas through this strategy, would simultaneously generate considerable oversupply in the major centres.

Further, by itself, this approach would not directly tackle impediments to the efficient and effective deployment of available workers, or to timely adjustment to changing care needs. It is for this reason that the Commission has focused its attention on measures to improve the efficiency, effectiveness and responsiveness of the health workforce system — the same focus that has underpinned reform programs in many other sectors.

Options for enhancing efficiency, effectiveness and responsiveness fall into two broad categories:

- those that address perverse incentives, but leave subsequent interactions between consumers and the various players in the system to determine the adjustment responses; and
- more active approaches that employ dedicated strategies to move the system in particular directions.

The main advantage of the former approach is that it avoids the need for policy makers to impose their judgments on consumers, those directly involved in delivering and regulating health workforce services and those responsible for educating and training the workforce.

However, in some cases, a more active approach could facilitate greater coordination across the various areas involved in the reform process. Perhaps most importantly, active approaches could be helpful in promoting greater integration across professional boundaries in policy making.

An integrated reform program

Ultimately, in the light of a demonstrated capacity for adjustment in the current system but difficulties in pursuing more complex reforms requiring coordinated action across interdependent areas, the Commission's judgment is that a mix of both approaches is required.

The Commission's proposals encompass a suite of reforms across the range of inter-related areas of health workforce arrangements, namely:

- workplace change and job 'innovation';
- education and training;
- accreditation of education and training courses;
- professional registration;
- funding and payment arrangements; and
- numerical projections of future workforce requirements.

The Commission has also given consideration as to how these generally applicable reforms, together with specific initiatives, would address health workforce concerns:

- in rural and remote areas; and
- for Indigenous Australians and others with special needs.

Importantly, the proposals are intended to deliver an integrated reform package that explicitly recognises the need for all of the cogs in the health workforce apparatus to be moving in concert. In so doing, they are designed to improve the broad institutional frameworks and processes within which specific initiatives to improve health workforce outcomes can be advanced. And while the proposals provide for the establishment of some new national health workforce bodies, those bodies would either subsume the functions of a host of existing entities, or consolidate various ad hoc processes and dialogue within a formalised and transparent framework.

Facilitating workplace change and job innovation

In coming years, changing care needs, technological advances that open up new treatment possibilities, and a likely tightening in the labour market from which health care workers are recruited, will require significant changes in workplace arrangements and the roles and scopes of practice of many health professionals.

> To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs. (Principle 5, NHWSF)

In this context, workplace change and job innovation can variously be a means for delivering better health outcomes, containing the cost of delivering particular services and accommodating changes over time in the required mix of services. And it can sometimes be a vehicle for increasing job satisfaction and therefore for enhancing recruitment, retention and re-employment.

Conceptually, workforce deployment is influenced by several linked sequential processes (figure 5). These include the 'review' and 'planning' phases, where workforce requirements are determined and the appropriate education and training arrangements are put into place, as well as an 'operation' phase where jobs are provided and ongoing competency is maintained.

As elaborated on below, various entities are involved at each of these stages, including: the Australian and State and Territory Governments; bodies with delegated powers (such as registration boards and some accreditation agencies); employers; educators and trainers; professional associations; industrial associations; and health insurers.

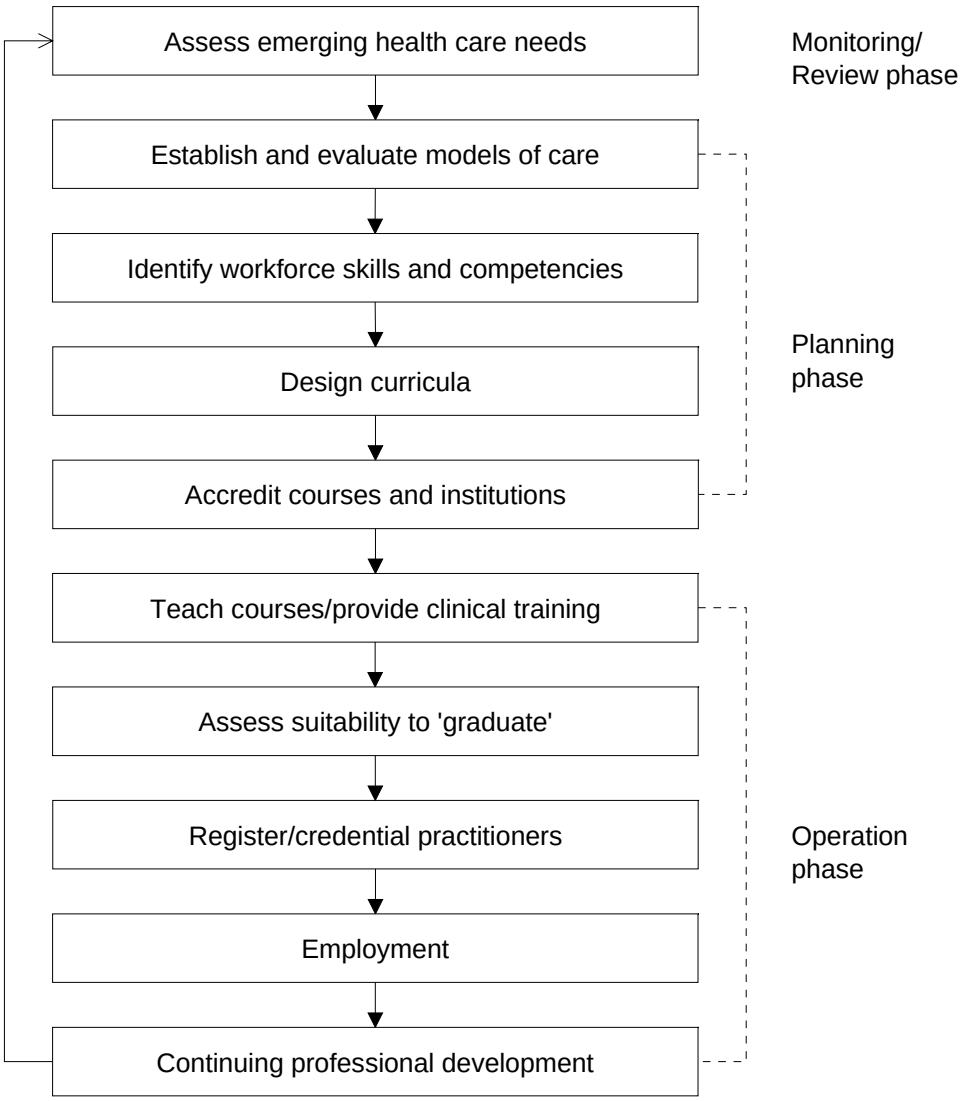
- Some play a role across a number of processes — for example, accrediting bodies may also be involved in curriculum design and in testing overseas trained practitioners for registration purposes.
- Also, responsibility for undertaking particular roles varies across the professions.

Mechanisms for funding health care services, and especially the configuration of payments regimes, are yet another significant influence on workplace practices and the incentives for health workers to embrace job redesign.

The Commission's proposals to improve institutional and procedural frameworks in several of these areas (see below) would help to promote more efficient and effective workplace deployment. So too would the proposed change to the MBS to

encourage medical practitioners to delegate more routine tasks to suitably skilled, but more cost-effective health workers.

Figure 5 **Processes influencing workforce deployment**



However, on their own, those initiatives are unlikely to be sufficient to ensure that opportunities for significant workforce innovation are considered on a national, systematic and coordinated basis. Indeed, given fragmentation of policy responsibility across and within governments, it may be difficult to ensure that all of the concomitant changes required in education and training arrangements, accreditation, registration and funding mechanisms are identified, let alone evaluated in a coordinated manner.

Recent experiences provide ample evidence of the problems of achieving significant job redesign within the current regime. For example, the introduction of nurse

practitioners — a professional group that has existed in some other countries for forty years — has been a drawn out process and is still encountering resistance from parts of the medical profession. Similarly, without some form of circuit breaker, contested issues in relation to the roles of physiotherapists, radiographers and the various levels of the nursing profession, seem likely to remain intractable.

Accordingly, and like several participants (see box 4), the Commission sees value in establishing a national health workforce improvement agency that would systematically examine major workforce innovation opportunities, particularly those which would cross current professional boundaries. Many such opportunities will have already been trialled in particular settings.

Detailed terms of reference and administrative and funding arrangements for the new agency would be a matter for resolution between the Australian and State and Territory Governments. In the broad, however, the Commission envisages that the agency would be an advisory entity which would:

- assess the benefits and costs of major job substitution and redesign opportunities, having regard not only to patient safety and the quality of patient outcomes, but also to the implications for education and training, accreditation and registration, government funding and private health insurance arrangements;
- have balanced membership which collectively provides the necessary health, education and financial expertise, as well as consumer representation;
- report to the Australian Health Ministers' Conference and liaise as appropriate with the proposed new health workforce education and training council, and the proposed national accreditation and MBS review bodies (see below); and
- be reviewed after five years.

In undertaking these functions, the Commission emphasises that the agency would complement rather than supplant other initiatives to improve workforce deployment. That is, its work would not preclude other job substitution and redesign initiatives — for example, in individual workplaces or within particular professions, or through greater use of inter/multidisciplinary approaches.

Making education and training more responsive to changing care needs

Responsibility for funding the education and training of Australia's health workforce, the delivery of those services and the provision of broad policy direction, involves a large number of players including: two tiers of government; universities; VET providers; specialist colleges and professional associations; accreditation agencies; and those entities delivering health services.

Box 4 **Support for a more active approach to major job redesign**

A more active approach to major job redesign is consistent with the NHWSF which notes that realignment of existing workforce roles and the creation of new roles may be necessary to make optimal use of workforce skills and ensure best health outcomes. It was also endorsed by a number of participants.

For example, the South Australian Government argued that:

> National leadership on the direction of workforce reform and the need to have breakthrough solutions that may fundamentally change the way current health professions are structured and trained is necessary if progress is to be made. It is essential that this be linked to the development of new service models.

The Queensland Nurses Union contended that:

> Appropriate consultative arrangements involving all key stakeholders must be established and proposed changes to skill mix and role boundaries must be based on evidence and any changes subject to rigorous monitoring and evaluation processes. … the primary objective is to ensure timely access to safe, high quality, evidence based and appropriate health services for the community.

More specifically, the Victorian Government proposed the establishment of a 'National Health Workforce Planning Council' which would have a number of roles, including to:

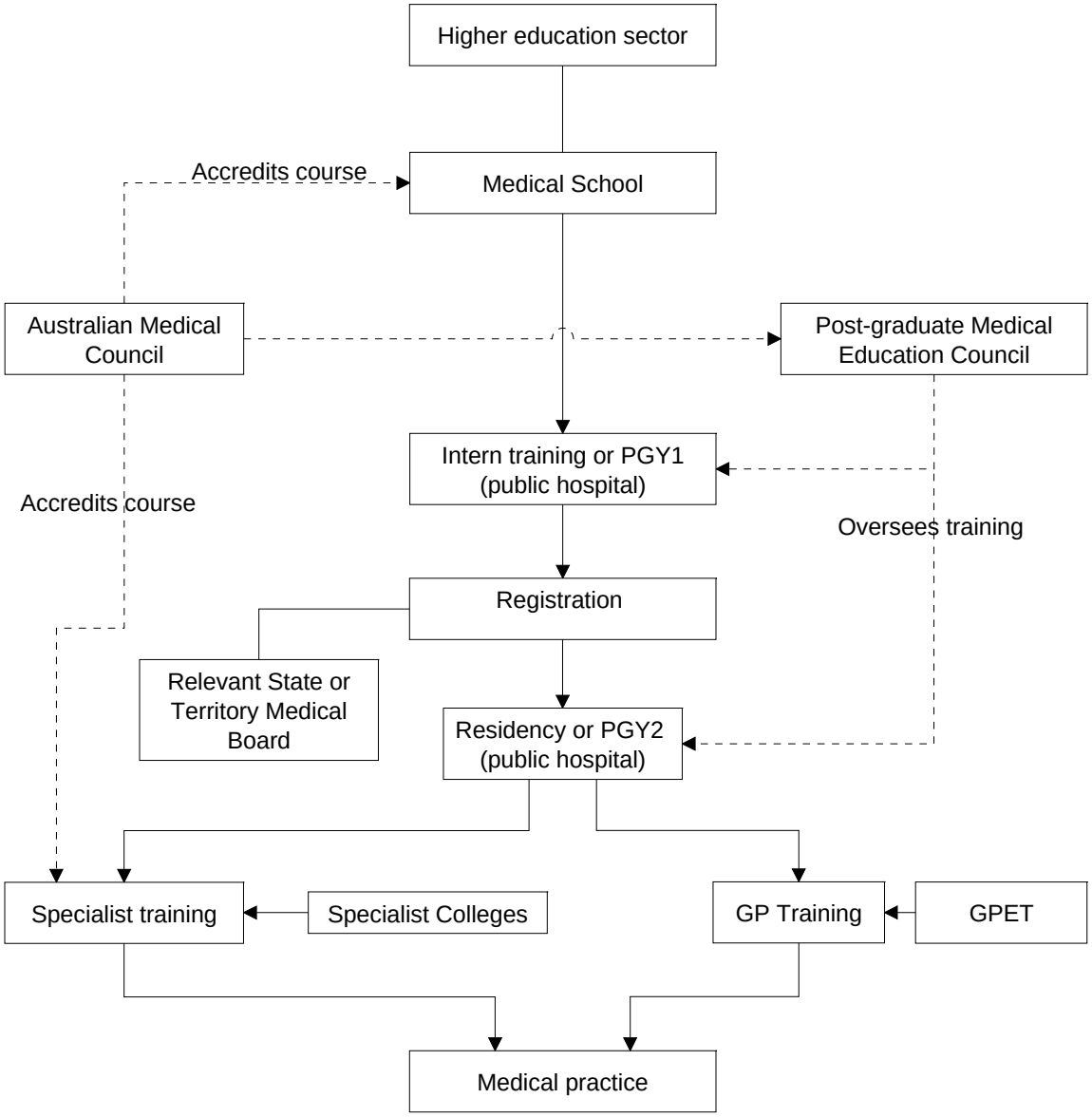
> … develop planning methodologies that support innovative workforce models and work redesign.

Within these complex arrangements — see figure 6 as they apply to medical practitioners — there has been considerable change in health workforce education and training over the years. In the university sector, new courses and teaching methods have been introduced and a wider range of graduate entry programs has increased the options for those seeking to become health workers. Similarly, general reforms in the VET sector have facilitated greater emphasis on competency-based learning and greater collaboration between service providers and those designing training programs.

However, it is also a system in which coordination problems abound and which many argue is not sufficiently responsive to changing health care needs. In addition to widespread concerns about inadequate numbers of education and training places in the university sector, submissions to this study have variously contended that:

- it is taking too long to train many health workers;
- there are significant difficulties in accessing clinical training in some key workforce areas; and
- some of those completing education and training programs are insufficiently prepared for the demands of the workplace.

Figure 6 **Medical training in Australia**



The Commission does not have the expertise to assess such issues in any detail — though it is clear they are of genuine concern to many health stakeholders, including education and training providers. What is also clear is that systemic impediments within the health workforce education and training regime underpin many of the more specific concerns put to this study. Accordingly, initiatives to tackle those impediments should be a policy priority.

Paramount in this regard is the need to improve coordination both within the education and training area, and between this area and other key components of the health workforce regime. Synthesising concerns about the lack of coordination in

current arrangements, the Australian Health Ministers Advisory Council (AHMAC) argued that:

> … rigidities, fragmentation and disconnects in the arrangements for funding and delivery of education and training adversely affect Australia's capacity to train and deploy the health workforce needed to meet current and future service delivery requirements.

Attracting most attention has been the lack of interaction by the Department of Education, Science and Training (DEST) with State and Territory health authorities when it is allocating funding for university-based education and training.

Also, in some areas, longstanding practice is a barrier to the exploration of better ways of educating and training the future health workforce. For example, efforts to facilitate greater private sector involvement in postgraduate clinical training of medical specialists has seemingly been impeded by the lack of transparency in the funding of that training and the consequent inability to increase contestability in the supply of training services.

Changing responsibility for the allocation of university places

The Commission received a range of suggestions for improving the allocation of funding available for the education and training of health workers. Some were simply directed at strengthening linkages between DEST and the health areas of government, at the State and Territory level in particular. But others involved more fundamental change, including:

- formally shifting responsibility for the allocation of funding for university-based education of health workers to the Department of Health and Ageing (DOHA), or to a multi-jurisdictional allocation body;
- creating State health colleges (effectively in competition with the universities) which would design, develop and teach new programs, or purchase and teach pre-existing accredited programs; and
- pooling university and VET funding available for the preparation of health workers.

The latter two approaches would be of uncertain benefit, have sizeable transitional costs and pose significant administrative challenges. Accordingly, in the Commission's view, they should not be pursued at this stage.

However, while responsibility for determining the overall quantum of funds available for university-based training of health workers appropriately resides with the Education Minister and DEST, making the health area of government

responsible for allocating that funding across health care courses and universities has some in-principle attractions.

- By taking advantage of the extensive linkages between health service providers and the health areas of government, it would provide for a better informed allocation process.
- More importantly, it would give greater control over the type of health workers being produced by universities to the area of government responsible for funding the bulk of service delivery, and (in the case of State and Territory Governments) delivering some of those services. Prima facie, this closer alignment of incentives would again increase the prospect that the mix of health course places is the best that can be achieved from available funding.

That said, there has been little hard evidence submitted to the Commission to indicate that the *mix* — as distinct from the number — of university-based health care places emerging from current arrangements is greatly distorted. And were the allocation of funding to be the joint responsibility of all the jurisdictional health departments — as some suggested — disputes about the distribution of funding across universities could become intractable.

However, as a means of addressing ongoing concerns about the current allocation process, a shift in primary responsibility within the Australian Government, from DEST to DOHA, warrants further consideration. Indeed, DOHA is already involved in the allocation process for medical places. As such, an extension of its role would be a less dramatic and potentially more workable shift in responsibilities than the alternative proposal for a multi-jurisdictional approach involving the States and Territories.

Of course, merely shifting primary responsibility from DEST to DOHA would not of itself address many of the concerns about the current allocation process — especially given perceptions that DOHA tends to focus on the medical workforce rather than the health workforce as a whole. Thus to be effective, such a shift in allocation responsibility would need to be accompanied by a formal requirement for DOHA to consider the needs of all university-based health workforce areas in its deliberations, and to consult with vice chancellors, DEST, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.

Facilitating change in health workforce education and training models

To assist those with policy or implementation responsibilities in the education and training area, there have been various assessments of opportunities to improve

aspects of health workforce education and training. Recently, however, there have been proposals to create a national council to provide for more systematic and integrated consideration of these opportunities. For example, the most recent Medical Education Conference advocated the approach as a way to both promote collaboration between stakeholders, and to provide evidence-based policy solutions to identified problems in health education. The Victorian and ACT Governments were among those participants who lent support to such a council.

In the Commission's view, a council-style arrangement would have several benefits:

- It would be a forum to draw together the views and expertise of the various stakeholders and to secure agreement on how worthwhile new directions in education and training of health workers (including vocational and clinical training) would be best implemented.
- With appropriate governance structures, including a balanced membership, it could act as an 'honest broker' on divisive issues and where existing interests might unduly influence outcomes under a more informal and less transparent process.
- It would facilitate consideration of education and training issues on an integrated rather than profession-by-profession basis. Amongst other things, this could provide greater scope to identify common education and training requirements across particular professions, and consequent opportunities to further develop inter/multi-disciplinary training approaches.

Moreover, given that such a council would be formalising and consolidating the current discussions of these issues, the Commission does not give weight to concerns that this would represent just another layer of bureaucracy. Further, while the council should be purely advisory and have no formal role in the accreditation of health-related education and training courses, it would nevertheless provide a valuable bridge between the proposed workforce improvement agency and a new national accreditation agency (see below).

A more sustainable clinical training regime

While several participants characterised the current state of play on clinical training as one of crisis, in the Commission's view, the pressures are neither uniform nor such as to suggest that the system will become dysfunctional in the near future.

Equally, there are systemic problems in current clinical training arrangements which, if not addressed, will continue to make it difficult to provide an appropriate number of places in the right settings and to deliver training services in the most cost-effective manner (see box 5).

Box 5 **Perceived shortcomings in clinical training arrangements**

Imbalance between demand for clinical training and training places

… access to quality clinical placements is likely to emerge as the major rate-limiting factor in an effort to ramp up professional training programs. (Australian Council of Deans of Health Sciences)

Lack of coordination within the education and training system

The lack of consultation and planning relating to the creation of new medical school places and new schools has produced chaotic effects in the health care sector, and has threatened to undermine many effective long-term relationships between individual medical schools and their partner health units and practitioners. … Creation of new medical schools must take account of the availability of clinical placements and not continually create the need for reactive responses to political whim. (Committee of Deans of Australian Medical Schools)

Doubts about the sustainability of pro bono training

Currently, pro bono work is an enormous contribution by senior fellows in all colleges; but is it sustainable? In general, people who contribute substantial time to college functions, such as examinations, education and training supervision, do so by their own choice but I am not confident this will continue for much longer. (Committee of Presidents of Medical Colleges (Child 2005))

There is a huge amount of pressure placed on public hospital physiotherapy departments to provide undergraduates with the experience they need to be job ready. The system largely functions on the good will of clinicians and is unsustainable. (Australian Physiotherapy Association)

Inappropriate funding arrangements

If Australia is to have a well-rounded health workforce, there is a pressing need to ensure that medical, nursing and allied health practitioners receive training in both the private and public hospital sectors. In order for this to occur, a coherent and equitable model of delivering and funding such training must be developed and implemented. (Australian Private Hospitals Association)

More effective coordination within the education and training sector is essential, to help avoid, for instance, the problems that recent large increases in undergraduate intakes are creating for those providing clinical training.

There is also a clear need for those with policy responsibility in this area to have more accurate and complete data on how the clinical training regime (and in particular specialist medical training) is actually working — who is providing clinical training; where it is being provided; and how its cost is distributed across the various players. Identification and quantification of the disparate and often implicit sources of funding for clinical training will be especially important in providing a coherent and transparent platform for future policy in this area.

Greater use of explicit payments to those providing infrastructure support for clinical training, and for the training services themselves, is likely to be necessary if the system is to remain sustainable over the longer term. Current arrangements that often rely on implicit infrastructure funding and pro bono provision of training services by qualified health workers make that training vulnerable to competing needs and inhibit the emergence of alternative competent training providers.

Greater reliance on explicit funding could be particularly helpful in encouraging the private sector to take on a larger clinical training role. It would also provide a means to make funding for clinical training more contestable. In turn, competition to provide training services is likely to enhance the efficiency of service delivery, and may facilitate the emergence of new training approaches. At present, training for GPs is the only major part of the clinical training regime where funding is contestable — and even here, regulatory constraints on the nature of that training reduce the degree of contestability. Notably, a number of other countries have been reconfiguring their clinical training arrangements to give more emphasis to explicit payments for services provided.

That said, the Commission emphasises that greater reliance on explicit funding and payment for clinical training services would not, and should not, preclude a continuing important role for pro bono training services. Indeed, notwithstanding some doubts about their sustainability over the longer term (see box 5), for the foreseeable future, pro bono services will remain a key component of Australia's clinical training regime.

An integrated approach to accreditation

The accreditation process is intended to ensure that the workforce skills and competencies required to meet community health care needs are properly reflected in education and training courses. To give effect to this goal, accreditation agencies assess and evaluate courses and institutions to ensure that appropriate standards are maintained and that there is sufficient consistency in training approaches and course content across institutions.

This process is complemented by registration (see below) which gives professionals the legal right to practise. However, to be registered, the professional concerned must have completed an accredited education or training program recognised by the registration body. Hence, beyond the immediate impacts on education institutions and the courses they provide, the decisions of accrediting bodies have an important influence on such matters as job design, the division of work between professions, and the scope for interdisciplinary and multidisciplinary approaches.

Much of the accreditation of university based education and postgraduate clinical training is undertaken on a national basis. Nevertheless, there are considerable differences in approaches across professions. Some accreditation bodies have explicit statutory functions, while others fulfil responsibilities delegated from registering authorities. In some professions, accreditation bodies were established in cooperation with, or as an initiative of, the respective peak professional associations. Accreditation arrangements in the medical area are particularly complex, reflecting in part the multi-tiered education and training regime.

Accreditation of VET courses in the health area similarly has a strong national focus, with the development of most training packages relevant to health progressed through the Community Services and Health Industries Skills Council. This is a tripartite national body representing relevant governments, employers and unions which operates across traditional professional boundaries.

From the viewpoint of the individual professions, existing accreditation agencies are often seen to be performing a necessary role in an adequate fashion. However, from a 'whole-of-workforce' perspective, current accreditation arrangements have some significant deficiencies.

- In particular, separation of responsibility for accrediting courses for individual professions is seen by many as reinforcing traditional professional roles and boundaries and thus constraining job redesign and workplace innovation.
- Also, inconsistency in the requirements of individual accreditation agencies imposes costs on educational institutions and trainers.

To address these problems, some participants argued for consolidating the accreditation function with a single, national agency (see box 6).

The Commission similarly sees considerable merit in this approach. Together with the formation of the proposed workforce improvement agency (see above), it would give much needed impetus to the consideration of workforce deployment and job design issues on an integrated basis, rather than in the professionally compartmentalised way dictated by the current institutional framework in this area. And, there would be some administrative and compliance cost savings.

Moreover, it would effectively establish nationally uniform standards for the various professions, which would in turn be a basis for uniform registration standards — a goal widely regarded as a key element of future workforce reform (see below).

Box 6 **Support for a national accreditation regime**

Problems identified with the current arrangements

Reinforcing traditional roles

> … current accreditation processes do not fit easily with the expansion of scopes of practice or new workforce roles, particularly roles which might combine aspects of two or more existing professions eg a generic allied health professional. (AHMAC)
>
> The single discipline focus is opposed to current policy directions that encourage inter-disciplinary approaches, optimal use of workforce skills and workforce adaptability. (Victorian Government)

Inconsistency in requirements

> The [accreditation] process is cumbersome, long — up to two years — and is relatively costly. Accreditation standards and the methods of inspection also vary significantly between professions and can be applied inconsistently across jurisdictions. The ACT requires a greater range of health courses but current accreditation processes appear to be an insurmountable obstacle to course growth. (ACT Government)
>
> If a coordinated approach to the accreditation of hospitals in relation to education and training was developed this would provide a significant improvement to hospitals and would cut down on a great deal of administration and save time. (Postgraduate Medical Council of NSW)

Calls to consider consolidation of accreditation processes

> The adoption of a cross-jurisdictional approach to accreditation across the range of health workforce education and training would support the development of a more responsive system by reducing inconsistencies and inefficiencies within current arrangements. … Linkages between workforce requirements and education and training could be made clearer and pathways for communication between stakeholders could be simplified. (AHMAC)
>
> Australia would benefit from a national review including regulation of competency-based qualifications that potentially cross professions and facilitation of the regulation of new roles as required. (Queensland Government)
>
> Victoria proposes that a multidisciplinary, nationally consistent approach to course accreditation and assessment of international practitioners be established through a national council. (Victorian Government)
>
> … some rationalisation in relation to accreditation and certification should be considered. (Committee of Deans of Australian Medical Schools)

Consolidation of accreditation within a single national body would of course have considerable transitional costs. And effective governance structures would be crucial to the successful operation of such a body.

Such considerations would put a high priority on careful and staged implementation of a national accreditation agency and call for a high degree of cooperation between governments and other stakeholders. But if that is forthcoming, the Commission's

judgment is that the benefits for the community from the resulting consolidation in the accreditation process could be significant.

Detailed arrangements and implementation pathways for a new national accreditation agency would need to be subject to further investigation. However, broadly, the Commission envisages that the agency would:

- exercise statutory powers across the full range of 'traditional' accreditation functions, and cover academic teaching as well as clinical and other forms of practical education and training, including postgraduate education and training;
- liaise with the proposed workforce improvement agency and health workforce education and training council, though it would not have any formal role in job redesign;
- initially be responsible for accreditation of education and training for medical practitioners, registered nurses, dentists and mainstream allied health workers, and also for the assessment of overseas trained health professionals seeking to practise in Australia;
- assume *responsibility* for the range of existing accreditation functions carried out by such bodies as the AMC, Postgraduate Medical Education Councils, the Australian Dental Council, the Optometry Council, and the allied health accreditation agencies;
- have broad-based membership, drawing on additional expertise as required; and
- be introduced on a staged basis under the auspices of the Australian Health Ministers' Conference.

Notably, the proposed initial coverage for the national accreditation agency excludes training of health workers in the VET system. As noted, accreditation of VET courses in the health area already occurs largely on a nationally consolidated basis. Moreover, the VET system is currently undergoing a range of other significant changes. Accordingly, in the Commission's view, a possible extension of the proposed national accreditation arrangements to the VET sector should be assessed at a later date, in the light of experience with the new regime.

Supporting changes to registration arrangements

As noted earlier, across Australia, there are more than 90 State and Territory boards that register health professionals as having the appropriate qualifications, experience and 'character' to practise in their chosen field. The boards are also responsible for ensuring compliance with requirements to practise, and for related continuing professional development.

The purpose of these arrangements is to promote safe and high quality care. However, not all health professions are covered by registration requirements. For example, safe practice by clinical perfusionists — who form part of cardiac surgery teams — is achieved through a mix of self regulation and the requirements of hospitals and other members of the care team. And for some professions, such as occupational therapy, registration requirements only apply in certain jurisdictions.

A range of concerns about registration arrangements have been put to this study. Some of these have related to the absence of formal registration requirements in particular professions, or to specific aspects of the functions carried out by registration boards. But most have been about the costs and other inefficiencies of the state-based system, including that it:

- involves considerable duplication of effort;
- continues to impede the movement of practitioners across jurisdictional borders, notwithstanding the operation of mutual recognition; and
- imposes unnecessary costs on practitioners needing to practise in more than one jurisdiction.

More broadly, there are also widespread concerns that, like the current accreditation arrangements, the professions-based approach to registration reinforces workplace rigidities, discourages exploration of new professional roles and job redesign, and thereby detracts from the efficient and effective deployment of the health workforce. Synthesising these concerns, DOHA contended:

> The separate, complex and profession-based regulatory provisions currently operating State by State adversely affect health workforce capacity. A nationally consistent approach to regulatory arrangements for health care professionals which is centred on individual competencies would encourage portability, workforce flexibility and help address workforce distribution issues.

Against this backdrop, many participants variously advocated the consolidation of registration functions within jurisdictions, the introduction of national registration standards, and the creation of a single national registration board covering all professions. Notably, agreement has recently been reached on introducing nationally consistent arrangements for the medical profession.

In the Commission's judgment, national uniform standards for the registration of health professionals are intrinsically desirable. In its view, there are few, if any, benefits from having divergent standards in this area, to set against the range of costs outlined above.

Importantly, the changes the Commission has proposed to the process for accrediting education and training courses for health workers would provide the

basis and mechanism for such nationally uniform standards. With those arrangements in place, the role of registration boards would largely be confined to one of administration and oversight of practice and continuing professional development requirements, disciplinary measures and the like.

However, under the staged implementation of the national accreditation agency that the Commission envisages, it could be some time before a complete 'package' of nationally uniform standards was available for implementation by registration boards. Accordingly, consideration should also be given to complementary initiatives to deliver greater uniformity in registration standards; and/or to reduce the costs emanating from jurisdictional differences in existing standards and the profession-by-profession approach to registration. Amongst other things, such initiatives could include:

- collective action by the States and Territories to improve the operation of mutual recognition in relation to the health workforce, including through the implementation of fee waivers for mobile practitioners and streamlining processes for short term provision of services across jurisdictional borders;
- exploration of alternatives to formal registration, especially for 'new professions', including through strengthened delegation processes. (To this end, and to facilitate the extension of MBS funding for delegated services (see below), the Commission is specifically proposing action to provide for a formal regulatory framework for task delegation);
- consolidation across professions of registration functions within each jurisdiction; and
- changes to the governance and membership of registration boards where existing arrangements are perceived to be hindering workforce change.

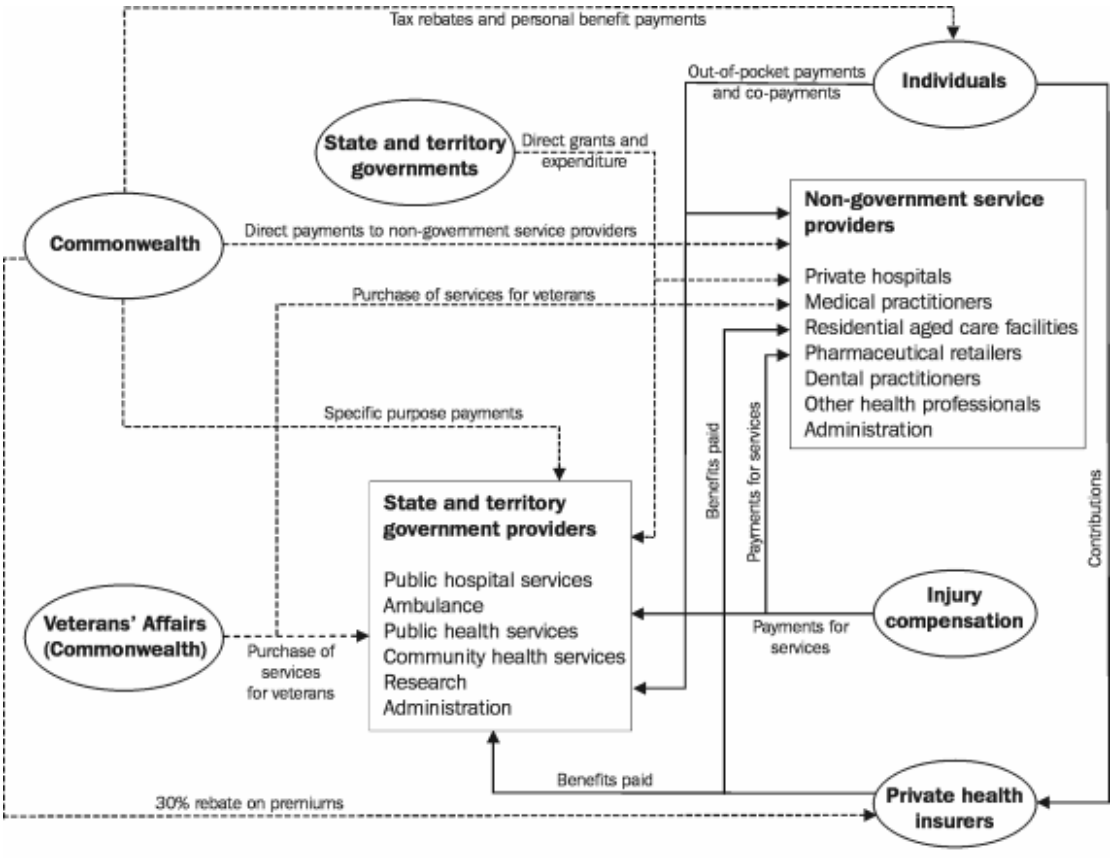
Modifying funding and payment mechanisms to improve incentives

Levels of funding for health care services — and, in particular, the degree of government support — have a pervasive impact on demand for health workers. But of particular relevance to this study is the way in which funding and payments mechanisms affect workforce efficiency and effectiveness, including through their impacts on: patient choice in regard to services consumed and from whom they acquire them; the career choices of health care workers; where those workers locate; whether they practise in the public or private sectors; and work practices.

Like other parts of the health workforce system, the funding and payments regime is very complex and interdependent (see figure 7):

- The Australian Government provides funding through Medicare and the PBS and, together with the States and Territories, jointly funds public hospital treatment. Both levels of government also provide funding for a plethora of smaller programs targeting: service provision in rural, remote and Indigenous communities and to various special needs groups; workforce improvement and restructuring; and so on.
- There are more than 40 entities offering private health insurance, with the nature of that insurance being subject to a range of regulations that affect the distribution of service provision across the public and private sectors.
- There are various expenditure control measures in place to contain budgetary risks for both governments and private health insurers.

Figure 7 **Health funding arrangements**



Source: AIHW (2004b).

Moreover, in the funding area more so than any other, health workforce and broader health care reform issues are difficult to separate. For example, the balance between

fee-for-service and salaried practice can have significant ramifications for servicing levels and the quality of services provided. Wider application of purchaser-provider approaches, as part of a broader health care reform program, would have major workforce implications. And the future distribution of the workforce across the public and private sectors will be influenced by the extent of public subsidies for private health insurance costs, the rules attaching to private health insurance cover, and charging practices for privately insured patients treated in public hospitals.

However, even taking broader health care settings as given, there are opportunities to modify funding and payments mechanisms to improve workforce performance and health outcomes.

Improving the 'configuration' of the MBS

The Commission has received evidence that various features of the MBS detract from the goal of ensuring that the right health professional delivers the right service, leading to inefficiencies in the distribution of tasks across the workforce and, in some cases, the provision of unnecessary services. Restrictions on who can refer patients for diagnostic tests and more specialised treatment, or prescribe drugs subsidised under the PBS can lead to similar inefficiencies (box 7).

Assessing proposed changes to such matters as coverage boundaries, rebate levels and relativities and referral rules is a complex task, which must have regard to a multitude of sometimes competing considerations and interacting consequences. Not the least of these are the fiscal impacts, given that changes to address the sort of workforce problems outlined in box 7 would often lead to higher servicing levels and therefore greater calls on government funding. Also, as past attempts to restructure MBS rebates illustrate, much time and effort can be expended for relatively little benefit.

Nonetheless, two changes could be helpful in this context. First, the Commission considers that there is a need for a better process for assessing requests to extend coverage of MBS rebates to a wider range of health practitioners. At present, such assessment occurs within government, without the transparency that would provide assurance of consistency in decision making and achieve closure in cases where requests to extend coverage are denied.

Box 7 **Workforce problems arising from the configuration of the MBS**

Limits on coverage

Most services provided by allied health professionals and nurses are excluded from the MBS. This may induce some consumers to opt for subsidised treatment by a doctor, even though provision by an alternative provider may be more cost effective.

> Existing Medicare arrangements perpetuate public reliance on doctor services, even when the services of other health professionals may be more effective and efficient in the management of the patient's condition. (Australian Physiotherapy Association)
>
> … services that could be effectively handled by allied health and nursing professionals are often handled by general practitioners simply because the Medicare rebate would not be available if delivered by a non-medical practitioner. (Victorian Government)

Incentives for highly qualified professionals to undertake routine tasks

Delegation by medical practitioners of more routine tasks is a vehicle for helping to ensure that the expertise of the health workforce is used to best advantage.

> The greatest expansion in the delivery of clinical care is likely come through the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner. (James Cook University Faculty of Medicine)

The MBS provides for a limited range of services (such as pathology) to be delegated. However, even if MBS subsidies were available for a wider range of delegated services, aspects of the rebate structure could reduce the uptake of the resulting workforce substitution possibilities. In particular, it is widely perceived that the structure of MBS fees favours procedures over cognitive and other non-procedural services.

> [The] time to undertake a procedural item of physician practice relative to that of cognitive consultative practice has decreased markedly without there being any recognition of this element in the fee for Medicare benefit quantum. (Royal Australian College of Physicians)
>
> Remuneration for procedural specialties is more generous than those for generalist specialties. … Generally physician specialties carry lower rebates than surgical specialties. … The same is seen across the physician specialties where procedures associated with gastroenterology, haematology and intensive care attract higher rebates than those associated with general medicine. (Victorian Government)

Such 'bias' in relativities may in turn discourage delegation of more straight-forward procedures if the alternative for the practitioner is to provide additional, less financially rewarding, consultative type services.

Inefficiencies associated with referral and prescribing restrictions

Under the MBS, subsidies for specialist medical and diagnostic services are usually only payable when the patient has been referred by a GP. While such restrictions reduce wasteful use of more specialised and often costly services, like the constraints on the coverage of the MBS, the inability of most allied health professionals to refer patients will sometimes entail inefficient or incremental use of GP services. So too may some restrictions on prescribing rights for subsidised PBS medicines.

Accordingly, it is proposing that a single, broadly-based and independent body be created to advise the Minister for Health on MBS coverage issues. This body would be similar in concept to the Pharmaceutical Benefits Advisory Committee which advises the Government on which drugs should be subsidised under the PBS. The new body would subsume the Medical Services Advisory Committee and the Medicare Benefits Consultative Committee which currently provide advice to the Government on coverage for services provided by medical practitioners. However, it would also provide advice on the benefits and costs of proposals to extend coverage of MBS rebates to non-medical practitioners and for related extensions of referral and prescribing rights. The body would be required to make formal recommendations to the Minister, and to report publicly on the reasons for those recommendations.

Secondly, the Commission sees considerable merit in the approach recently proposed by Professor Stephen Duckett to encourage greater delegation of less complex medical tasks to other health professionals. Consistent with that approach, the Commission is proposing that:

- For a progressively wider range of services covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional.
- The service would be billed in the name of the delegating practitioner who would retain responsibility for the health and safety of the patient.

To allow the Government and the community to share in the resulting cost savings, the rebate should be set at a lower level than would have applied if the delegating practitioner had provided the service.

However, in setting the level of discount, some significant trade-offs will be involved:

- A low level of discount would provide strong incentives for delegation, but would almost certainly lead to a significant increase in the overall cost of subsidising services. That is, there would be relatively small savings for government attaching to the delegated services in question. And delegating practitioners would be able to provide a significant number of additional subsidised services.
- Conversely, a high level of discount would provide more substantial cost savings on delegated services, but would reduce the incentive to delegate.

A further complexity is that discount rate for delegated services would need to take account of the apparent bias in current MBS rebates towards procedural medicine (see box 7). That is, if the alternative for a practitioner delegating more routine

procedural services is to provide additional, less financially rewarding, consultative services, delegation may be discouraged — notwithstanding the fact that this reallocation of tasks may make better use of available workforce skills.

Ultimately, the 'appropriate' level of discount will depend on the extent to which the Government is prepared to finance the provision of the additional services that would result from greater delegation. To achieve major task delegation without significant expenditure increases, would most likely require more fundamental change to MBS rebate structures — a matter beyond the remit of this study.

Against this backdrop, the Commission is proposing that changes which would enable greater delegation be introduced progressively and that their impacts be reviewed after three years.

Improving numerical projections of future workforce requirements

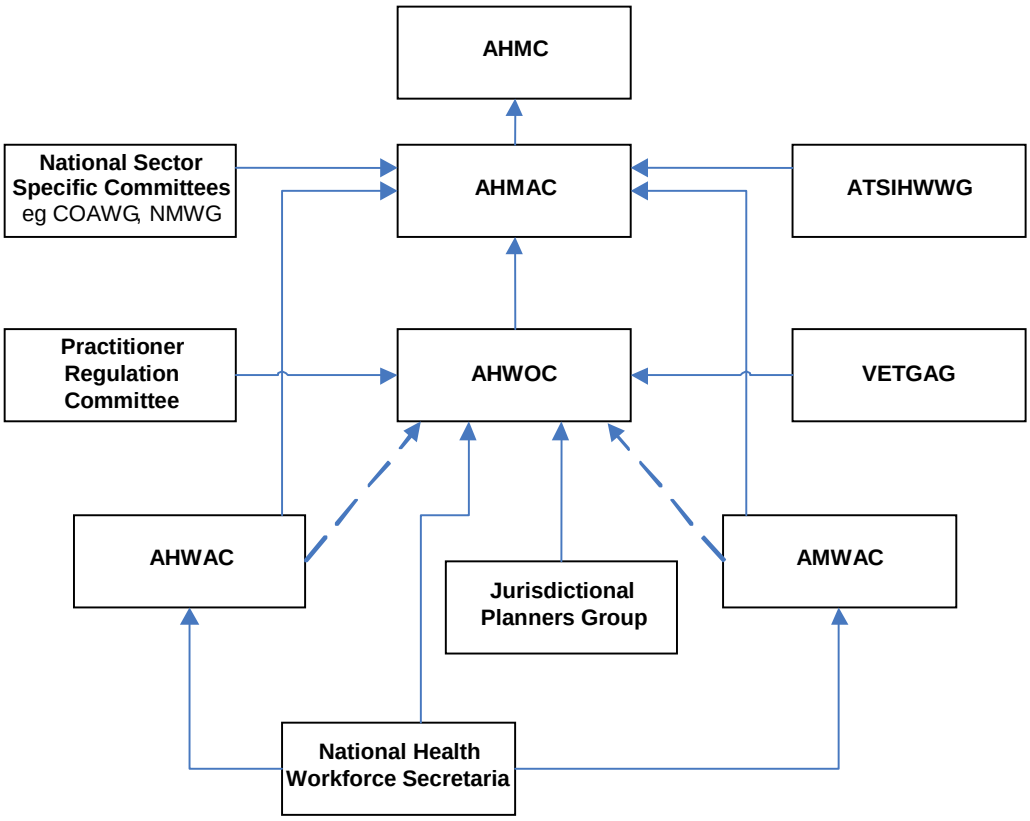
Numbers-based projections of future workforce needs are one component of a broad planning process aimed at ensuring continued availability of quality health care services. Their main purpose should be to help inform governments on the numbers of students required at various points along the education and training pathway to meet future health services demand. As such, these projections are a tool to assist policy makers avert major mismatches in workforce demand and supply — and not, as they are sometimes mistakenly portrayed to be, a centralised command and control device.

However, in the Commission's view, there is scope to both reinforce directions in which projection approaches have been moving, and to streamline current institutional and procedural arrangements (see figure 8).

A scenarios-based approach

As a matter of course, future workforce requirements should be projected for a range of different demand and supply scenarios, rather than for a single benchmark estimate of future health care needs, or a single set of supply-side assumptions. In recognising the wide range of future demand and supply possibilities, such scenario analysis will bring additional transparency and information to the decision making process. In particular, in an environment where demand is so heavily dependent on the level of government support, scenario analysis can help to illustrate the consequences of different policy settings for future education and training requirements in particular.

Figure 8 **National health workforce planning reporting structure**



Source: Victorian Government submission.

There is already considerable use of scenario analysis in the projection process. However, in the Commission's view, there would be value in giving even greater emphasis to the need for, and role of, scenario analysis in the relevant planning frameworks.

Also, the projection process should focus on those professions which have the greatest impact at the undergraduate education and training level, namely, medical practice in the broad, dentistry, nursing, and some of the larger allied professions. Indeed, reflecting their importance in this regard, formalised projections for these groups should be regularly updated, consistent with education and training planning cycles.

This does not mean that estimates of future requirements for individual medical specialties or smaller allied health professions will not be required — either to feed into the process for determining numbers of undergraduate places, or to plan for their particular clinical and advanced training requirements. Nor would it obviate the need for this estimation process to provide for dialogue with the relevant professional bodies about the appropriate numbers of professionals in these areas.

However, in the Commission's view, such estimates could be made as and when required, and without the need for major modelling exercises.

A simplified institutional framework

As is apparent from figure 8, the framework within which numerical workforce projections are prepared is quite complex. In the Commission's view, there are too many bodies involved in what is, in some senses, a quite technical task.

It is therefore proposing that the current institutional structure be rationalised through the abolition of AHWAC and AMWAC, in particular. Under this simplified structure, the National Health Workforce Secretariat would report directly to AHMAC — though, as at present, it would continue to draw on appropriate professional expertise.

Improving outcomes in rural and remote areas

Many submissions to this study have raised concerns about health workforce services in rural and remote areas. The major focus has been on access difficulties. As noted earlier, aside from nurses, practitioner to population ratios are much lower in rural and remote areas than in the major population centres (see figure 3). Moreover:

- Such averages hide the fact that for many living in more remote areas, access to even basic primary care services can be many hours away.
- And to access more specialised services available only in the major population centres, even longer travelling times and costs are usually involved.

Especially for those requiring frequent care for chronic conditions, the ensuing disruption to employment, education and family life can be very significant. Access difficulties can in turn have wider social impacts, through making it more difficult to attract and retain other activities and services necessary for viable and well-functioning communities.

Furthermore, though the difficulty in accessing health workers is the predominant concern for those in need of care, it is not the only health workforce problem in rural and remote areas. As in the major population centres, there are also a range of issues relating to competencies, scopes of practice, and education and training regimes. And for the health workers providing care in rural and remote areas, issues related to remuneration and working conditions loom large, with consequent implications for recruitment and retention (see box 8).

Box 8 **Health workforce concerns in rural and remote Australia**

Apart from the difficulties of accessing health workers, other areas of concern in rural and remote areas include the following.

Competencies and scopes of practices

In an environment where access to health workers is often limited, it is clearly important that those workers have the appropriate skills and are used to their best advantage.

While the nature of the skills needed in rural and remote areas continues to be debated — and especially the balance between generalist and specialist skills — the predominant view is that education and training regimes often do not pay sufficient regard to the competencies required for effective practice in these areas. There are also concerns that previously noted institutional, regulatory and custom and practice constraints on job redesign, and on the recognition of 'new professions', have more severe impacts in rural and remote areas where workforce shortages put a premium on workplace flexibility and innovation.

Working conditions and lifestyle issues

While practise in rural and remote areas has some lifestyle and professional attractions, hours of work can be very long, often with limited or no access to locum services. Supporting health care infrastructure, peer support and professional development opportunities are more limited than in the major population centres, and career pathways more restricted. There are fewer career options for spouses and educational choices for children. And quality of housing issues, lack of access to various community and social services and isolation can further discourage health workers from locating in these areas.

Implications for recruitment and retention

Such working condition and lifestyle considerations create major problems for those seeking to recruit health workers in rural and remote areas, whether to build service capacity, or simply to replace workers leaving the workforce. In addition, recruitment and retention in these areas is made more difficult by:

- the concentration of education and training facilities in the major population centres. This both reduces participation in health workforce training by those living in rural and remote areas, and diminishes the likelihood that students will practise in these areas after they have finished their training; and
- MBS rebate structures which can encourage medical graduates to pursue careers in specialties that require a large patient base.

That said, the outlook for the health workforce outside of the major cities is not universally negative. Access outcomes in a number of the major regional centres, although not always satisfactory, are not greatly different to outcomes in the cities and their outer metropolitan suburbs in particular. Those regional centres are in turn

providing a service base for residents in surrounding communities. Also, there are examples of smaller communities that have successfully implemented innovative programs to improve their access to health workers and health services.

There are limits on what can be achieved

More generally, the problems outlined above are not unique to health care. Access to a whole range of services is a problem for many smaller communities, especially those experiencing population drift to metropolitan and regional centres.

In the face of such loss of critical mass in these smaller communities, the range of services that can be viably delivered on site will necessarily shrink. The implication for this study is that there are limits on the degree of improvement possible in regard to the range and quality of health workforce services that are directly, and immediately, accessible in rural and remote areas. Thus the focus has been, and will continue to be, on the accessibility, quality and safety of primary care services.

But significantly better outcomes are attainable

Such observations do not, however, obviate the need to look for fiscally responsible ways of ameliorating the difficulties currently facing patients and health workers in rural and remote Australia.

Indeed, many of the changes that could be expected to ensue from the broad institutional, procedural and funding and payment mechanism reforms put forward by the Commission would be helpful in rural and remote areas. For example, the proposal to create stronger incentives within the MBS for the delegation of less complex tasks to suitably skilled, but more cost-effective health workers, would reinforce the considerable delegation that has been occurring in publicly provided care services in these areas.

The uptake of opportunities made possible by system-wide change will in turn be facilitated by consideration of rural and remote policies as part of mainstream policy formulation. Consistent with this, the brief for the proposed workforce improvement agency should explicitly cover rural and remote job design issues.

In the Commission's view, such system-wide reforms should be the primary vehicle for pursuing better health workforce outcomes in rural and remote areas. At the same time, to address particular problems, there will also be a continuing role for specific initiatives — though these must be complementary with broader frameworks and processes. In this regard, the Commission has received a plethora

of specific suggestions on what could be done to improve or augment current programs and approaches. The range of suggestions is briefly canvassed in box 9.

Though detailed assessment of these suggested measures would be impossible in a study of this nature and duration, many may well have merit. In particular, as a means of improving access to health workforce services over the medium to longer term, the Commission is attracted to a strong focus on the provision of education and training opportunities in rural and remote areas.

- There is evidence that providing such opportunities increases participation by people from rural backgrounds in the health workforce and that these people are more likely to practise outside the major population centres.
- It may also encourage trainee professionals from metropolitan areas to spend more time in rural and remote areas.

Accordingly, such initiatives may be a more cost effective way of boosting workforce numbers in the bush, than seeking to entice 'unwilling' practitioners from the cities through the use of financial incentives.

Better evaluation a pre-requisite for more effective future programs

However, in the absence of rigorous cross program evaluation (or even proper evaluation of some individual programs), there is considerable uncertainty about what approaches work best. This uncertainty relates not only to the likely effectiveness, over the longer term, of support for regionally-based education and training compared to a range of alternative measures, but also to:

- financial incentives versus coercive mechanisms such as the bonding of graduating health professionals; and
- the provision of such financial incentives through loadings to MBS rebates for particular services, relative to practice grants and other payments that are unrelated to servicing volumes.

Accordingly, the Commission is proposing that the Australian Health Ministers' Conference initiate a series of cross program evaluations to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the accessibility, quality and sustainability of health workforce services in rural and remote Australia. Such evaluations could draw on experiences with different approaches in other countries — though it is important to recognise that in an area like health care, experience does not always readily translate across countries.

Box 9 **Suggested rural and remote health workforce initiatives**

In addition to more funding, approaches for enhancing health workforce outcomes in rural and remote Australia put to this study include:

Making more efficient use of the available workforce

- extending and/or broadening the competencies of qualified health workers (and others able to provide care services) already living in these areas;
- facilitation of wider scopes of practice through clinical protocols that establish minimum levels of quality and standardised processes for care:

  Such guidelines and protocols reflect the best available distilled evidence … There is outstanding evidence that this approach improves care. (Dr. Patrick Cregan);
- further development of hub and spoke models; and
- further development of telemedicine:

  Telemedicine, used now to provide Medicare rebateable consultations to rural and remote areas for psychiatry, does have the ability to improve the delivery of surgical services. (Royal Australian College of Surgeons)

  (Telemedicine issues are also discussed in the Commission's recent report on *Impacts of Advances in Medical Technology in Australia.*)

Recruitment and retention

- targeting professionals during stages of their careers when they are more likely to be willing to work in rural or remote areas; and
- active support from local communities for recruitment, including through contractual arrangements that reduce the risk of 'lock-in' for those coming to the bush.

Education and training

- the provision of more regionally-based training opportunities:

  … it is in the national interest to encourage training in regional/rural/remote locations for long-term workforce retention in these areas (School of Medicine, James Cook University);
- further tailoring of course content to meet the particular needs of rural and remote areas — though there are various views on precisely what is required; and
- greater recognition of, and support for, rural and remote practice within the peak professional body structure — though there is again debate about the detail.

Changes to funding approaches

- a loading in MBS rebates for services provided in rural and remote areas:

  Differential MBS fees weighted for rurality/remoteness should definitely be considered in support of general practitioners and specialists working outside metropolitan centres. (Royal Australian and New Zealand College of Obstetricians and Gynaecologists); and
- geographic provider numbers.

Further trials of 'block funding' approaches could assist such evaluation

Consideration should also be given to further trials of block funding to support desired levels of services in particular communities or regions, as distinct from top-up payments to providers for individual services. This would entail contracting for the provision of an agreed list of services in those communities and regions.

Depending on the community and the breadth of the services covered, winning tenderers could be individual providers or consortia of providers, hospitals, or specialist health managers who would then sub-contract or otherwise engage individual health professionals to deliver the services in question.

Such an approach has a number of potential benefits:

- It would make it incumbent on governments to be explicit about minimum levels of access and service quality that must be met in rural and remote areas, and to provide funding commensurate with those levels.
- By channelling funding into a single program, employing a competitive tender process, it could be expected to reduce the costs of delivering any particular level of service access and care quality.
- It could encourage innovation in the delivery of health workforce services in rural and remote areas.

And though needing to address some significant implementation and administrative issues that have arisen in previous trials, further experimentation with this approach would, at the very least: shed additional light on the practical applicability of the approach; provide valuable insights into different ways of meeting care needs in rural and remote areas and on the most appropriate mix of care services; and provide hitherto lacking quantification of the costs of meeting access and quality goals in rural and remote areas through subsidising service provision. The latter could in turn inform the proposed cross program evaluation exercise.

Addressing special needs

As well as catering for 'mainstream' needs in both the cities and regional areas, effective health workforce arrangements must address the requirements of a range of groups with special needs. Most obviously, Indigenous Australians suffer particular disadvantage, and require access to, amongst other things, culturally sensitive health workforce services. However, those requiring mental health care, disability services and aged care (in both institutional and community settings) also face particular problems and have some specific workforce needs.

Like the provision of workforce services in rural and remote areas, the system-wide institutional, procedural and funding changes proposed by the Commission would help to underpin better outcomes in these special need areas. For example, its proposals to facilitate wider scopes of practice are particularly relevant to Aboriginal Health Workers (AHWs) — the Commission was told that with fairly modest additional training (and supportive clinical protocols), these workers could potentially take on a range of new tasks including performing injections, undertaking routine X-rays, and conducting renal dialysis and midwifery functions.

Indeed, it is very important that the broader institutional frameworks in the health workforce system provide for explicit consideration of special needs issues. Apart from guarding against the potential marginalisation in the policy making process of groups with special needs, embodiment within broader frameworks will help to promote complementarity between policies for these groups and generally applicable health workforce arrangements.

Time constraints have limited the Commission's capacity to examine more specific workforce problems and solutions in the mental health, disability services and aged care areas. However, it has been able to look in some detail at what more might be done to enhance the workforce services available to Indigenous Australians.

Improving Indigenous health will require multi-faceted responses

The parlous state of Indigenous health has been extensively documented (box 10). Put simply, Indigenous Australians are not only likely to die at a considerably younger age, but also to suffer more extensive health-related disability than their non-Indigenous counterparts.

It is also widely recognised that improving Indigenous health will require action on a variety of fronts extending well beyond the health arena:

- Further enhancing educational attainment is paramount. This would have a direct impact on health outcomes through improving health awareness and dietary practices, and increasing willingness and capacity to seek medical treatment. It would also encourage greater Indigenous participation in the health workforce, and help to increase overall living standards, another key determinant of health outcomes.
- Other mechanisms to promote higher living standards will be similarly important, especially those that focus on building capacity for self-driven economic and social development.
- Less commonly raised in the context of improving health and health workforce outcomes, but no less important, will be mechanisms to enhance community and

health service governance practices. This is an area where there may well be opportunities to tailor approaches to the particular circumstances involved.

Box 10 **The state of Indigenous health**

As amply demonstrated in the recent report by the Steering Committee for the Review of Government Service Provision on *Overcoming Indigenous Disadvantage*, the health status of Indigenous Australians is significantly below that of the Australian population as a whole. This discrepancy has been long-standing and sits alongside a number of other social disadvantages in the Indigenous community.

- Compared to the total Australian population, infant mortality is almost double and Indigenous life expectancy is around 17 years lower.
- Indigenous people have higher rates of environment and trauma-related disabilities. Factors that heighten the risk of non-genetic disabilities for Indigenous people include diabetes, some infectious diseases, accidents and violence, mental health problems, and substance abuse.
- Hospitalisations from kidney-related complications of diabetes are some thirteen times higher for Indigenous than non-Indigenous people.
- The rate of hospitalisation of Indigenous children aged four years and under for infectious diseases is more than double that for non-Indigenous children.

A host of factors underlie these poorer outcomes. Most broadly, economic and social disadvantage and lower rates of educational attainment play a key role. More specifically, poor dietary practices, unsanitary living conditions and difficulty in accessing health services are major contributors. In regard to the latter, for example, Indigenous people are more likely both to live outside urban areas than the rest of the Australian population and be without a vehicle.

As part of the push to improve Indigenous health outcomes, the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework aims to build:

> … a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples …

The framework, which also maps out a range of strategies for achieving these goals, is now embodied within the NHWSF.

What health workforce-specific directions look most promising?

Submissions to this study have put forward a wide range of specific initiatives to improve the access of Indigenous Australians to health workers, and the effectiveness of the services provided. Many of these were directed at immediately increasing the numbers of health workers available to treat Indigenous Australians not only in communities, but also in the cities. However, others were variously

directed at improving the use of health workforce resources available to treat Indigenous people; enhancing service quality; facilitating greater Indigenous participation in the health workforce; and increasing the emphasis on preventative health.

Greater emphasis on preventative health strategies seems especially important given that many of the factors that contribute to the poor health status of Indigenous Australians are preventable. However, the specific requirements to give effect to such a shift in emphasis go well beyond a study into the health workforce.

Beyond that, the Commission considers that the following reform areas warrant particular policy attention in an Indigenous context.

- *Encouraging further widening of scopes of practice for those providing services to Indigenous people*. Though often acute shortages of health workers have led to some worthwhile changes of this nature, this process could clearly go further. The previously noted opportunity to extend the roles of AHWs is but one example.
- *Giving greater recognition to prior learning and on-the-job training*. In conjunction with wider scopes of practice, this would enhance career pathways for Indigenous health workers, allowing AHWs for instance to more easily progress to nursing and other professions. In turn, this would encourage greater Indigenous participation in the health workforce.
- *Providing increased health workforce education and training opportunities for Indigenous students in, or adjacent to, their communities*. As in rural and remote areas more generally, greater availability of locally-based training options would further increase incentives for Indigenous participation in the health workforce. Those Indigenous people contemplating a health career are often important members of their communities and, as such, reluctant to travel long distances, or spend extended time away from those communities for training purposes. Moreover, training provided in larger centres may not pay sufficient regard to cultural and other issues pertaining to specific Indigenous communities.
- *Ensuring that training wages provide appropriate incentives for Indigenous participation in health workforce education and training.* While it appears that remuneration for those who have completed training provides reasonable incentives to pursue a health career, the level of payments for some of those in training seems more problematic. This is especially the case as many Indigenous people considering employment in the health sector are of mature age, have significant financial commitments and family responsibilities, and may not be eligible for some of the support available to younger students.

But as in many other health workforce areas, there has not been much evaluation of the relative effectiveness of the various approaches for achieving better Indigenous health workforce outcomes. Hence, better evaluation of existing and proposed programs in this area should similarly be a high policy priority for the future.

Indeed, there might well be value in encompassing the evaluation of Indigenous programs within the broader evaluation initiative which the Commission has proposed for rural and remote health workforce policies. And again, that evaluation could draw on the extensive overseas experience with providing health care services to Indigenous groups — subject to the caveat on the extent to which it is possible to translate such experiences across countries.

Other matters

After hours GP services near hospitals

In recent years, there have been various initiatives to improve access to after hours primary care services (box 11). But despite these measures, access to these services is far from uniform across Australia.

Box 11 **Improving access to after hours primary health care**

In the past, after hours primary care was typically provided by GPs through home visits, rostered after hours services and locum services.

But that care model is changing, with much greater emphasis on after hours 'deputising' services rather than 'own-practice' after hours care. Hence, after hours clinics are becoming increasingly common. There are now also some specialist management companies providing fee-for-service administrative support to groups of practitioners delivering deputising GP and related services.

For its part, the Australian Government has sought to facilitate better access to after hours services through increased financial support, including through the Practice Incentive Program and more generous MBS rebates for after hours services. It has also provided funding for experimental services via the After Hours Primary Medical Care Program. This program, which is designed to test the effectiveness of alternative approaches for providing after hours care, has financed trials of different care models in a variety of locations.

However, the after hours issue raised in the terms of reference for this study is a narrower one — namely, the relationship between after hours GP services provided in a community setting and 'equivalent' services delivered in acute care hospitals.

Two considerations appear to underlie the request for advice on this matter:

- The reduced availability of after hours and locum GP services in some parts of Australia may be contributing to increased low acuity presentations at emergency hospital departments. There are concerns that such added pressure on emergency departments has been to the detriment of patients in genuine need of acute care.
- And, with the Australian Government providing support for services provided by GPs, and the States and Territories operating public hospitals, greater provision of primary care type services in emergency departments can have intergovernmental financial implications.

Evidence to support the contention that patients with acute needs presenting at emergency departments are being disadvantaged is far from conclusive. Triaging protocols mean that those with serious complaints receive priority over those requiring more basic care. Indeed, several participants argued that the major treatment 'blocker' for more seriously ill admitted patients is a shortage of public hospital beds.

Moreover, consistent with the principle that funds should follow function, the Australian Government has provided exemptions under the *Health Insurance Act* to allow up to 10 after hours GP clinics, that are to be set up with assistance from States and Territories within or adjacent to their public hospitals, to access Medicare funding.

Nonetheless, there remains a more general need for governments to ensure that adequate after hours primary care services are available and that, as far as possible, those services are provided in the most appropriate settings.

In many cases, lack of alternative services, or the particular needs of patients, will mean that the use of emergency departments (or co-located after hours clinics) is warranted. However, there will be some patients who seek treatment from these departments or clinics solely or primarily on the basis that services are available without charge. In contrast, unless an equivalent service provided by a practitioner in a community setting is bulk billed, the patient will incur a charge. Inevitably, this charging structure will lead to some distortion in the care mix.

Given the many current initiatives to improve access to after hours care in community settings, the Commission is not in a position to offer any firm view on the likely significance of this distortion. It does, however, consider that resolution of the underlying issue would require more fundamental reform to health funding arrangements.

The influence of policies in other areas

While this study is focusing on health workforce reform, policy settings in a range of other areas will have an influence on the efficiency and effectiveness of future arrangements. For example, in addition to the configuration of the broader health and education systems:

- Medical indemnity arrangements will continue to affect, among other things, career choices and workplace practices.
- Australia's general labour market arrangements may variously help or hinder some specific health workforce reforms.
- Migration rules will affect the scope for, and cost-effectiveness of, supplementing locally trained health workers with those trained in other countries.
- Taxation and superannuation policies will influence workforce participation and exit decisions, as well as the opportunities for older health workers to continue to contribute in a part time capacity.
- Improvements to Australia's transport and communications infrastructure will help to enhance access to health services in rural and regional Australia.

The next step

In this Position Paper, the Commission has sought to map out a series of reforms which could assist in the development of sustainable and responsive health workforce arrangements. Its particular focus has been on improving the frameworks within which health workforce policy formulation and decision making occurs, rather than prescribing specific detailed changes in what is a very complex and interdependent area.

Its proposed reform package comprises a mix of:

- changes to improve the incentives for those using and providing health workforce services; and
- more active approaches for overcoming the fragmentation, poor coordination, inflexibility and workplace behaviours that, if not addressed, will impede the capacity of the health workforce system to respond effectively to the major challenges ahead.

The Commission emphasises that these active approaches, which are focused on establishing more effective frameworks and processes, would still provide for a continuing strong role for normal marketplace interactions between service

providers, health workers and consumers in determining changes to detailed workforce arrangements. Indeed, to complement these active approaches, the Commission has also proposed measures that would serve to strengthen the role for incentives in driving necessary change to current arrangements.

Moreover, rather than creating major new layers of bureaucracy, the Commission's proposals to establish some new institutions seek to consolidate a number of entities and/or functions within more responsive, accountable and transparent national bodies or regimes. But most importantly, the Commission's proposed changes to both incentives and institutional structures are designed to engender an integrated approach to policy formulation and the delivery of services that spans current professional boundaries and scopes of practice. Those proposed changes and their expected impacts are summarised in table 2.

The Commission invites comments from interested parties on these proposals and the underlying arguments. Drawing on that input, it will then prepare a set of final recommendations for CoAG by the end of this year.

Table 2 **A summary of the Commission's draft proposals**

Current problem	*Proposed response*	*Main benefits of change*
Facilitating workplace innovation		
Lack of timely and objective processes to assess significant job redesign, leading to lost opportunities to make better use of available health workforce skills.	Establish an advisory health workforce improvement agency to examine major workforce innovation opportunities, particularly those which would cross current professional boundaries.	Independent assessment of the benefits and costs of such opportunities, and identification of implications for education and training, accreditation and registration, government funding and private health insurance arrangements.
More responsive education and training arrangements		
Lack of coordination between the education and health areas of government, leading to mismatches between available education and training places and service delivery requirements.	Consider shifting primary responsibility for allocating the quantum of funding available for university based education and training from DEST to DOHA.	Better alignment of the mix of health course places with the health needs of the community and the workforce needs of service providers.
Longstanding practice a barrier to exploration of better ways of educating and training the future health workforce.	Establish an advisory health workforce education and training council to provide for systematic and integrated consideration of different health workforce education and training models and their implications for courses and curricula.	Facilitate consideration of education and training issues on an integrated rather than profession-by-profession basis. Council to be an 'honest broker' on issues where existing interests might unduly influence outcomes under a more informal and less transparent process.
Current clinical training regime may not be sustainable over the longer term, due to lack of transparent and explicit funding and insufficient opportunities for competition in training delivery.	Improve understanding of operation of system and enhance transparency and contestability of funding frameworks.	Better information base for policy formulation. Competition from new providers leading to more efficient delivery of training services and encouraging innovative training models.
A consolidated national accreditation regime		
Profession-based accreditation impedes workplace innovation and job redesign. Inconsistent requirements of individual accreditation agencies impose costs on educational institutions and trainers.	In a staged manner, move towards a single consolidated national accreditation agency for university-based education and training and post graduate training; subsuming existing accreditation functions as part of this process.	Lend further impetus to 'across-profession' consideration of workplace innovation and job design issues. Provide the basis for nationally uniform registration standards for health workers. Reduce costs and inconsistencies arising from multiple accreditation agencies.

(continued)

Table 2 **continued**

Current problem	*Proposed response*	*Main benefits of change*
Supporting changes to registration arrangements		
Current state-based regime involves duplication of effort, impedes professional mobility, imposes costs on those practising in more than one jurisdiction.	Introduce nationally uniform registration standards based on the work of the proposed national accreditation agency. More focused role for registration boards.	Further increase in systemic capacity for timely job redesign and workplace innovation. Fewer barriers to the movement of appropriately trained professionals within Australia.
Professions-based approach reinforces workplace rigidities and discourages job redesign.	Improve operation of mutual recognition; explore alternatives to formal registration; consider consolidation of registration functions across professions; and improve governance structures for registration boards.	Lower administration and compliance costs.
Absence of formal provisions to underpin delegation of service delivery, discouraging more efficient task allocation.	Amend registration Acts accordingly.	Better use of workforce. Support proposed change in MBS arrangements (see below).
Improving funding-related incentives for workplace change		
No transparent process for considering the possible extension of MBS rebates to a wider range of practitioners, leading to some inefficient use of GP services.	Establish an independent review body (subsuming existing committees) to advise on services to be covered by the MBS and on referral and prescribing rules.	Facilitate transparent consideration of requests for changes in the coverage of the MBS that would help to improve workforce efficiency and effectiveness and enhance outcomes for patients.
Limited incentives under the MBS for delegation of routine tasks to less highly qualified, but more cost-effective, health professionals.	Progressively introduce (discounted) rebates for a wider range of delegated services.	Encourage better use of available health workforce skills. Allow the community to share in cost savings from delegation.
Better focused and more streamlined projections of future workforce requirements		
Current projections not always well focused on major education and training needs, reducing their policy relevance.	Concentrate formal projections on the key workforce groups. Undertake scenario analysis as a matter of course.	Better use of resources available to undertake projections. Greater transparency re the impact of policy settings on future workforce requirements.
Current institutional structure cumbersome.	Rationalise structure through abolition of AMWAC and AHWAC.	Some cost savings. Addresses any residual concerns about undue professional influence in process.

(continued)

Table 2 **continued**

Current problem	*Proposed response*	*Main benefits of change*
More effective approaches to improving outcomes in rural and remote areas		
Rural and remote issues not always properly considered as part of mainstream policy formulation.	All system-wide frameworks in the health workforce area to make explicit provision for consideration of rural and remote issues.	Greater consideration of opportunities to improve workforce services in rural and remote areas through system-wide changes.
Limited evaluation of which specific approaches for improving outcomes in rural and remote areas work best.	Initiate a cross-program evaluation exercise.	Better platform for determining the most cost effective ways of enhancing health workforce outcomes in rural and remote areas.
Ensuring that the requirements of groups with special needs are met		
Workforce requirements of groups with special needs not always addressed as part of mainstream policy formulation.	All broad institutional frameworks to make explicit provision to consider the needs of these groups.	Guard against any marginalisation of groups with special needs. Ensure that specific initiatives for these groups are compatible with generally applicable arrangements.

Draft proposals

DRAFT PROPOSAL 3.1

In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

DRAFT PROPOSAL 3.2

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

DRAFT PROPOSAL 4.1

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- ***Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.***

DRAFT PROPOSAL 5.1

The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- ***consider the needs of all university-based health workforce areas; and***
- ***consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.***

DRAFT PROPOSAL 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- ***opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and***
- ***their implications for courses and curricula, accreditation requirements and the like.***

DRAFT PROPOSAL 5.3

To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- ***improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;***
- ***examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;***
- ***better linking training subsidies to the wider public benefits of having a well trained health workforce; and***
- ***addressing any regulatory impediments to competition in the delivery of clinical training services.***

DRAFT PROPOSAL 6.1

The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- ***It would develop uniform national standards upon which professional registration would be based.***
- ***Its implementation should be in a considered and staged manner.***

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

DRAFT PROPOSAL 6.2

The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.

DRAFT PROPOSAL 7.1

Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

DRAFT PROPOSAL 7.2

States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

DRAFT PROPOSAL 7.3

Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

DRAFT PROPOSAL 8.1

The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- ***the range of services (type and by provider) covered under the MBS;***
- ***referral arrangements for diagnostic and specialist services already subsidised under the MBS; and***
- ***prescribing rights under the Pharmaceutical Benefits Scheme.***

It should report publicly on its recommendations to the Minister and the reasoning behind them.

DRAFT PROPOSAL 8.2

For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- ***the service would be billed in the name of the delegating practitioner; and***
- ***rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.***

This change should be introduced progressively and its impacts reviewed after three years.

DRAFT PROPOSAL 9.1

Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

DRAFT PROPOSAL 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- ***be based on a range of relevant demand and supply scenarios;***
- ***concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and***
- ***be updated regularly, consistent with education and training planning cycles.***

DRAFT PROPOSAL 10.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

DRAFT PROPOSAL 10.2

The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- ***assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and***
- ***as appropriate, consider major job redesign opportunities specific to rural and remote areas.***

DRAFT PROPOSAL 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- ***the provision of financial incentives through the MBS rebate structure versus practice grants; and***
- ***'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.***

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

DRAFT PROPOSAL 11.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

1 About the study

Australia's health system has many strengths. Overall health outcomes compare quite favourably with those in other developed countries. For example, Australians have among the highest life expectancies in the world — including when 'disability adjusted' for years of 'good health'. Yet total spending on health care as a percentage of GDP and per capita is not overly high by advanced OECD country standards (AIHW 2004a).

To a considerable degree, the system has managed to respond to growing financial pressure and changing community health needs. However, the sustainability of the system is under increasing pressure in various respects. There are poor health outcomes for particular groups in the community and difficulties in accessing services for some care needs and in some parts of Australia. Workforce shortages are contributing to these problems.

Further, continuing strong growth in demand — reflecting rising incomes and community expectations, technological advances and an ageing population — will only serve to increase the pressure on the current health care system and its workforce. It is far from clear that present arrangements will be able to cope with this pressure, in turn raising questions about the sustainability of Australia's health care goals. Not surprisingly, therefore, how to increase workforce supply and improve the efficiency and effectiveness of that workforce has been the focus of much policy attention.

This particular research study by the Commission provides an opportunity for the review of health workforce arrangements in this context — and in light of the adoption of the *National Health Workforce Strategic Framework* (NHWSF) by Australian Health Ministers in 2004 (see chapter 3). The study was requested by the Australian Government in March 2005 in response to a decision by CoAG in June 2004.

At its subsequent June 2005 meeting, CoAG agreed that 'Australia has one of the best health systems in the world', but noted that there is room to discuss a number of areas for improvement (box 1.1). Consequently, Senior Officials have been asked to consider ways to improve Australia's health system and report back in December 2005 on a plan of action to progress reforms in a number of areas, including the supply, flexibility and responsiveness of the health workforce. CoAG has also asked

the Commission to report by December 2005 so that it can consider the Commission's views along with the action plan from CoAG Senior Officials. This brings forward the original reporting date of 28 February 2006 and is just over 9 months from receipt of the Terms of Reference.

Box 1.1 **Extract from the CoAG Communiqué of 3 June 2005 relating to Australia's health system**

CoAG agreed that Australia has one of the best health systems in the world. However, there is room for governments to discuss areas for improvement, particularly in areas where governments' responsibilities intersect.

The Australian, State and Territory governments recognised that many Australians, including the elderly and people with disabilities, face problems at the interfaces of different parts of the health system. Further, the governments recognised that the health system can be improved by clarifying roles and responsibilities, and by reducing duplication and gaps in services.

Ways in which the health system could be improved include:

- simplifying access to care services for the elderly, people with disabilities and people leaving hospital;
- helping public patients in hospital waiting for nursing home places;
- helping younger people with disabilities in nursing homes;
- improving the supply, flexibility and responsiveness of the health workforce;
- increasing the health system's focus on prevention and health promotion;
- accelerating work on a national electronic health records system;
- improving the integration of the health care system;
- continuing work on a National Health Call Centre Network; and
- addressing specific challenges of service delivery in rural and remote Australia.

CoAG agreed that Senior Officials would consider these ways to improve Australia's health system and report back to it in December 2005 on a plan of action to progress these reforms. It was also agreed that where responsibilities between levels of government need to change, funding arrangements would be adjusted so that funds would follow function.

Health Workforce Study

CoAG noted that an issues paper has been prepared for public discussion by the Productivity Commission on the health workforce study. CoAG will ask the Productivity Commission if it can report by December 2005, so that CoAG can consider this report along with the action plan from CoAG Senior Officials.

Source: CoAG (2005).

1.1 Scope and focus of the study

Wide scope of issues

The scope of this study is broad, with the terms of reference potentially covering any relevant factor affecting, or likely to affect, the demand for and availability of health workers and the services they provide over the next 10 years or so. In summary, the Commission has been asked to:

- consider factors affecting the supply of health workforce professionals;
- consider the structure and distribution of the health workforce and the consequences for its efficiency and effectiveness;
- consider factors affecting demand for services provided by health workforce professionals;
- consider the specific health workforce needs of rural, remote and outer metropolitan areas and issues of Indigenous health;
- provide advice on the identification of, and planning for, Australian health care priorities and services; and
- provide advice on the issue of general practitioners in or near hospitals on weekends and after hours.

Coverage of professions and services

The study adopts an expansive definition of the health workforce, with the term 'health workforce professional' defined to cover 'the entire health professional workforce', from a number of education and training backgrounds, including vocational, tertiary, post-tertiary and clinical. Without attempting to be exhaustive, examples of relevant occupations covered include: doctors, nurses, midwives, physiotherapists, podiatrists, pharmacists, psychologists, occupational therapists, dentists, radiographers, optometrists, Aboriginal Health Workers, ambulance officers and paramedics. Generally, people must be registered before they can practise in most of these occupations.

The terms of reference do not restrict the scope of the study to any particular health care settings. Indeed, health care professionals work in a range of settings, extending from mainstream primary and acute care, to aged care, mental health, disability services and the provision of community services more generally (with many working in a voluntary rather than paid capacity). Although the Commission has focused on the work of health care professionals (as defined above) in

mainstream care, its analysis and conclusions also have relevance for other settings. This is so particularly as the boundaries between services are becoming less clearly defined, and many health workforce issues increasingly range across those services.

Defining 'workforce planning'

Many of the issues discussed in this study involve an element of 'workforce planning', as they broadly concern how best to make provision for future workforce needs. Thus, the term is used in the paper as a shorthand way of describing efforts to determine the appropriate nature and extent of government involvement in the health system in relation to the health workforce (see below).

Sometimes, however, the term has a narrower interpretation, being used to describe the processes employed by AMWAC and AHWAC in their more focused consideration of the *numbers* of workforce professionals of various descriptions likely to be required to sustain service delivery in future. Chapter 9 of this paper adopts that interpretation.

1.2 The Commission's approach

Taking account of the health system objectives

Although this study is centred on the health workforce, the issues examined and solutions proposed need to be seen in the context of the community's desire for a health system which meets a number of specific objectives. These can be expressed in several different ways, but the summary set out in the most recent Report on Government Services is helpful (SCRGSP 2005b). It portrays the overall objectives of the health system, as follows:

- efficiently and effectively protecting and restoring the health of the community by:
  - preventing or detecting illness through the provision of services that can achieve improved health outcomes at relatively low cost;
  - caring for ill people through the use of appropriate health and medical intervention services;
  - providing appropriate health care services that recognise cultural differences among people;
  - providing equitable access to these services; and

– achieving equity in terms of health outcomes.

Chapter 3 adapts these broad objectives to more specifically focus on the health workforce. It also notes the role for performance criteria against which changes that affect the workforce can be assessed. Throughout this paper, the Commission has been mindful that changes that affect the health workforce need to support the overall objectives of the health system.

Assessing the nature and extent of government involvement

The characteristics of health care services (and indeed of many other human services) are such that the scope to give competitive market forces free rein is often less than in markets for other goods and services. These characteristics justify significant government involvement in health care. For instance:

- There are strong equity grounds for ensuring that low income should not preclude people from accessing appropriate services.
- The health care transaction does not always involve a willing purchaser. Often, people do not 'choose' to purchase health care in the normal sense, but do so because of need, or in response to circumstances beyond their control.
- There is a lack of, and asymmetric, information. People can have difficulty in judging their own best health care interests. Consequently, individuals may be unable to judge effectively the abilities and recommendations of practitioners. Further, the consequences for consumers of 'wrong' purchasing decisions can be very severe.
- The likely future cost of health care for most individuals is highly uncertain, but can involve a risk of high expenditure. As such, insurance arrangements can be effective in helping individuals make sufficient financial provision for their health care contingencies. But the pooling nature of insurance requires collective governance, and a measure of government regulation to deal with information asymmetry, moral hazard and similar concerns.
- There are important spillovers from the consumption of health care. Health care services have the capacity to contribute to the physical, emotional, social and intellectual wellbeing of consumers and their families. Their consumption can have significant flow-on benefits for broader community welfare. Access to effective health care services is also important for a productive workforce. And there are public benefits from a well trained health workforce, in addition to the spillovers from education more generally.

Governments thus contribute to health services funding, deliver some core health services, regulate the provision of health services, including by health workers, and regulate insurance arrangements. As well, governments are heavily involved in the

education and training sector through funding courses and, sometimes, in their provision. As such, governments have far reaching impacts on the numbers, types and skills of health workers available and on their delivery of health services.

In this study, the Commission has taken as given these broad rationales for government intervention in relation to health services provision in general and the health workforce in particular. However, the actual nature and extent of intervention in particular situations is a matter for judgment — to be assessed against efficiency, effectiveness, quality and safety criteria. This is at the heart of much of this paper.

Adding value through this report

With CoAG requesting an earlier reporting date for this study, to December this year, the Commission considers that it can best focus debate and further contributions by publishing its draft report in the form of a Position Paper. The preliminary proposals have been limited to a relatively small number of high level issues which the Commission sees as central to achieving a more efficient and effective health workforce system over the longer term. And in seeking to expedite the process for the very many participants who are continuing to make valuable contributions, the Paper traverses lightly through much of the background that is well known to most.

Many of the previous studies, analyses and reports into health workforce issues, both in the Australian and international contexts, have focused on particular professions, processes, regions or short-term crises. Even within such a narrow purview, many of these issues are inherently complex; they are often interrelated; they range over both the health and education sectors; and they play out in an environment of rapid and significant change.

The Commission's remit, in contrast, is to encompass the whole of the health workforce, to consider both supply and demand issues, and to look out over a timeframe of a decade or more. Thus, while drawing on previous work where relevant, and on particular professions and practices for illustration, it has focused its efforts primarily at a system-wide level. Specifically, it has endeavoured to identify the reform frameworks and principles that will enable the institutions, the funding, educational and regulatory processes and the workforce itself to be responsive to emerging problems and challenges, so as to continue to deliver high quality, safe, efficient, effective and financially sustainable health services.

The Commission considers that it would add little value by way of replicating the assessment of the numerical workforce requirements in any of the individual professions, critiquing the technical content of training curricula, or by attempting

to prescribe the optimal deployment of the available workforce across geographical regions. However, the systemic changes proposed by the Commission in this paper should facilitate the detailed consideration of such matters by relevant stakeholders and appropriate technical experts.

Finally, this is not a study into the adequacy of existing health budgets or the appropriate levels of future health expenditure. Per capita expenditure has been increasing in real terms in recent years and is expected to increase even more rapidly in future (chapter 2). The Commission sees its primary task as advising on how to make best use of the health workforce within the context of whatever expenditure constraints are set by governments, the community and other funding agents.

Providing opportunity for extensive public input

To the maximum extent possible within the time constraint, the Commission has provided opportunity for public input into this study. To this end, it has held discussions and roundtables with around 90 organisations and individuals, and considered almost 180 submissions received as at the date this paper was finalised. Those submissions, from a wide range of organisations and individuals, have been very thoughtful and often very detailed. The debate is much richer for their time, effort and wisdom.

Details of the Commission's procedures are set out in appendix A.

2 Context for policy development

Key points

- Health workforce pressures will escalate in the future as increasing incomes and community expectations, technological advances and population ageing strongly stimulate demand for health services, while supply constraints tighten.
- Without action, these influences will add to the current problems facing the health workforce and thereby detract from health outcomes.
- In the face of these pressures and the constraints on government funding for health care, productivity enhancing improvements to health workforce arrangements will be vital to ensuring a sustainable health care system.
- There will also need to be a greater emphasis given to improved community health, to preventative measures and to managing the consequences of chronic diseases.
- The responsiveness of the health workforce to current and emerging challenges is limited by a number of systemic impediments, including:
  - the inherent complexity and inter-dependency of the system;
  - the fragmented roles and responsibilities of governments and other stakeholders;
  - ineffective coordination between stakeholders at a number of levels;
  - distortionary funding and payment mechanisms; and
  - entrenched custom and practice, including the maintenance of traditional professional barriers.

Despite current problems, the health care system, as noted in chapter 1, has responded to changing community health needs within the constraints imposed by growing financial pressures. This does not mean that the current problems should be downplayed or ignored. Indeed, in their submissions, many participants understandably concentrated on workforce issues of immediate concern.

However, given the forward looking nature of this study, the Commission has not only considered current issues, but has also looked across the array of new issues and challenges for the health workforce that might arise over the next decade and beyond.

Of course, attempting to predict the future is fraught with danger. While broad trends can be identified, the ways in which these trends will interact and play out

are often unclear. In the face of such uncertainty, what is required is a health workforce with the capacity to respond to those issues and challenges in a sustainable manner.

After briefly summarising key workforce trends and current issues of concern raised by participants, this chapter discusses some of the challenges likely to be important in shaping the future health workforce and the way in which it delivers care. It then highlights some of the systemic impediments to workforce adjustment and change, with the following chapters taking up particular themes in more detail.

2.1 Key workforce trends

The health workforce has changed considerably in recent years. To set the context for the study, the Commission has identified the following key workforce trends, both current and emerging, likely to have important implications for future policy.

- Aggregate health expenditure has grown strongly over the last decade or so to some $72 billion in 2002-03. The annual real growth rate has averaged about 4.5 per cent, significantly higher than population growth of about 1.2 per cent. As a consequence, over the period, the ratio of health expenditure to GDP has increased from 8.2 per cent to 9.5 per cent. Expenditure on workforce services has also been growing strongly and, while it is difficult to be precise, it currently accounts for about two thirds of overall spending.
- The nursing group of occupations makes up more than 50 per cent of the health workforce of about 450 000 people, with the medical group accounting for about 12 per cent. Allied health workers in total account for about 9 per cent.
- Workforce numbers for most professions, with the possible exception of nurses and dentists, have been growing significantly faster than population growth. Between 1996 and 2001, the health workforce increased by over 11 per cent, nearly double population growth of 6 per cent. Over that period, the numbers of allied and complementary health workers grew by more than 25 per cent.
- Although workforce numbers have increased significantly, several key trends are affecting workforce participation and availability. They include:
  - workforce ageing;
  - feminisation across a wider range of professions;
  - lower average working hours;
  - increasing specialisation in a number of professions;
  - issues of job satisfaction and other factors which result in a considerable number of health workers not practising in their profession; and

  - changing models of care and service delivery.
- Policy, funding and payment arrangements in recent years have reinforced a trend towards provision of services in the private health sector.
- Changes in the education and training sector directed at enhancing qualifications and skills have had the side effect of lengthening the training pipeline.
- The health system has become increasingly reliant on overseas trained professionals, particularly for the medical occupations. For example, OTDs now make up 25 per cent of the overall medical workforce compared to 19 per cent a decade ago.

Appendix B sets out the relevant characteristics of the Australian health workforce and the key institutional and regulatory settings within which it works.

2.2 Current workforce issues

Many of the current issues of concern have been well canvassed in other documents and forums, including the Commission's own Issues Paper (PC 2005b). Several are explored in some detail below so as to lay in place some foundation stones for the draft proposals contained in this Position Paper.

Workforce shortages

Given the nature of 'demand' for health care, and the extensive involvement of governments in delivering or otherwise influencing the level of resources provided to meet that demand, defining a workforce 'shortage' is no easy matter. Furthermore, the focus on 'professions' rather than health workforce competencies can distort the conclusions about the capacity of the current workforce to meet health care needs. Nevertheless, participants presented evidence that there are shortages in overall numbers across a range of the medical, nursing, dental and allied health professions.

Some of these shortages may be short term. Where the training is of short duration (such as in some allied health and nursing programs), workforce numbers can respond relatively quickly. Indeed, most health professions operate in an environment where many of the signals that dictate behaviour in less regulated markets still come into play. Hence, workforce shortages will often allow an upward drift of remuneration levels, with the higher financial rewards in turn attracting more workforce entrants — though underlying impediments such as fiscal constraints, distortionary payment arrangements or inappropriate limits on scope of practice can limit the benefits of such increases in supply.

Moreover, in some cases, the current shortages have engendered explicit policy responses — for example, the Australian Government has significantly increased the number of undergraduate medical places and nursing has been declared a national priority area. However, some participants considered that little government recognition had been given to current and projected shortages in other areas, including dental and allied health services.

Also, in many areas of service need, evidence points to longer term structural shortages which will only be overcome through more fundamental reform.

Workforce distribution

It is widely recognised that the geographic spread of the health workforce does not reflect the distribution of the population. In particular, apart from nurses, the relative number of health professionals diminishes for communities located further away from major centres. Thus in 'remote' areas, for example, the GP to population ratio is slightly over half of that in the cities, for physiotherapists it is less than a half and for specialists it is under one-fifth (see chapter 10).

That said, the outlook for the health workforce outside of the major cities is far from universally negative. Access outcomes in a number of the major regional centres, although not always satisfactory, are not greatly different to outcomes in the cities and their outer metropolitan suburbs in particular. Those regional centres are in turn providing a service base for residents in surrounding communities. Also, there are examples of smaller communities that have successfully implemented innovative programs to improve their access to health workers and health services more generally. A range of government initiatives including financial incentives, bonding arrangements and alternative remuneration structures have also been introduced to improve access to health workers in rural and remote areas. Those initiatives are discussed in chapter 10.

Making the best use of existing competencies

Using the skills of the existing workforce in the most effective way possible is an obvious way to lessen the impact of workforce shortages and distribution problems. In this respect, many concerns were expressed about impediments affecting allowable scopes of work, appropriate mix of competencies and job redesign and substitution. Representatives of registered nurses, physiotherapists and pharmacists, for example, considered that their training and skills suited them for 'higher level' tasks. Many submissions called for greater development of an 'assistant in' stream of workers to take over some of the 'lower level' tasks — including from those whose scope of practice would be directly affected (such as physiotherapists).

However, such specific proposals for change require detailed consideration, including of their likely impacts on the quality and safety of service provision. They are thus beyond the remit of this study and the competencies of the Commission. That said, as succinctly stated by AHMAC, the guiding principle to enable the best use of scarce workforce resources should be that :

> … wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care. (sub. 166, p. 9)

These issues are explored in chapter 4.

Education and training

Education and training arrangements are adapting to the changing health services needs of the community and the consequent changing requirements for the health workforce. Nonetheless, there were various references by participants to rigidities, fragmentation and disconnects in the system. Two major issues raised were:

- a lack of coordination between health planners and those responsible for setting the number of university places in the various health professional areas, resulting in gaps between health service needs and the numbers of appropriately trained professionals; and
- inadequate availability and funding of clinical training which, according to participants, also fails to expose students to the full range of health care settings.

Many curriculum issues were also canvassed, as was the nature of the postgraduate professional year (for nursing, in particular) needed to make graduates 'job-ready'. However, in contrast to their views on university-based health workforce training, a few participants commented favourably on the flexibility, delivery modes and competency-based focus of the VET sector. Education and training issues are discussed in chapter 5.

Funding and payment arrangements

Current arrangements for funding and payment of the services provided by the health workforce detract in a number of ways from its effectiveness and also serve to inhibit workforce change (see section 2.4). For example:

- Division of funding responsibility for different services across two levels of government has created incentives for cost shifting.
- There have been ongoing disputes between state and territory health departments and specialist colleges over funding for clinical placements.

- Supply side controls to contain costs, such as restricted access to MBS provider numbers, may not pay sufficient attention to the need to match appropriate workforce skills to health needs.
- Greater provision of health care in private settings, particularly private hospitals, has led to an associated shift in patient load and workforce and put more pressure on clinical training in public teaching hospitals.
- Some relativities in payment schedules do not appropriately reflect differences in the complexity and intrinsic value of services to the community.
- The structure of the MBS, coupled with the fee-for-service model, may also increase practitioner resistance to job substitution and redesign.

Many participants considered that levels of remuneration and inadequate funding were the underlying causes of many current problems and called for additional government support to be provided. Without question, if funding was substantially increased, many of these problems could be reduced. Nevertheless, as outlined above, funding is already increasing significantly in real per capita terms. And, as discussed below, the future challenges facing the workforce will only magnify these expenditure pressures.

The Commission has focused much of this study on practical, financially responsible ways to make best use of the health workforce within the context of whatever expenditure levels are set by governments and the community. Improvements to funding and payment arrangements to address the distortions outlined above are considered in chapter 8.

Job satisfaction and retention

Many participants commented on a range of factors that adversely affect the job satisfaction of workers and thus their productivity and, ultimately, their willingness to remain in the health workforce. This problem should not be underestimated — the Australian Nursing Federation (Vic Branch), for example, pointed out that:

> … some 30 000 registered nurses in NSW alone are not working … because of lack of job satisfaction, poor pay and conditions and a rigid inflexible management structure' (sub. 133, p. 1).

In the specific area of mental health, the Royal Australian College of Psychiatrists noted that the stigma associated with the profession was causing problems as was '… an environment perceived as being continually in crisis mode: highly stressful, unrewarding and unsafe.' (sub. 79, p. 7) The Australian College of non-VR General Practitioners said that because their members (which account for 10 per cent of the

total GP workforce) receive less than 70 per cent of the Medicare rebate available to vocationally registered GPs:

> Non VR GPs have been leaving general practice … and moving into other sub specialities such as women's health, cosmetic surgery, skin clinics, insurance companies and workcover clinics where the rate of pay is more attractive. (sub. 128, p. 1)

While recognising the importance of these problems, the Commission has not sought to map out detailed strategies to address them, at least directly. This in part reflects the Commission's view that it can add greater value through the development of system-wide reform frameworks and principles. That said, given the linkages between job satisfaction, job design, scopes of practice and funding arrangements, the Commission considers that its broader reform proposals in those areas will go some way toward improving job satisfaction.

2.3 Emerging challenges

As well as dealing with current problems, health workforce policy will need to grapple with the implications of changes in the nature and quantum of demand for health services, as well as with important workforce supply side factors.

Per capita demand will increase strongly

Future health care demand will depend on many factors, including both population growth and the growth in per capita demand. The primary drivers of the latter being technological advances, higher incomes and expectations and ageing. Their impacts will play out against the backdrop of a substantial change in the burden of disease.

Changes in the burden of disease

The nature of future health care demand is expected to change in line with anticipated changes in the burden of disease facing the community. This will fundamentally affect the models of care employed in service delivery, as well as the number and types of health care workers that will be required (see box 2.1).

Of particular importance in this context will be the increase in the incidence of chronic disease as the population ages (fuelling a shift in demand from episodic acute care to ongoing team-based management and care in community settings). For example:

- The Victorian Department of Human Services and Health (HSV 1999) estimated that by 2016:
  - dementia will replace ischaemic heart disease as the most prevalent disease condition affecting females (it ranked fourth in 1996);
  - type II diabetes will become the second most common condition affecting males (fifth in 1996);
  - prostate cancer will become the third most prevalent condition affecting males (eighth in 1996) and lung cancer the fifth most common condition in females (eleventh in 1996); and
  - the incidence of stroke is expected to fall significantly from being the second most common disease for both males and females to ninth and tenth respectively.
- The New South Wales Department of Health estimates that between 2001 and 2026: the incidence of diabetes will increase by 176 per cent, dementia by 107 per cent, vision disorders by 93 per cent, hearing loss by 87 per cent and chronic musculoskeletal disorders by 79 per cent (NSW Health 2005, p. 4).

The health behaviours of the population are driving some of these changes. In NSW in 2004, of the population aged 16 years and over, 23 per cent of males and 19 per cent of females were current smokers. For this age group overall, 48 per cent were classified as overweight or obese, only 52 per cent reported adequate levels of physical activity, 13 per cent were at high risk from drinking alcohol and the level of protection from the sun (hats and sunscreens) amongst secondary school students was declining.

These trends have increased attention on the potential to influence demand through a shift to preventative rather than curative medicine — not just for the perceived health benefits but also because it is seen as a means to reduce future workforce requirements. In this context, AHMAC noted that:

> Improving health [though investment in disease prevention] has the potential to reduce demand for health services and hence reduce the need for more highly skilled health professionals. (sub. 166, p. 29)

Box 2.1 **Some participants' views on future health needs**

Professor Wayne Gibbon:

> Hospitals and health service structures, as they currently exist were defined to meet the needs of the past. New technologies and treatment modalities, and changing demographics provide both the requirement and the opportunity to establish contemporary models of care that are more attuned to the needs of contemporary society. It is an economic and social imperative that we establish models of care that are community based and that enable people to be cared for and managed within the community. (sub. 48, p. 1)

Committee of Deans of Australian Medical Schools:

> … the growing provision of health care by teams rather than individuals, particularly for the aged and chronically ill, has presented the as yet largely unrealised challenge of interprofessional education and learning … suggested a different paradigm of medical practice, one which was more community-based and more generalist. (sub. 49, p. 6)

Australian Health Policy Institute:

> At present, patients with complex health issues are typically managed in the same way as patients with discrete problems — by a succession of individuals addressing specific problems, often without relative priorities or proper recognition of the interactions. As the population ages the proportion of patients with multiple or complex health care needs will increase. Each patient needs to be managed by a form of case manager who is able to coordinate a team of multi-/ inter-disciplinary care providers and establish a care plan by consultation and then ensure it is delivered. These managers can be more generalist health care workers because they will not actually be providing service delivery, just managing it. (sub. 22, p. 1):

Australian Nursing Federation (Vic Branch):

> There has been scant regard or research given to actual models of health care which may be suitable and sustainable in the future. Much of the debate is hospital centric, with an illness focus. Consumer focused primary health and health promotion models of care also need to be factored into the equation. (sub. 133, p. 3)

Faculty of Medicine, Health and Molecular Science, James Cook University:

> The ageing population, the burden of chronic disease, professional workforce shortages, changing demographics and aspirations of graduates, development of information and communication technology and emergence of new health disciplines — all mean that new ways of thinking about the organisation of health workforce labour and health service delivery structures need to be explored. (sub. 106, p. 11)

General Practice Education and Training:

> Much medical education occurs in acute care settings but increasingly the system must focus on chronic conditions managed by … multidisciplinary teams in community settings. (sub. 129, p. 28)

The Royal Australian College of General Practitioners:

> Research has demonstrated that [Point of Care Testing] is accurate, practical and a community appropriate way of monitoring chronic conditions including diabetes. … The use of PoCT is likely to enable a reduction in repeat appointments currently required to provide results and make changes to treatment. Empirical evidence also suggests that it may result in more efficient workforce utilisation through reduced need to refer testing to other service providers and the administration involved in this process. (sub. 143, pp. 12-13)

AHMAC suggested a number of possible approaches to develop improved public health and support individuals in managing their own health including:

- Increased investment in early intervention and prevention activities to avoid the development of illnesses and diseases or minimise their progression to an acute stage;
- Increased support for self-management by individuals; and
- Integrated health education and health promotion initiatives to improve the information available to health consumers and encourage them to make personal investments in preventing or better managing health conditions. (sub. 166, p. 30)

These types of measures would sit alongside a range of existing government policies aimed at controlling or altering the nature of demand for health care and health workers — such as controls over Medicare provider numbers, the gate-keeping role played by primary care providers and queuing for non-urgent treatment in public hospitals.

Technological advances

As new drugs, treatments and medical procedures are developed, and existing treatments with higher quality are offered, medical practitioners and consumers will seek to take advantage of the perceived benefits (see box 2.2).

Some particular technological changes are likely to be cost reducing, rather than increasing. However, the Commission has estimated in its related study into the *Impacts of Advances in Medical Technology in Australia* (PC 2005c), that over the decade to 2002-03, technological change has resulted in annual per capita real growth in expenditure averaging about 1.9 percentage points per year — excluding the linked income effect (see below). If anything, it could be expected that this rate will increase into the future.

Technological advances have a range of effects on the demand for health workers and their skill requirements. For example, the surgical fitting of increasingly complex prostheses requires an understanding of engineering concepts, and advances in remote monitoring technologies enable, and stimulate demand for, care in the home. Some technologies also reduce the need for hospitalisation, surgery or extended residential care. Others create new cohorts of patients to be treated, extend treatment periods, or require new types of workers to deliver them. In the extreme, some technologies, such as robotics, have the potential to substitute for conventional health workers. Thus, the impact of technological change on aggregate demand for health workers is extremely difficult to predict.

Box 2.2 **Technology and health expenditure**

The use of new medical technologies has been a major driver of growth in health expenditure. Over the period 1992-93 to 2002-03, over one third of the annual growth in Australia's real health care expenditure was attributable to technological advances. Such pressures are expected to continue, or even accelerate.

Decisions to use particular technologies are usually driven by practitioners, in consultation with their patients, and are influenced by the various incentives and constraints imposed by the health system. The major factors influencing provider decisions to use newer technologies include:

- awareness of technological advances and their potential benefits;
- assessment of clinical need;
- financial and other incentives provided to practitioners and institutions, for example, by reimbursement arrangements and liability laws;
- budget and other constraints, such as regulations and guidelines, imposed by governments and institutions, including hospitals; and
- the skills and availability of health professionals.

Whether particular advances in medical technology increase or decrease spending on health care depends on the impact on unit treatment costs, the level of service use and their impact on spending on other services. To date, technology appears to have played a key role in driving spending growth in two key areas — hospital care and pharmaceuticals. For hospital care, the average cost of treatment has risen, partly due to growth in spending on increasingly expensive technologies such as prostheses. And while new pharmaceuticals have improved treatment options they have also expanded those options, as well as increasing the average cost of PBS-listed drugs.

Of course, increases in expenditure have brought benefits — there have been measurable improvements in various indicators of health and mortality in recent years. However, it is difficult to apportion these to health spending or particular technologies with any degree of precision.

Source: PC (2005c).

Higher incomes and expectations

As incomes rise, communities and individuals alike are usually willing to spend more on maintaining and improving their health. Particularly at an individual level, the size of this effect is linked to the development and dispersion of new technology (PC 2005c). That is, new technology provides the wherewithal for translating increased willingness to consume health care services into actual spending decisions. Even so, the Commission has recently estimated that per capita real growth in health expenditure due to income growth (excluding the technology link)

over the decade to 2002-03 averaged some 1.5 percentage points per year (PC 2005c).

Income linked expenditure growth is expected to continue into the future. Further, with better education and the availability of much more relevant information (for example, through the internet), health care consumers are becoming more discerning, with higher expectations about the services they require. This, too, will tend to increase per capita expenditure.

That said, the health care expenditure implications of higher incomes and technological change should possibly be of less concern than demand growth due to population ageing (see below) — as income growth affords, in large part, the means to fund greater willingness to spend on health care services and the technological advances that this stimulates.

An ageing population

The fourth factor impacting on the per capita demand for health services is ageing. As the average age of the Australian population rises, per capita demand for health services will rise, as older people typically need more health services than young people (see box 2.3). Currently, across health services as a whole, expenditure on the over 65s is around 4 times more per person than that on those under 65, and rises to 6 to 9 times more for those over 85 (PC 2005a).

The Commission has estimated that over the decade to 2002-03, population ageing increased real per capita health expenditure by some 0.6 percentage points per annum on average (PC 2005c). However, population ageing in Australia is still at an early stage. It is expected that, driven by long-term declines in fertility and increased longevity, one-quarter of Australians will be aged 65 years or more by 2045, around double the present proportion. Although there is a degree of debate between commentators in the field, and there are interacting effects of trends in disability and disease prevalence (see box 2.3), the Commission's view is that ageing is likely to strongly increase the future rate of health expenditure growth.

Workforce supply factors are also important

The extent to which health service needs can be met, and consequently the level of health expenditure, is affected not only by trends in demand, but also by supply side factors. Health workforce supply is influenced by both developments in the broader labour market and health specific issues including the level of workforce re-entry, retention rates, overseas recruitment and how effectively the existing workforce is deployed.

Box 2.3 **Ageing and health expenditure**

Over the period 1991-92 to 2001-02, population ageing accounted for an estimated 13 per cent of the growth in real health care expenditure (PC 2005a, p. 47). However, in future, ageing is expected to play an increasing role in driving expenditure growth, both in its own right and as it interacts with other pressures:

- As technology improves, more medical procedures can be performed safely on elderly people, and society's expectation is currently that the elderly will receive such treatment.
- Research and technological developments tend to focus on where the disease burden is greatest (and where commercial payoffs will be highest) — commonly illnesses associated with ageing.

That said, there is not a complete consensus on the *extent* to which population ageing will increase future health care needs. Some commentators argue that the effect of ageing will continue to be swamped by the effects of income growth and technology, that people will be healthier in the future thereby offsetting the impacts of ageing, and/or that most costs are associated with the last years of life, so that living longer will not involve significantly higher health costs.

Nevertheless, after considering the available evidence, a recent report by the Commission on the implications of ageing concluded that:

- demand and technology are acting to increase per capita expenditure more for older age groups, suggesting that the rising share of older people in the future will compound the underlying growth in health expenditure arising from income growth and technology;
- foreseeable trends in disease prevalence and disability seem unlikely to alleviate the fiscal pressure associated with ageing; and
- available data supports the view that costs rise with age rather than arising predominantly at the end of life.

Ageing of the population will also result in increased demand for aged care, in both residential and community settings.

Source: PC (2005a).

Broader labour market issues

For the labour market as a whole, the ageing population will be a major influence on future workforce supply. Labour participation falls significantly after the age of 55 — many in this age group reduce their hours or move out of the labour force altogether. Thus, as the population ages in future, aggregate labour participation rates will decline, all other things being equal. Recent Commission projections suggest that, in 2044-45, the labour force participation rate will be 7 per cent lower,

and average hours worked per person 10 per cent lower, than in the absence of population ageing (PC 2005a).

Thus, effective labour supply (the total number of hours actually worked each year) will grow more slowly than it would have in the absence of ageing. For example, given a continuation of existing participation trends, labour supply growth is projected to be slower than population growth from 2011-12 (PC 2005a).

These influences within the broader labour market will stimulate both short-term and long-term responses. Upward pressure on real wages is likely to emerge, stimulating changes in the participation rate as some people are encouraged to work longer or re-enter the workforce. In the longer term, changes in real wages will also trigger movement of workers between sectors, generate substitution between labour and other inputs, and focus attention on the scope for changes in education and training regimes to expedite workforce preparation.

Given the labour-intensive nature of many health services, and the more limited scope to substitute other inputs for labour — although this may change somewhat as medical technology develops — it is likely that real wage pressures in the health area will be stronger than in many other parts of the economy. Redistribution of workers from other sectors, and retraining or re-entry of health workers, will only partly offset this. And as many other countries are likely to experience shortages of workers, it is likely to become more difficult to source appropriately trained professionals from overseas. Thus, wage-related cost pressures will be significant.

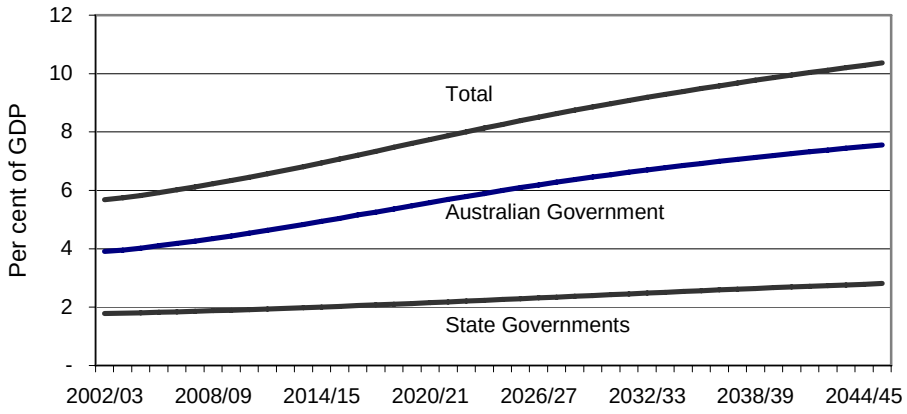
This of itself is likely to stimulate efforts to develop new models of care that economise on the use of the supply of increasingly valuable and costly health workers. However, wage costs aside, the difficulty of securing sufficient numbers of workers to sustain current service delivery models is likely to require significant adjustments in parts of the workforce. As the South Australia Government succinctly stated: ‘fine tuning at the margins will not be sufficient to effect the necessary structural changes to address the problem’ (sub. 82, p. 21).

Such pressures are also likely to focus policy attention on retaining existing health workers for longer; attracting some workers who have left the workforce or who are working in other sectors back into the health area; and improving the effectiveness of recruitment of overseas trained health workers. In the latter case, for example, it was put to the Commission by Professor Wayne Gibbon that Australia could even look at establishing health education and training facilities in developing countries where labour will be more plentiful (sub. 48, p. 5).

Enhancing productivity

With health services demand likely to continue to grow strongly over the next decade and beyond and the costs of employing health workers likely to rise, policy changes will be required to prevent future per capita expenditure on health workforce services and health care more generally from escalating rapidly. Indeed, the Commission has recently projected that total health care expenditure could account for at least 16 per cent of GDP by 2044-45. As governments between them currently fund two-thirds of all health costs, their fiscal burden would be at least 10 per cent of GDP (see figure 2.1).

Figure 2.1 **Projected (own-source) government expenditure on health care as a proportion of GDP 2003-04 to 2044-45**



a Projected using a non-demographic growth rate of 0.6 percentage points above the projected growth in GDP per capita.

Source: PC (2005a).

Many have questioned the fiscal sustainability of such growth in spending. The National Rural Health Alliance and the College of Medicine and Health Sciences, ANU, came to the following conclusion:

> … where the supply of public services is necessarily limited by what is politically and economically possible through the tax system, it is not practicable for governments to meet all consumer demands for 'health' or, for that matter, for education, recreation, transport or housing services. (sub. 126, p. 5)

To help contain future expenditure growth, it is important that service delivery becomes more efficient and cost-effective. As the major input to service delivery, there is a similar imperative to make the best use of the available skills and competencies of the current health workforce while maintaining appropriate levels of quality and safety.

This broad productivity imperative was widely recognised in submissions and is also central to the National Health Workforce Strategic Framework which provides an agreed foundation for the long term development of the workforce across the entirety of the health system (see chapter 3).

From this point on, there is an increasing divergence of views on how best to pursue these commonly agreed goals.

2.4 What inhibits workforce change?

In keeping with the rest of the health care system, Australia's health workforce arrangements are both extraordinarily complex and highly interdependent. As the Commission has found, understanding how the various components of the arrangements fit together, and what policies and programs apply in each area is a major challenge in itself. This, in turn, renders policy formulation more difficult and increases the incentive to approach policy development on a compartmentalised basis. But in developing effective reform proposals, it is important that the various cogs which drive health workforce productivity move in reinforcing directions.

In addition, when it comes to the actual design and implementation of reform proposals, it is necessary to identify and overcome a variety of systemic impediments to sustainable and responsive workforce arrangements. The Commission has grouped these impediments into the following categories.

Fragmented roles, responsibilities and regulatory arrangements

The health workforce is planned, educated, deployed, funded and regulated by a myriad of different public and private entities. This can be advantageous in a number of respects. For example, it provides for the development and application of specialised knowledge in specific areas.

But the number of entities involved, and especially the division of responsibility for the various parts of the health workforce system between and within governments, results in conflicting objectives, inefficiencies and cost and blame shifting. All of this detracts from developing a consensus on how to improve workforce productivity. In the words of the Australian Private Hospitals Association:

> Realistically, until an adequate resolution of this fragmentation [of roles and responsibilities] can be found, sustainable, long-term solutions to shortcomings in the health workforce are unlikely to be developed, let alone agreed. (sub. 109, p. 4)

Importantly, in the communiqué issued after its June 2005 meeting, CoAG noted that 'governments recognised that the health system can be improved by clarifying roles and responsibilities, and by reducing duplication and gaps in services' (CoAG 2005).

Ineffective coordination between governments, planners, educators and service providers

Effective coordination could potentially ameliorate some of the problems arising from the fragmentation of roles and responsibilities between the many bodies involved in health care. This point was highlighted by AHMAC which said:

> Better integration and coordination … between the two levels of government … will be essential to addressing health workforce shortages. This cooperation is essential to the success of short-term improvements in the system for example in improving the interface between education and health sectors. (sub. 166, p. i)

Similarly, the Council of Deans of Australian Medical Schools noted that:

> … a national coordination mechanism for the continuum of medical education is essential so that flexible, viable and innovative new models can be explored and, if feasible and successful, funded. (sub. 49, p. 3)

However, an array of input to this study indicates that coordination and collaboration has been deficient in a number of key areas and has been a major contributor to existing problems. Specific shortcomings that have been raised include:

- ineffective coordination between governments at the planning phase — leading, for example, to difficulties in accessing data from individual jurisdictions and subsequent restrictions on the range of information available to individual service providers when undertaking their own strategic planning exercises;
- failure to support the development of a minimum health workforce data set and common terminology;
- failure to adequately link projections of the numbers of health workers likely to be required in future, and the needs of employers, with the number and occupational distribution of education and training places;
- failure to ensure that the potential number of postgraduate clinical training places is likely to match student outflows from the university and VET sectors; and
- limited coordination of reform initiatives between jurisdictions, inadequate sharing of evaluation outcomes and little effort devoted to identifying best practice strategies.

Inflexible regulatory practices

Regulation has an important role to play in the health sector in ensuring appropriate clinical standards and promoting safety and quality objectives. However, as is evident in the discussion in a number of the later chapters, some aspects of the current arrangements are unduly rigid and thus may actually impede a more efficient and effective health workforce. For example, by focusing narrowly on existing professions, many registration arrangements (see chapter 7) reduce the flexibility of the workforce to develop new competencies and scopes of work in response to the changing health care needs of the community. In this respect, the Queensland Government said:

> ... the jurisdictional and siloed approach to regulation undermines the capacity for the development or expansion of roles that might best, flexibly provide the health care of the future. (sub. 171, p. 9).

Current arrangements for the accreditation of education and training programs (see chapter 6) similarly serve to reinforce traditional professional roles and boundaries and impede job substitution and redesign. In addition, the multitude of accreditation agencies has resulted in a lack of consistency across those agencies in the requirements they impose on educational institutions and trainers. This has contributed to increased complexity in health workforce arrangements, as well as imposing added compliance costs on these institutions and trainers.

Distortionary funding and payments mechanisms

Current funding and payment arrangements for the services provided by the health workforce detract in a number of ways from its effective deployment and also affect the career choices of those contemplating a career in the health area. Moreover, changes to overcome such problems could reduce the incomes of some of those already in the workforce. Not surprisingly, this can make it very difficult to break down some of the professional boundaries, workplace rigidities and inefficiencies that current funding arrangements reinforce.

Entrenched custom and practice

Custom and practice are important drivers of behaviour in the health workforce, as they are in various other workforces. Often, of course, the experience underpinning such custom and practice serves patients well. However, along with remuneration concerns, it can also stifle necessary and justifiable innovation and change in workplace practices and the evolution of job design and education and training arrangements. Among other things this can, in turn:

- impede transferability of skills across professional boundaries;
- prevent appropriate recognition of prior learning;
- constrain the move to a more competency-based education and training system; and
- discourage the further development of multidisciplinary care approaches.

Similarly, inflexible practices in the workplace can reduce productivity and job satisfaction.

Relative to some other sectors, professional associations and other interest groups necessarily play a major role in policy formulation and implementation in the health area. But there have been concerns that the entry rules and conduct codes administered by some professional bodies, while primarily directed at maintaining quality and safety standards, can involve an element of income and workload protection.

Quality and safety issues have, in fact, been prominent in debates regarding the appropriateness of a range of potential policy initiatives — changes to scopes of practice being a notable example. This highlights the need for careful evaluation of the costs and benefits of particular reform options to ensure that change is not blocked by unsubstantiated claims.

Significantly, effective transparency and accountability mechanisms and structures that would help to minimise the scope for unwarranted 'patch protection' seem to have been lacking within parts of the health workforce sector. The Australian Competition and Consumer Commission highlighted this issue in its determination on the training, accreditation and assessment practices of the Royal Australian College of Surgeons (ACCC 2003).

Cultural attitudes within the health workforce also entrench notions of 'high status' and 'low status' work areas. This can reinforce the difficulties faced by such service areas as mental health, disability care and aged care, in attracting and retaining sufficient numbers of appropriately trained staff (see chapter 11).

In summary, a number of systemic barriers and impediments have prevented Australia's health workforce from achieving its full potential and from providing Australians with accessible, high quality and safe health services in the most efficient, effective and financially sustainable manner. If not addressed, these systemic blockers are likely to become increasingly costly as the workforce seeks to meet the significant challenges ahead.

3 Objectives and strategies

Key points

- To fully address some of the systemic impediments to better health workforce outcomes, changes to the broader health and education and training systems would be required. However, even within the more limited purview of this study, there is still scope for considerable improvement.
- The key objective of workforce reform should be to enhance community access to high quality, safe, efficient, effective and financially sustainable health services, through facilitating the development of health workforce arrangements that: maximise the contribution and efficiency of the available health workforce at any point in time and help to reduce its maldistribution; and are able to respond in a timely effective manner to changing needs and pressures.
- The National Health Workforce Strategic Framework provides a reasonable foundation for the pursuit of better outcomes. CoAG endorsement of the framework (with one modification) would help to lock in commitment from the education, finance and central policy coordination areas of governments.
- Two broad approaches will be required for reform:
  - the removal of impediments to more responsive workforce arrangements; and
  - more active approaches that seek to define and pursue explicit pathways for desired change.
- Successful reform across the health workforce arrangements will be facilitated by:
- clear and well enunciated objectives;
- stakeholders working in a collaborative and cooperative fashion;
- strong leadership at the political level;
- adherence to good regulatory and governance practice;
- willingness to explore new ways of doing things, including through the potential to harness competition and market disciplines; and
- effective engagement with those affected by change.

As noted in chapter 1, health workforce policy is only one component of the wider health care system. There have been numerous recent calls for a review of the totality of the system, including by the Commission in its report on National Competition Policy (PC 2005d). Indeed, this current study is paralleling a review for CoAG by Senior Officials of some wider health issues, including: improving the integration of the health care system; addressing problems at the interface between the health and aged care and disability systems; increasing the health system's focus

on prevention and health promotion; and accelerating work on a national electronic health records system.

Some reforms to the wider health care system — and especially to the way health care is financed and the quantum of that funding — would have major effects on workforce demand and supply. They would also widen the available menu of options for improving workforce productivity and, in some cases, enhance the impact of changes that could be implemented within the current parameters of the health care system.

Subsequent chapters draw attention to some of these wider reform issues. But the Commission has been mindful that this is not an investigation into the health care system as a whole, or even into health care financing, let alone into general education and training policies. This necessarily constrains what might be achieved in regard to workforce reform within the context of the present study.

However, as the detailed and thoughtful submissions to this review have pointed out, there are considerable workforce efficiency and effectiveness gains to be reaped within the constraints of the current health care system and the public expenditure limits placed on it by governments and the community.

3.1 Objectives for an efficient and effective workforce

As part of the broader health care system, health workforce arrangements are in some senses a means to an end. Hence, options to remove or ameliorate institutional, procedural, regulatory and funding impediments to better workforce arrangements must ultimately be assessed on the basis of their contribution to the achievement of broader health care goals. Accordingly, the Commission considers that the objective of the reforms that emerge from this study should be:

- to enhance community access to high quality, safe, efficient, effective and financially sustainable health services, through facilitating the development of health workforce arrangements that:
  - maximise the contribution and efficiency of the available health workforce at any point in time and help to reduce its maldistribution; and
  - are able to respond in a timely effective manner to changing needs and pressures.

Working toward such an objective should increase the prospect that reformed health workforce arrangements would, within any given expenditure constraint, deliver an appropriate number of health workers with the right skills mix. These arrangements

should also deliver them when and where required, in terms both of care settings and geographic distribution.

The appropriateness and success of health workforce changes and reforms could be assessed against a number of performance indicators, including measures of:

- improvements in the productivity of health workers;
- quality and safety;
- the nature and extent of evolution in job design and responsibilities;
- the costs and times taken to educate and train health workers;
- the ability of those completing health workforce training to utilise their competencies to participate fully in changing workplace environments; and
- how well models of care and service delivery adapt to the changing burden of disease.

A menu of potential indicators — both input and output based — is provided by the broader National Health Performance Framework developed by the Steering Committee Reporting on Government Service Provision (see box 3.1).

Foundation stone — the National Health Workforce Strategic Framework

In 2004, key stakeholders in the health care sector agreed to the National Health Workforce Strategic Framework and it was subsequently endorsed by all Health Ministers. As outlined in box 3.2, the NHWSF sets out a range of principles and objectives for the health workforce and broad strategies for achieving those objectives. It also incorporates related frameworks for Indigenous and rural and remote health workforces and links to other areas such as the National Mental Health Plan 2003-2008 (Australian Health Ministers 2003).

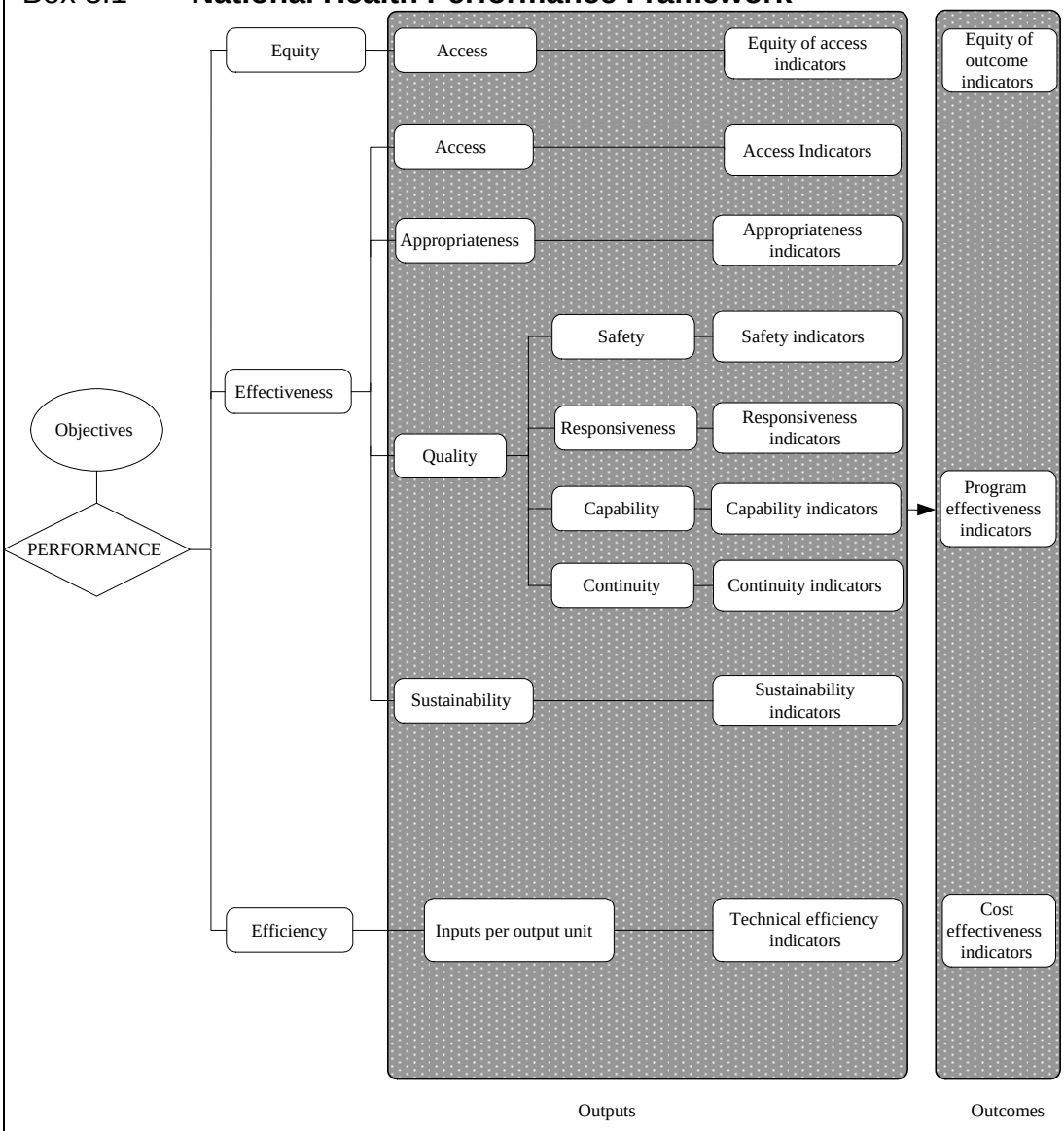
More recently, the NHWSF has been complemented by the National Aged Care Workforce Strategy (NACWS) — developed by the Ministerial Aged Care Workforce Committee comprising representatives from a cross-section of aged care interests. The NACWS is intended to provide a framework 'for the aged care sector to plan and develop best practice workplace models that will help deliver high quality care for older Australians'. (CoAG 2005, p. iii).

There was some scepticism about the value of such a framework in its current form. For example, the Australian Private Hospitals Association said:

> … while the Framework was formed from a consultative process and it does identify common principles, the Framework does not adequately point to the ways in which these principles can be implemented to achieve genuine reform. (sub. 109, p. 5)

However, most participants who commented on the NHWSF in particular saw it as a positive step in bringing health workforce stakeholders together; getting high level agreement on what needs to be done; encouraging a longer term focus rather than short term crisis management; and establishing a useful reference point for specific reform directions.

Box 3.1 **National Health Performance Framework**



Source: SCRGSP (2005b).

Box 3.2 The National Health Workforce Strategic Framework

The NHWSF is intended to guide national health workforce policy and planning over a 10 year time frame. It was developed in consultation with governments, consumers, carers, Indigenous groups, professional organisations, health service providers and the education and training sectors. It incorporates related frameworks covering the Aboriginal and Torres Strait Islander health workforce and the health workforce in rural, regional and remote areas, and also links with the National Mental Health Plan (2003) and with the work of the Australian Council for Safety and Quality in Health Care.

The framework embodies seven core principles designed to provide 'a simple set of rules, guidelines and aims which allow all stakeholders to apply them to their own circumstances with a minimum of prescription'. The principles are:

1. Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.
2. Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.
3. All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.
4. Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.
5. To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.
6. Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.
7. Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require:
   - cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;
   - stakeholder commitment to the vision, principles and strategies outlined in this framework;
   - a nationally consistent approach;
   - best use of resources to respond to the strategies proposed in this framework; and
   - a monitoring, evaluation and reporting process.

(continued)

Box 3.2 **continued**

The framework also outlines a range of potential strategies for pursuing these principles — though the listing is not intended to be exhaustive, or directly linked to an 'audit' of current initiatives. Indeed, the explicit intention is for the framework to evolve over time:

> … new community expectations and changing economies and environments will mean that the health needs of the Australian people, and the workforce required to meet those needs, will almost certainly change over time beyond this framework. Accordingly, the framework should be seen as an evolutionary document that will require regular updating and reassessment.

Source: AHMC (2004b).

The Commission concurs with these latter views and sees the NHWSF as providing a reasonable foundation stone for the range of specific initiatives that will be required to deliver more responsive and sustainable health workforce arrangements. With one exception, its core principles, which emphasise the importance of collaboration amongst stakeholders; the role of an evidence-based approach to policy formulation; the need to monitor, evaluate and report on progress; and the need to recognise links to the broader health care system — appear appropriate.

However, the Commission has a concern with the particular reference in Principle 1 to achieving 'national self sufficiency'. In its view, provided there is compliance with ethical protocols, it is appropriate for Australia to draw on suitably qualified, overseas trained, professionals to supplement the locally trained workforce, and to recognise that its own health workers will migrate to other countries, either temporarily as part of their broader development, or permanently.

Accordingly, the Commission considers that the first principle in the NHWSF should more actively embrace the international nature of the health workforce and should be couched in terms of the need for Australia to produce sufficient numbers of health workers such that there is not an unsustainable reliance on health workers trained in other countries. The Commission notes, in this regard, that the framework is intended to be an evolutionary document, providing scope to modify any objectives or strategies that prove to be inherently inappropriate, or that are overtaken by changing circumstances.

Moreover, at the institutional and procedural level, there are also some avenues by which the effectiveness of the NHWSF could be increased.

First, though the framework has been signed off by Health Ministers, it does not have the explicit endorsement of their counterparts in education and training, or from Ministers responsible for finance or central policy coordination. This may

limit the value of the framework as a reform reference point, at least where coordination between these different areas of government is important to achieving better health outcomes.

In its Issues Paper, the Commission canvassed the value in having the NHWSF endorsed by the Council of Australian Governments (CoAG), so as to embrace the education, finance and central policy coordination areas of government. The Commission remains of the view that this would have considerable merit.

DRAFT PROPOSAL 3.1

In its upcoming assessment of ways to improve the level of integration within the health care system, CoAG should consider endorsing the National Health Workforce Strategic Framework, subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

Second, while there is provision for the evaluation of progress made against the framework's objectives, it appears that responsibility for such monitoring is intended to lie primarily with entities involved in developing and implementing the framework. Thus, the Australian Health Workforce Officials Committee (AHWOC) will report annually to the Australian Health Ministers Advisory Council and Australian Health Ministers.

Notwithstanding the expertise that AHWOC will bring to the evaluation process, experience elsewhere points to the value of independent monitoring in ensuring that deficiencies that emerge in reform programs are given proper airing, and in minimising the potential for particular interest groups to undermine the reform process. Further, as it is proposed that CoAG should consider endorsing the framework, it would be appropriate for Senior Officials to drive the reviews and co-ordinate the responses of various areas of governments to the outcomes of those reviews.

DRAFT PROPOSAL 3.2

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

3.2 Broad strategic approaches

One important part of the strategy to overcome current workforce shortages and future pressures will be to expand supply through, for example, training more health

workers and increasing retention rates. However, by itself, this will not be enough. In particular, it will also be important to improve the efficiency, effectiveness and responsiveness of the health workforce arrangements. In its Issues Paper, the Commission observed that:

> The most fundamental requirement for achieving better workforce outcomes seems clear. It is to create incentives and supporting institutional, funding and regulatory arrangements that encourage all parties to work efficiently, effectively and cooperatively to further the interests of patients and the wider community. This is important not only for getting maximum benefit from the available health workforce at any particular time, but also for promoting a system which can 'self adjust' to changing needs. (PC 2005b)

Input from submissions and in consultations and the Commission's further analysis has confirmed its view that this is what is broadly required.

Removing barriers and impediments

As is evident in the following chapters, in some cases, the Commission considers that more sustainable and responsive workforce arrangements can be achieved by addressing barriers and impediments in the current institutional and procedural frameworks that create perverse incentives, or otherwise detract from the efficient and effective delivery of health workforce services.

Though on occasion the removal of barriers and impediments may result in the cessation of particular arrangements, it is more likely to lead to the modification or streamlining of existing arrangements, where they continue to have legitimate objectives. For example, professional registration arrangements provide assurances to the community in terms of quality and safety, but could be amended, in conjunction with changes to accreditation, to facilitate wider scopes of practice and job redesign (see chapter 7).

To a large extent, this approach would enhance workforce responsiveness in accordance with the limited 'market forces' that exist within the current framework. That is, adjustment would be driven by the incentives facing the various stakeholders — the mechanism relied upon in most markets to deliver the best possible outcomes. As such, the approach would avoid some of the risks inherent in a more directed approach where policy makers override existing market forces and impose their own judgments as to what constitutes appropriate workforce arrangements (see below). It would also allow the workforce to develop and adapt in 'familiar territory' and build on the considerable change that has occurred to health workforce arrangements in recent years.

A more active approach

Equally, there are limits to what such an 'incentives-based' approach could achieve:

- As noted, many of the incentives are driven by the constitution of the broader health and education and training systems, which are not under review in this study — fee-for-service medicine being a case in point.
- The approach would not provide explicit levers to address entrenched custom and practice, or to deliver the coordination required to ensure complementary change in the different parts of the health workforce apparatus.
- And under this approach, there is no process by which the complexities and trade-offs often involved in major job substitution and redesign can be fully evaluated.

In such situations, an active approach which both identified the desired end point of reform and mechanisms for achieving those desired outcomes, is likely to have advantages over a non-directive and incremental 'incentive-based' approach. As well as providing a vehicle for cutting through entrenched custom and practice, it would also facilitate the effective coordination of the reform process. As noted, especially for significant workforce changes, complementary policy actions are often required at several points in the system, usually involving different levels of government. And perhaps most importantly, an active approach could be helpful in promoting greater emphasis in policy making and evaluation on how to get best value from the workforce as a whole, rather than from particular groups of health workers.

The Commission acknowledges that such an approach is not without risks. As experience in a range of other areas illustrates, directive judgements made by policy makers do not always prove to be correct, imposing sometimes significant costs on the community and impeding rather than facilitating adjustment.

However, in the Commission's view, with sensible implementation, such risks need not be excessive. Accordingly, and in the light of the limitations in some situations of relying solely on improved incentives, it has proposed more active reform approaches in a number of key areas.

3.3 Facilitators of successful reform

Australia's two decades of successful microeconomic reform provide important insights into broad factors that can help to both progress reform and ensure that the reforms are in the best interests of the community as a whole. Though the health

care sector is very different from many other parts of the economy that have undergone reform programs, several of the lessons learned are nonetheless applicable. Indeed, given the diverse range of entities involved across the health workforce arrangements, and the pervasive nature of government intervention, some of these facilitators will arguably be more important than in less complex areas. In the exploration of health workforce reform in subsequent chapters of this report, the Commission has drawn on the following elements of good program design.

Clear objectives

Successful policy reform requires agreement among key stakeholders on: the problems with the current arrangements that must be addressed; the objectives of the reform program; the strategies to be implemented; and a pre-agreed evaluative framework to assess the level of success and any need for strategy modification.

Collaboration, cooperation and leadership

As National Competition Policy has highlighted, where more than one level of government is involved in an area, a collaborative and coordinated approach will often deliver much better outcomes than can be achieved through individual governments acting independently. So too will collaborative effort between different areas of government involved in a particular policy area. As outlined above, facilitation of such collaboration and cooperation is one of the advantages of the more active approach to reform which the Commission is proposing in a number of areas.

Effective consultation and engagement with those directly affected by a reform process is also important in engendering support for reform, or at least reducing resistance to change, as well as in developing consensus on specific reform directions.

Finally, while collaboration and cooperation are crucial there must also be strong leadership of the reform process, especially at government level. As John Menadue remarked in his submission:

> I am sure that workforce reform requires, most of all, courage by health ministers, governments and senior officials to face down the powerful vested interests that oppose reform of the workforce and want to protect their privileged positions. Ministers, governments and officials must win the case for change and drive the process. Waterfront reform was a minor issue compared with this one. (sub. 149, p. 3)

Good regulatory and governance practice

As the work of the Office of Regulation Review has shown, it is important that the need for regulation, and the nature of that regulation, is determined within a framework that fully assesses costs as well as benefits (see box 3.3).

Governance structures for the entities involved in health workforce policy development and implementation should also be carefully designed so as to promote, rather than detract, from better outcomes. The Commission has been particularly mindful of this requirement where it is proposing changes to institutional mechanisms to facilitate major workforce change.

Harnessing competition and market disciplines

The characteristics of health care, including extensive government intervention in the sector (see chapter 1) constrain the scope to give competitive market forces free rein, relative to markets for most other goods and services. But there is scope for competition or market-style instruments to play a greater role in facilitating cost-effective health service delivery — even where those services continue to be heavily subsidised by governments.

Reducing resistance to change

Even reform programs that offer the prospect of major benefits for the wider community will inevitably impose costs on some. Managing and reducing the resultant resistance to reform will be particularly important in the health workforce area, given the potential ramifications of reform for the status, incomes and workloads of some health professionals, and the power of particular regulatory bodies, for example. As well as engaging effectively with the health workforce and the wider community about the need for and nature of reform, governments can also reduce opposition to change by dealing with transitional issues up front, and, as far as feasible, pursuing reform on a broad front.

In considering the case for change, it will therefore be important to undertake sound, evidence-based evaluation of the costs and benefits of alternatives to current arrangements. Such evaluation will necessarily include the impacts, if any, of reform options on the safety and quality of health services. While safety and quality issues are obviously of paramount importance in the health area, effective evaluation will ensure that they are not used inappropriately as a shield to protect existing interests.

Box 3.3 **Regulatory and governance principles**

Several participants pointed to the growing burden of regulation associated with the practice of health professionals. For example, while accepting that regulation is required to protect quality and safety, the AMA commented that:

> Doctors are subjected to a huge amount of regulation and it is increasing daily. … Reducing red tape and bureaucracy, and providing more opportunities for GPs to spend face to face time with patients must be a key priority. It will improve the image of general practice and allow GPs to increase their patient load and impact positively on morale. … Many … regulatory activities are not related to safety and quality and where a relationship is claimed, such alleged relationship cannot be demonstrated by evidence. (sub. 119, pp. 8-9)

Concerns have also been raised about the impact of regulation on patient care. In the Commission's report into General Practice Administrative and Compliance Costs (PC 2003b, p. 81), Campbell Research and Consulting noted:

> There is a cumulative effect of paperwork on GPs frustration levels. Each paperwork activity may be justified and would not raise much concern by itself. However, when added together, GPs feel that they spend an increasing amount of time away from what they see as their core function, patient clinical care.

Some such costs are unavoidable if regulation is to meet its objectives. However, those costs are likely to be kept to a minimum if governments follow good regulatory principles (PC 2003c, 2004):

- The need for regulation should be clearly established and linked to particular objectives that government is seeking to pursue.
- Regulation should only be employed where less intrusive means of pursuing those objectives are unlikely to be successful.
- Regulation should only be introduced after a rigorous assessment of its benefits and costs and those of alternative approaches.
- Where regulation is employed, it should be designed to achieve goals at least cost and to minimise the risk of unwanted side effects.
- Existing regulations and policy programs should be periodically reviewed in a transparent fashion to ensure that they continue to achieve their objectives in an efficient manner.

Similarly, the risk that reform progress will be frustrated by the unwillingness of the architects of previous arrangements to address mistakes, or by capture of the arrangements by particular interests, can be reduced by good governance practices.

- There should be a degree of separation in policy making and policy administration.
- Responsibility for monitoring the implementation and impacts of major policy changes should be separate from the policy making function.
- While policy making, administration and evaluation should engage interest groups and draw on their expertise, those groups should not generally have a predominant role in determining broad policy settings.

4 Workforce innovation

Key points

- There has been considerable change and innovation in health workforce deployment across Australia in recent years.
  - Improvements in on-the-job efficiency have been made and there has been growing use of inter-disciplinary and multidisciplinary approaches to patient care.
- However, the evidence suggests that many opportunities for more significant workforce innovation, including job redesign and changing scopes of work, have not been progressed, or even properly evaluated.
  - Where consideration has been given, as in the case of nurse practitioners, it has been somewhat ad hoc, jurisdictionally based and drawn out.
- Adjustments to institutional, regulatory and funding arrangements, as discussed in succeeding chapters of this paper, will encourage some ongoing workforce innovation.
  - On their own, however, they are unlikely to be sufficient to guarantee that major opportunities for innovation will be considered on a national, systematic and timetabled basis.
- There would be merit in establishing an intergovernmental advisory agency to evaluate and facilitate the more significant possible workforce innovations:
  - Its framework would be based on quality, safety and cost effectiveness. It would assess implications for the workforce directly and for such matters as education and training, accreditation and registration and funding.
  - The agency is likely to be most successful in evaluating and facilitating workforce innovation if there is cooperation from all the key stakeholders.
  - The agency would draw on a range of existing innovations and complement other initiatives to improve workforce deployment and job redesign.

A key message from preceding chapters is that increases in the level of demand for health services, as technology develops, the population ages and community expectations increase, are likely to lead to major health expenditure pressures over the next few decades. As well, the nature of health services demand is changing significantly. And a range of existing problems must be addressed.

Accordingly, the imperative for the health workforce to continually improve its efficiency and effectiveness is unquestionable. Many participants in this study saw

considerable opportunity for such improvement. This would lead to better health services for the community and also result in greater job satisfaction for many of those employed in the health industry.

Importantly, improving efficiency and effectiveness, through better workplace practices, enhanced coordination between professionals or the introduction of new roles, can require policy action across a range of policy areas, for example: education and training; accreditation and registration; and funding and payment arrangements. Several of these are discussed in the following chapters.

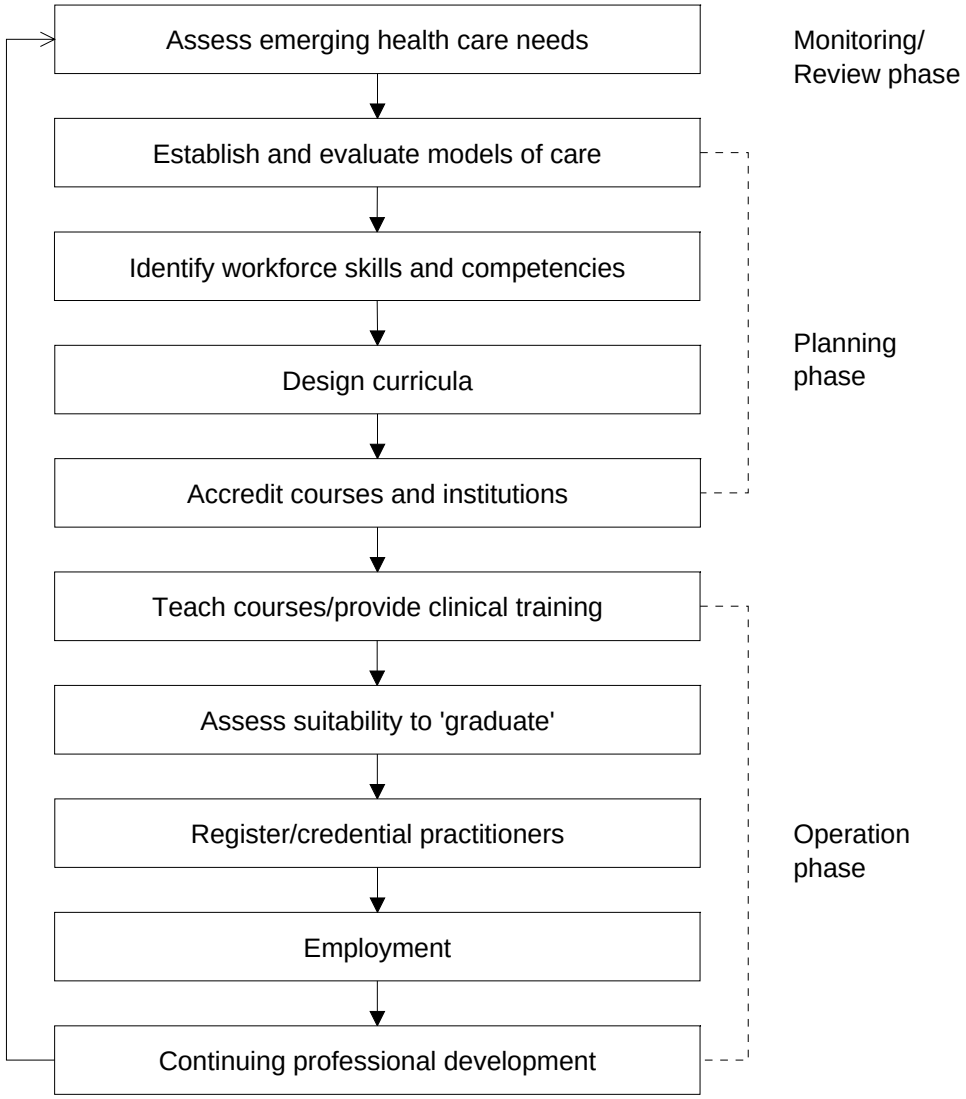
However, by way of introduction, this chapter first overviews relevant institutional and regulatory arrangements and looks briefly at recent developments in workforce deployment in Australia and overseas. Then, based on the Commission's judgment that the changes canvassed in this paper's following chapters are unlikely on their own to be sufficient to guarantee the consideration of 'major' opportunities for workforce innovation and improvement, the chapter discusses the role for a health workforce improvement agency.

4.1 The institutional and regulatory framework affecting workforce deployment

Conceptually, workforce deployment is influenced by several linked sequential processes (figure 4.1). These include a planning phase, where workforce requirements are determined and the appropriate education and training is put into place, as well as an operation phase where jobs are provided and ongoing competency is maintained. This is followed by monitoring and review. All of these processes can have a very significant influence on how and by whom health services are provided. 'External' factors such as funding and payment arrangements are also important in this context.

A number of health sector institutions and regulatory bodies are involved at various stages of job design and deployment. Some play a role across a number of processes — for example, accrediting bodies may also be involved in testing overseas trained practitioners for registration purposes and in curriculum design. Further, there are differences across professions as to which entities undertake which roles — for example, accreditation is carried out by professional associations for some professions, by registration boards for others and, in some cases, by specialist accreditation agencies. And as well as there being health-specific institutions and regulatory arrangements, and health services funding and payment arrangements, there are also broader arrangements that impact on health workforce deployment, such as the generally applicable industrial relations system.

Figure 4.1 **Processes influencing workforce deployment**



Some of the most prominent entities that control or impact on workforce deployment and scopes of practice include: governments; bodies with delegated powers (including registration boards and some accreditation agencies); employers; educators and trainers; professional associations; industrial associations; and health insurers (box 4.1). State and Territory Governments play a particularly important role — even where national approaches are warranted, the ability to 'make things happen' often lies with those jurisdictional governments.

4.2 Recent developments in Australia and overseas

Australia

Within these broad institutional and regulatory arrangements, there has been

considerable change in workforce deployment practices in Australia over recent years, across a number of areas. New or extended roles for workers in particular job settings have been adopted and there has been growing use of inter-disciplinary and multidisciplinary team-based approaches to care. Box 4.2 gives some examples.

Box 4.1 **Roles in workforce deployment**

Governments

Even though the Australian Government provides a significant share of funding, the State and Territory Governments carry ultimate responsibility for many matters affecting the workforce, including quality and safety, registration, and laws on poisons. Governments also have an influence through the broader industrial relations system.

Registration and accreditation bodies

Most health practitioners are required to be registered to protect public health and safety. Registration boards often assess practitioners against relevant qualifications approved by accreditation agencies.

Educators/trainers

Universities, VET and other education and training institutions, professional associations, health service providers and individual clinicians deliver education and clinical training to health workforce professionals. They develop course structures, curricula and training programs, often subject to approval from the relevant accreditation agencies, and examine the competence of students and trainees.

Employers and industrial associations

Workplace practices, rules and regulations play a role in shaping workforce deployment through, for example: workplace-specific processes for credentialing and defining the scope of clinical practice for various practitioners; rules governing whether and how frequently practitioners may practise within the establishment; and through their influence on industrial relations agreements.

Professional associations

Professional associations influence deployment through their formal and informal input into accreditation, registration, credentialing, and education and training, including continuing professional development. Entry rules and conduct codes administered by such bodies also influence what is possible in the workplace.

Insurers

The nature and extent of coverage provided by both medical indemnity insurers and private health insurers affects the settings and by whom health care is provided and the nature of that care.

In relation to one example of major job redesign in Australia in recent years —nurse practitioners — box 4.3 shows that the process has been jurisdictionally based, drawn out and how, even today, the concept of the nurse practitioner is not universally accepted.

In general, however, most workforce changes have involved either initiatives in particular job situations or greater use of team based approaches. Even allowing for the exception of nurse practitioners, and some limited experiments and trials in other areas, there appears to have been little consideration in Australia of major job innovation possibilities, particularly on a national, systematic and timetabled basis.

Box 4.2 **Examples of workforce changes in Australia**

'On-the-job' improvement

- At the Flinders Medical Centre, a study of the patient journey to highlight duplication, delays and potential errors, led to improvements in patient care, increased productivity and a reduction in staff turnover (sub. 82, p. 39).
- In a number of Queensland hospitals, physiotherapy departments in conjunction with orthopaedic surgery departments have commenced a 'fit for surgery' project, which aims to reduce cancellations for elective surgery through ensuring fitness preoperatively (sub. 171, p. 12).

Formalised teamwork and multidisciplinary approaches

- In Victoria, Barwon Health has developed a Community and Mental Health Program based on a multi-disciplinary, care management model. Its Community Mental Health Teams, for example, comprise a psychiatrist, a psychiatric registrar, nurses (with psychiatric registration or endorsement by the Nurses Board of Victoria) and at least one social worker, psychologist and/or occupational therapist. Barwon Health considers the teams a success and are transferring the model to other services.
- In NSW, integrated primary health care services are being developed, where groups of GPs, community health workers and other clinicians will provide 'accessible and appropriate care' in the community, with the aim of preventing unnecessary admissions or readmissions to acute care (sub. 20, pp. 11–12). In addition, as part of the Sustainable Access Program, hospital-level innovations are being trialled. Solutions to patient flow problems identified by staff at John Hunter Hospital, for example, included multidisciplinary care meetings to improve coordination of patient care between units (ARCHI 2004).
- Two rounds of coordinated care trials have been funded by the Australian Government (the second round is due to finish in late 2005), with the aim of reducing hospitalisation of people with chronic or complex needs by managing and coordinating their care (see box 10.4 in chapter 10). Individual care plans spanning primary, acute and allied health services, and the pooling of funding from existing government programs, are key features of the trials.

(Continued next page)

Box 4.2 (continued)

New or extended roles and practitioner substitution

- There has been an expansion in nursing roles. For example, Queensland employs Rural and Isolated Practice Endorsed Nurses and Sexual and Reproductive Health Endorsed Nurses, while South Australia is trialling a nurse colonoscopist role.
- In some jurisdictions, midwives may undertake 'enhanced roles', which allow them to order and interpret routine laboratory tests during pregnancy, labour and delivery, as well as administer pharmaceuticals.
- According to the Council of Remote Area Nurses of Australia, in remote primary care clinics, nurses and Aboriginal Health Workers substitute:

  … a range of GP and allied health services in the absence of ambulances, chemists or pharmacies, radiology services, dentists, social workers, and drug and alcohol services (sub. 134, p. 6).

Sources: Queensland Health (2005a); WA Legislative Assembly (2004).

While the Commission offers no judgments about the merits of particular changes, the case study of podiatric surgeons (box 4.4) shows the lack of a formal process under which the merits of innovation can be explored and its consequences for such matters as education and training, registration and funding assessed.

The UK and USA

In many cases, other countries appear to have moved faster and more proactively than Australia in workforce innovation. The specific institutional and regulatory arrangements of these countries appears more favourable towards a strategic and systematic approach to such innovation than in Australia.

For example, the United Kingdom has trialled a large number of new roles in recent years, across the spectrum of health professionals. As it was considered that expanding the workforce would not, by itself, be sufficient to deliver the desired improvement in patient service, the National Health Service (NHS) Modernisation Agency set up a Changing Workforce Programme (CWP). This created 13 pilot sites to focus on testing, developing and implementing role redesign.[1] The pilots were assessed in early 2003; overall, it was found that role redesign had made a

[1] The CWP closed at the end of March 2005, but aspects of its work are continuing through other programs, such as the National Practitioner Programme (NPP) and the Career Framework for Health. The Modernisation Agency was dissolved and superseded in July 2005 by the NHS Institute for Innovation and Improvement.

difference and led to service improvements — reductions in waiting times, more personalised care, better management of workloads, increased job satisfaction, development of specialist skills, reduced vacancies and turnover, better attitudes to change and the creation of more attractive jobs (NHS 2003, p. 5).

Box 4.3 **Nurse practitioners in Australia**

Nurse practitioners are nurses with advanced educational preparation who can function autonomously and collaboratively in an expanded clinical role. They may prescribe medications, initiate diagnostic investigations and refer patients, but only in accordance with clinical guidelines while practising in defined positions. From initial investigation of the concept in the early 1990s, there are still only a handful of authorised nurse practitioners operating in Australia, with NSW having the most (54 currently employed with a further 26 in transitional arrangements — Queensland Health 2005b).

Doctors and pharmacists have been reluctant to accept the introduction of nurse practitioners, expressing concern over a number of issues, including with prescribing. Recently, the AMA has stated that patients are being 'short-changed' when offered care by a nurse practitioner instead of a GP:

> When GPs examine a particular ailment, they are assessing the whole person. … [Nurse practitioners] don't have the diagnostic ability to analyse patient history and look at symptoms with regard to total systems in the body. Nor can they work out management plans for an individual that take into account the whole person. (Glasson 2005)

There are also regulatory and funding barriers to the wider practice of nurse practitioners, for example:

> … as there is limited opportunity for nurse practitioners to operate under the Medicare Benefits Scheme, it is difficult for such roles to exist, when clients who use a nurse practitioner are required to pay full fees. (South Australian Government, sub. 82, p. 32)

And in seeking to introduce nurse practitioners, each jurisdiction has moved at a different pace, with seemingly uncoordinated processes of review and different trial procedures. While jurisdictions have had to work through their own legislative barriers to change, such as Poisons Acts and so on, it appears that opportunities for greater inter-jurisdictional learning, coordination and cooperation have been missed. The experience with nurse practitioners also illustrates that such major change can be very difficult to progress in the face of opposition from key workforce groups.

The United States also has a wider range of professional roles than Australia, many introduced decades ago in response to demand and supply pressures. For example, the first physician assistants graduated in 1967 — they now number more than 50 000 and, in 2003, treated around 192 million patients, under physician supervision, but often without their immediate involvement (AAPA 2004, p. 12). They are able to conduct physical examinations, diagnose and treat illnesses, order tests, counsel on preventative health care, assist in surgery and, in virtually all

States, can write prescriptions (Department of Health and Ageing, sub. 159, p. 18). And certified registered nurse anaesthetists began practising prior to 1900, now carrying around 65 per cent of the anaesthetic workload, often independently (Professor Wayne Gibbon, sub. 48, att. 2, p. 1).

Box 4.4 **Podiatric surgeons**

Most foot surgery in Australia is carried out by orthopaedic surgeons specialising in foot and ankle surgery. However, some podiatric practitioners also offer surgical services — the profession emerged in Australia in 1978 and there are currently 25 podiatric surgeons, with a similar number of trainees. Countries such as the US and UK utilise podiatric surgeons to a much greater extent — for example, 80 per cent of all foot surgery in the US is performed by podiatrists.

Podiatric surgeons have argued that there is scope for them to undertake a greater amount of foot surgery, at lower cost and with the same or better outcomes than surgery provided by orthopaedic surgeons. They have claimed that greater usage of podiatric surgeons has the potential to increase the productivity of both podiatric surgeons and orthopaedic surgeons, as each professional group would provide services more in line with their skills and training. The Australasian College of Podiatric Surgeons also argued that regional areas could benefit — 'there are podiatric surgeons available to provide a service but the barriers … prevent their workforce participation' (sub. 131, p. 9).

However, as well as opposition from orthopaedic surgeons, there appear to be various regulatory and funding barriers to greater workforce substitution in foot surgery:

> As a small emerging profession [podiatric surgery] is struggling in an environment which has systemic and regulatory constraints maintained by governments, private health insurers and the model under which the current health care system operates. (Australasian College of Podiatric Surgeons, sub. 131, p. 5)

The College went on to provide a list of specific barriers which included:

- state regulations which exclude podiatric surgeon from the definition of medical practitioner;
- lack of access to surgical rights in public hospitals;
- unwillingness of private health insurers to provide rebates for services provided by podiatric surgeons;
- lack of rebates to medical practitioners (eg anaesthetists, pathologists and radiologists) who provide services to patients of podiatric surgeons; and
- no uniform or national access to prescribing privileges for the independent management of patients' pharmacological needs (sub. 131, p. 3).

Importantly, such job redesign has been explicitly facilitated by changes to other policies — for example, while the advanced practice nurse role in the United States evolved in response to shortages of physicians and advocacy by the nursing

profession, it was notably supported and encouraged with federal funding and legislative changes (Buchan and Calman 2005, p. 37).

4.3 An active approach to job redesign

Succeeding chapters discuss a range of barriers and impediments to better health workforce deployment arising from such areas as education and training arrangements, accreditation and registration, and funding and payment mechanisms. Changes proposed in those chapters should encourage better utilisation of the workforce. However, in the environment described above, the Commission considers it is unlikely that such changes will be sufficient to guarantee that major job innovation opportunities receive the consideration they deserve, even on a jurisdictional basis, let alone on a national, systematic and timetabled basis. Thus, without other initiatives, Australia will continue to miss out on the benefits that such innovations can bring. Although not all such possibilities will be beneficial, the likely advantages and disadvantages of major job substitution and redesign options should be investigated so that informed judgments can be made.

While several participants urged caution in considering workforce innovation, others considered that the challenges facing the health workforce can only be met if job substitution and redesign options are systematically assessed and put in place when likely to be beneficial (box 4.5). These views are largely in accord with the National Health Workforce Strategic Framework, which notes realignment of existing workforce roles and the creation of new roles may be necessary to make optimal use of workforce skills and ensure best health outcomes (see box 3.1 in chapter 3).

The support of some participants for role change was selective. For instance, while supportive of nurse practitioners, a number of nursing organisations, such as the Nurses Board of Western Australia (sub. 141) and the Australian Nursing Federation (Victorian Branch) (sub. 133), were concerned that unskilled workers could be introduced to undertake roles that are currently undertaken by registered health professionals such as nurses. They considered this would lower safety standards and public confidence in the health system (NSW Nurses' Association, sub. 139). Comments such as these add to the desirability of detailed case by case studies in which the advantages as well as the disadvantages of particular proposals can be comprehensively and independently assessed.

Major job design issues can be complex, with implications for not only the health workforce but also for health service providers, education and training

Box 4.5 **Participants' comments on assessing job substitution and redesign options**

Queensland Nurses' Union (sub. 80, p. 17):

> Appropriate consultative arrangements involving all key stakeholders must be established and proposed changes to skill mix and role boundaries must be based on evidence and any changes subject to rigorous monitoring and evaluation processes. … the primary objective is to ensure timely access to safe, high quality, evidence based and appropriate health services for the community.

Professor Wayne Gibbon (sub. 48, p. 5)

> Significant workforce reform is required to change existing service delivery models and roles within the workforce. … What is being proposed now, nationally and internationally, is that the health provider community should plan such reform in a well considered way, design the changes that are required and educate for them …

The Victorian Government (sub. 155, p. 38) proposed the establishment of a 'National Health Workforce Planning Council' which would have a number of roles, including to:

> … develop planning methodologies that support innovative workforce models and work redesign.

South Australian Government (sub. 82, p. 43):

> National leadership on the direction of workforce reform and the need to have breakthrough solutions that may fundamentally change the way current health professions are structured and trained is necessary if progress is to be made. It is essential that this be linked to the development of new service models.

ACT Government (sub. 177, p. 1):

> [there should be] a national focus on workforce and workplace redesign with the goal of realigning competencies with improved job roles. A focused, targeted examination of health professional workers, such as allied health professionals, might provide the initial evidence for piloting expanded scopes of practice that includes more complex clinical skills.

CDAMS (sub. 49, p. 2):

> To address the problems of healthcare workforce shortage and maldistribution, there is a need for appropriate short and long term planning underpinned by well validated evidence and real understanding of the community's needs which requires a coordinated and cooperative approach and a long term vision which transcends electoral cycles.

AMA (sub. 119, p. 4):

> Many of the proposals for substitution would have a marginal impact on the availability of medical practitioners and create very significant quality and safety issues at first consideration. It is up to the proponents of these schemes to make the case that they can be introduced without detriment to quality and safety.

arrangements, accreditation and registration agencies, governments in their capacities as health funders, private insurers and so on. Changes in one area can have flow-on effects in others — for example, enhancing the ability of nurses to substitute for doctors in some roles could merely exacerbate an existing nursing

shortage. Difficult judgments are often required in relation to the weightings that should be accorded to the range of conflicting objectives that can arise in such situations. And uncoordinated or ad hoc approaches to job design may well be counterproductive, especially if they focus on short term problems or ignore inter-jurisdictional issues.

These considerations suggest that there would be merit in establishing a formal institutional arrangement to consider and advise on such opportunities on a national basis. In effect, an intergovernmental agency could be established to review the benefits and costs of possible major job innovation opportunities on a systematic basis. At a very broad level, some parallels can be drawn with the National Competition Council — established as part of National Competition Policy — which has provided a spur to reform in the wide range of areas encompassed by that policy. More specifically, within the health sector, the model for such an agency could draw on the UK approach and on the proposed Western Australian Centre for Health Innovation (box 4.6).

Box 4.6 **A Western Australian Centre for Health Innovation**

In 2004, the Western Australian Education and Health Standing Committee of the Legislative Assembly made the following recommendations:

- The Committee recommends the establishment of a locally based organisation, the Western Australian Centre for Health Innovation, to facilitate and support a coordinated approach to the development, implementation and evaluation of new models of health care delivery in Western Australia. The organisation would also assess emerging models of health care delivery in other jurisdictions with a view to evaluating their applicability to Western Australia.
- The Western Australian Centre for Health Innovation should have equitable representation for all stakeholders, including the various health professional groups, the different health sectors and policy makers.
- The Committee recommends the utilisation of Expert Advisory Groups to provide advice to the Western Australian Centre for Health Innovation and to facilitate resolution of legislative, educational and clinical practice issues with regard to new models of health care delivery.
- The Committee recommends that exploration of new and redesigned roles to address workforce shortages should be a priority for exploration through the Western Australian Centre for Health Innovation.

Source: WALA (2004).

The work of such an agency would not be directed specifically at solving shortages of particular skills, nor merely at reducing expenditure through improved efficiency of service delivery, although this could form part of its work. Its role would extend

to examining all areas of major job substitution where there could be a net benefit to the community when assessed against the full range of efficiency and effectiveness criteria, including quality and safety outcomes.

In essence, the agency would represent an active approach towards transparently investigating job innovation opportunities in an unbiased and objective manner. Clearly, its success in this role is likely to be much greater if it receives support and cooperation from governments, employers, professional and industrial associations, and other key stakeholders.

Establishing a health workforce improvement agency

It would be possible to add the functions outlined above to the responsibilities of existing agencies or committees, such as AHMAC, or to form a new even broader agency which encompasses this new task, as well as taking over existing tasks, such as numerical workforce projections — in effect, the approach favoured by some participants including the Victorian Government (see box 4.5). However, because of the differences in the nature of the work, and the composition of the board membership required (see below), the Commission considers that it would be preferable to establish a new health workforce improvement agency with this sole responsibility.

A wide range of issues would have to be considered in the process of establishing the agency. Although detailed terms of reference and administration and funding arrangements would be matters for resolution between the Australian and State and Territory Governments, the Commission envisages that:

- The agency's terms of reference would concentrate on major job substitution and redesign opportunities potentially involving significant overlap or reallocation of current responsibilities. These would both cover situations where work tasks could be changed and where changing the legal responsibility for the patient's welfare is contemplated. The focus would be on changes which could be applied widely across many workplaces, rather than changes which might better be developed at the individual workplace or employer level.
- Particular projects could be referred by stakeholder groups through AHMAC or initiated by the agency itself, drawing on Australian or overseas experience where appropriate. Some opportunities for change will already have been trialled in particular settings — this would continue to be encouraged. The agency should have an established work program so that major job opportunities can be analysed on a systematic and timetabled basis.

- The agency's broad objective would centre on making the most efficient and effective use of the available health workforce, having regard to such factors as access, quality and safety and the legitimate needs of the workforce itself.
- A benefit–cost multidisciplinary approach would underpin the agency's assessments — it would consider not just the likely effects for the health workforce of change, but the broader institutional and regulatory implications for the health and education systems, including accreditation and registration, as well as the financial implications. Where relevant, the agency would draw on international experience and research. Sub-committees or working parties could be established as appropriate to consider particular aspects.
- The agency would be national, established by the Australian Government in consultation with the other jurisdictions through AHMC.
- It would not take over any of the statutory powers exercised by other agencies, but would be an advisory body, reporting to the AHMC through AHMAC. Where appropriate, it would liaise and cooperate with the proposed health and education council (chapter 5), the proposed national accreditation agency (chapter 6) and the proposed MBS review body (chapter 8). Further, its published reports would assist those agencies in their work.
- The agency would be comprised of members who collectively would bring with them the necessary health, education and finance knowledge and experience required. Although members could be nominated by such bodies as governments, employers, universities and professional associations, it would be preferable for them to be appointed as individuals, rather than as representatives of those sponsoring bodies.
- As discussed in chapters 10 and 11, the agency should be explicitly required to take account of issues relating to rural and remote Australia and to special needs groups in its work.
- There should be a review of its effectiveness after it has been established for 5 years.

The Commission stresses that the establishment of such an agency would not preclude, but rather would complement, job substitution and redesign progressing through other ways and means — for example, in individual workplaces or within particular professions, or through greater use of inter- and multi-disciplinary approaches.

DRAFT PROPOSAL 4.1

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce

innovation possibilities on a national, systematic and timetabled basis.

- ***Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.***

During the course of this study, participants have canvassed a wide range of specific job innovation opportunities, and others arise from the observation of health workforce innovation overseas. Some of these are more appropriately examined in the context of individual workplaces or jurisdictional health systems. However, several appear to deserve broader consideration on a national basis by the proposed agency. These include:

- 'new' professions such as physician assistants, surgical care practitioners, rural health practitioners, nurse anaesthetists, medical assistants and paramedic practitioners;
- expansion in the scope of practice for midwifery and for Aboriginal Health Workers;
- expansion in the scope of work of various allied professions including physiotherapy, podiatry, occupational therapy, radiography, pathological laboratory scientists, and pharmacy;
- revisions to skill mix in emergency departments; and
- the division of work in nursing, various allied health professions and pharmacy between more highly qualified and lesser qualified professionals, for example between registered and enrolled nurses, and between physiotherapists and assistants in physiotherapy.

The Commission has no strong views on which of these should form the basis for the agency's initial investigations. Ideally, of course, the agency would start with those possibilities likely to bring the greatest net benefit to the community on a national basis. Often, however, that may not be readily determined until after investigations are undertaken.

5 Health workforce education and training

Key points

- Responsibility for policy direction, funding and delivery of education and training for Australia's health workforce is shared across a broad range of players.
  - The system is complex, poorly coordinated, and insufficiently responsive to changing needs and circumstances.
- Additional funding for education and training will be required as part of a multi-faceted response to current workforce shortages and growing future demands for health care.
- Changes to institutional, regulatory and funding mechanisms are also necessary, to:
  - deliver better education and training outcomes from available funding; and
  - ensure efficient and timely adjustment of education and training arrangements to the changing requirements of those receiving and delivering health care services.
- Consideration should be given to shifting responsibility for allocating the overall funding available for university-based education and training of health workers to the Department of Health and Ageing.
- To facilitate a more coherent approach to skills development, a health workforce education and training council should be established to provide independent and transparent advice on:
  - opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and
  - their implications for courses and curricula, accreditation requirements and the like.
- To put clinical training on a sustainable longer term footing, policy attention should focus on improving the transparency and contestability of institutional and funding frameworks, including through:
  - clarifying how the clinical training regime currently works;
  - examining the role of greater use of explicit payments for training services, within a system that will continue to rely on considerable pro bono service provision;
  - better linking training subsidies to the wider public benefits of clinical training; and
  - addressing any regulatory impediments to competition in the delivery of clinical training services.

5.1 Objectives of education and training

In a broad sense, the objective of health workforce education and training is to underpin the efficient and effective delivery of health services by providing the appropriate number and mix of health workers, equipped with the right skills and competencies. With skill needs continually evolving as a result of advances in technology, changes in the burden of disease and demographic shifts, it is particularly important that the health workforce education and training system is responsive to the changing demands put upon it.

Health workforce education and training outcomes are of course heavily influenced by the configuration of the broader health care and education systems. Settings in these broader systems impact on both the demand for, and supply of, health care workers and the services available to educate and train them.

And, requirements for health workforce education and training are necessarily aligned to the permitted scopes of practice for qualified practitioners in the various occupational groups. This again serves to highlight the need for the reform process to recognise linkages across the system so as to ensure that all of the cogs in the health workforce apparatus are moving in concert.

5.2 How does the current system work?

Responsibility for policy direction, funding and delivery of education and training for Australia's health workforce is shared across a broad range of players including two tiers of government, universities, vocational education and training providers, specialist colleges and professional associations, accreditation agencies and health service delivery bodies. The result is a complex system in which coordination problems abound, and which many claim is not sufficiently responsive to changing health care needs, or to opportunities to provide workforce services in new and more effective ways.

The complexity of the system, and the delineation of responsibility across levels of government, have also posed considerable challenges for the Commission in seeking to identify policy options that would deliver better outcomes in the future. As the later discussion in this chapter illustrates, in most areas, there are a number of reform possibilities, each with strengths and weaknesses. Hence, the choice of approach entails a degree of judgment.

University-based education

Education of most health workers is university-based, including for medical practitioners, registered nurses, dentists, pharmacists and all of the main allied health occupations.

The Australian Government has primary responsibility for policy and funding of the university sector (and for the accompanying HECS and student loan arrangements). It provides (differential) funding support for an agreed number of places in set discipline clusters, primarily on the basis of dialogue between the vice-chancellor of each university and the Minister for Education, Science and Training. However, for medicine, new places are jointly determined by the Minister for Education, Science and Training and the Minister for Health and Ageing.

In the past, universities have had considerable scope to subsequently vary the actual number of places in most health care courses (depending on demand and the cost of course provision), and even to unilaterally close or suspend entry to courses (eg podiatry), including in areas of workforce shortage. However, the Minister for Education has decided to introduce a clause in funding agreements which will require consultation before specialised and nationally significant courses are closed. This clause covers specialised heath courses in areas experiencing a national skills shortage. Also, under the new funding framework, adjustments can be made to a university's funding if the total actual number of places delivered by that institution varies beyond parameters set out in legislation and guidelines.

Students in places supported by the Australian Government pay fees (HECS) which vary according to course type. Universities can also enrol full fee-paying domestic and international students within certain limits.

Degree program design, content and length are determined by universities in consultation with the relevant professional associations/colleges and accreditation agencies such as the Australian Medical Council; the Australian Nursing and Midwifery Council; State and Territory Nursing Boards; and peak allied health bodies. Degree length is 3 years for nursing, 4 to 5 years for allied health courses and 4 to 6 years for medicine.

VET

Though having a lesser overall role in health workforce education and training than the universities, the VET sector is the setting for the preparation of several important workforce groups, including enrolled nurses, various 'assistants' to more qualified professionals, some Aboriginal health workers and personal care workers.

These VET courses are funded by a mix of government funding and student fees. Two-thirds of governments' contribution comes from the States and Territories, with the balance provided by the Australian Government through specific purpose payments to the jurisdictions.

Until now, States and Territories have been primarily responsible for planning the numbers of publicly supported VET places, although the Australian Government has exerted influence through its coordination and funding role. That planning process has had regard to the needs of industry and an assessment of state priorities and economic development needs. However, under new arrangements, commencing from 1 July 2005, national training priorities and targets, including in relation to specific skill needs, will be given greater weight.

The specific training packages for health workers, providing nationally endorsed competency standards, qualifications and assessment guidelines, are progressed through the Community Services and Health Industry Skills Council, in consultation with State/Territory health departments, jurisdictional nursing bodies, training authorities, and the Department of Employment, Science and Training (DEST). Course duration is 12 to 18 months on a full-time equivalent basis. In addition, on-the-job or practical training is provided through traineeship and apprenticeship schemes which are subsidised by the Australian Government.

Clinical training

Undergraduate clinical training

Undergraduate clinical training in medicine and nursing usually involves placements in public hospitals. Much of the clinical training component of allied health courses also involves public hospital placements, though some is provided in private hospitals and in private practices. In public hospitals, trainers are either salaried employees or Visiting Medical Officers providing their time on a pro bono basis — though some States and Territories indicated that a training component is included in remuneration arrangements. In other settings, delivery of training is typically pro bono.

Public hospitals may receive some payment from universities for the use of their facilities for clinical training purposes. Indeed, there is an explicit clinical training component in the Government's contribution to medical and nursing course costs. Also, provision has been made for additional funding of $54 million for clinical training provided to nurses (DEST personal communication). However, for allied health courses, there is no separately identified clinical training component in

government funding. Hence, universities must meet the cost of any payments to public hospitals (or other training providers) from general funding sources.

Postgraduate clinical training

While there are postgraduate clinical training requirements in some nursing and allied health areas (see appendix B), such training is usually of limited duration.

However, specialist medical postgraduate training can be up to 10 years in duration.

- The first step involves an intern year in an accredited public teaching hospital. Successful completion allows for registration to practice, but not access to the MBS. This is followed by a residency year, also in a public hospital.
- Those seeking to become general practitioners then enter General Practice Education and Training (GPET). This training is delivered by private regional training providers (RTPs), mainly in community-based GP practices.
- Those seeking to specialise in other areas seek entry to a specialist training program approved or accredited by the relevant professional college. The bulk of this training is provided in public teaching hospitals, largely by college fellows on a pro bono basis. However, as discussed below, the private sector is playing a greater role than in the past.

The GPET program is fully funded by the Australian Government, with funding allocated to RTPs through a competitive tender process. These RTPs in turn engage practising GPs to provide education and supervision to trainees.

The cost of postgraduate training in other medical specialties is shared between several parties. In addition to supervision provided by college fellows:

- State and Territory Governments meet infrastructure costs for the training conducted in their hospital facilities, as well as the labour component of training delivered by salaried hospital staff and, depending on contractual arrangements, some of the cost of supervision provided by college fellows.
- The States and Territories also meet the salary and infrastructure costs of some unaccredited training positions in particular specialties. (However, lack of accreditation means that such training does not lead to college membership — a requirement to access MBS funding.)
- Trainees make a contribution through payments to the relevant colleges, including to meet the administrative costs for the colleges of oversighting training programs and assessing trainees.

- Private hospitals are providing and funding a small but growing amount of training to postgraduate medical students. In areas like dermatology and pathology, the private sector also provides training outside of the hospital setting (with such training places supported by subsidies from the Australian Government). The private hospital sector has also long played a role in postgraduate nurse training.

5.3 How well is the system performing?

By any measure, there has been considerable change in health workforce education and training in Australia since the early 1990s. Examples include:

- major modifications within the university-based component to curriculum design, course content and teaching methods (including common course modules allowing for inter-disciplinary education and problem-based learning);
- expansion in the range of course options in allied health sciences;
- the introduction of graduate entry programs that have increased the options available to potential trainees and facilitated some streamlining of courses to reflect relevant undergraduate training in other areas;
- better grounding in clinical sciences for registered nurses through the move from hospital-based preparation to a degree course; and
- an increased focus on structured, competency-based learning in the VET sector, with greater collaboration among stakeholders.

Indeed, according to some commentators, such changes are evidence of considerable dynamism in the current arrangements (see, for example, Brooks, Doherty and Donald 2001 and Dowton et al 2005).

However, as the following discussion illustrates, most participants in this study considered that the outcomes delivered by the current health workforce education and training regime are still far from ideal. And looking to the future, there was widespread concern that if inefficiencies, rigidities and coordination problems in the current regime are not addressed, effective and timely adjustment to the changing needs of health care providers and care recipients is unlikely.

Major performance gaps identified by participants

Insufficient places

In the light of existing workforce shortages, most participants commenting on education and training issues saw the major problem as being insufficient education and training places, especially in the university system. Such concerns were raised in relation to all of the main workforce areas, with nursing and allied health interests keen to emphasise that the shortage of places was not a problem only in the medical area. For example, the Australian Nursing Federation (Victorian Branch) commented that:

> Unless the Commonwealth Government expands University places for nursing undergraduates, the future supply of registered division one nurses for our major teaching hospitals and specialty fields of nursing across the state will be damaged irreparably. (sub. 133, p. 8)

The Health Professions Council of Australia said that:

> Australia needs more allied health professionals. However, decisions on how many students to enrol at universities are not based on need but on commercial concerns. (sub. 70, p. 9)

And the Australian Council of Deans of Health Sciences (sub. 67, p. 3) commented that while there are workforce shortages across the full spectrum of health professions, 'the level of investment to address problems of undersupply and maldistribution of allied health professions has been relatively modest to date.'

As discussed further below, there were also widespread concerns about shortfalls in clinical training places, especially in some key medical and allied health areas — with those shortfalls excepted to worsen in coming years due to recent increases in undergraduate medical intakes.

In contrast, relatively few concerns were raised about numbers of health places in the VET sector. This may partly reflect the lesser overall role of the sector in the preparation of health workers. However, as elaborated on in box 5.4, the fact that State and Territory Governments both provide much of the funding for VET training, and are the main employer of health workers trained in the system, provides a considerable incentive for them to ensure that numbers of places are sufficient to meet demand.

The quality and relevance of the education and training provided

Despite significant and ongoing change in health workforce preparation, State and Territory Governments in particular contended that education and training courses have not kept pace with developments in health care needs and changing care models. The ACT Government, for example, said that it:

> … is increasingly recruiting health workers who require further education, upskilling and training to reach the skill level required to meet the job requirements and the growing needs of certain population groups, for example the aged. This is most evident in nursing and medicine … [It] reflects a lack of alignment between course content and current job roles … (sub. 177, pp. 8-9)

And in arguing for the development of a nationally agreed set of basic medical procedures, the Postgraduate Medical Council of New South Wales said that:

> There is currently a great deal of variability in the ability of students and [international medical graduates] to perform basic procedures on day 1 of their internship/year of supervised training. This is sometimes a reflection of the competence of the individual, but can also be the result of different curricula approaches of different Universities. (sub. 153, p. 2)

The duration of education and training

Several participants said that the often lengthy duration of health workforce education and training — especially in the medical area — reduces the capacity of the system to respond to shortages in a timely fashion and complicates broader workforce planning. Some further contended that, in many areas, the absence of streamlined retraining pathways, or appropriate recognition of prior learning, exacerbates the difficulties of accommodating demands for additional workers or replacing those who exit the workforce.

However, while there was general acceptance of the need for appropriate recognition of prior learning in course structures and retraining programs, there was less consensus on the scope to substantially speed up current timeframes.

Some believed that accelerated entry to the workplace could be achieved without compromising quality standards by, for example:

- moving to a 'skills escalator' model of education and training as is occurring in some other countries, possibly embodying shorter 'generic' health degrees (see box 5.1);
- allowing medical students to begin to specialise in their undergraduate years;
- training some doctors in narrow specialist fields and limiting the scope of practice to these areas; and/or

- introducing competency-based (as opposed to time-based) clinical training.

Box 5.1 **Alternative models of health workforce preparation**

Multi-skilled health workers

A frequently cited option for accelerating entry to the workforce and enhancing workforce flexibility, is the preparation of multi-skilled health workers through the development of a common degree program. Under this model, a relatively short generic health degree would provide a common preparation in foundation sciences (eg physiology, anatomy, human behaviour) and a core skill set based on the achievement of specific competencies in assessing basic human physical function. This basic core skill set would then provide a platform for *earlier* specialised training in more specific areas.

Skills escalators

Under, the 'traditional' model of health workforce preparation, trainees must fully complete applicable education and training programs before being able to practise. In contrast, under a so-called 'skills escalator' model, trainees would be able to:

- exit their education and training program on attainment of pre-determined skills and be certified to practise according to the skill level attained; and
- re-enter the program in order to progress to higher levels (with appropriate recognition of prior learning).

There are already elements of this approach in the Australian system. For example, there are opportunities to enter some health professions via postgraduate as well as undergraduate courses. And, as noted earlier, medical practitioners that have completed their intern year can practise prior to entering specialist training.

However, proponents claim that wider application of this approach, based around common learning modules and possibly short generic health degrees (see above), would enable earlier participation in the workforce, as well as facilitating: greater integration across the health professions; structured assimilation of overseas health workers; entry from non-health occupational fields; and greater scope for delegation of tasks within the workplace. This approach is currently being introduced in the United Kingdom under the National Health Service Modernisation Strategy.

Source: Based on Duckett (2005a).

However, other participants argued that significant advances in medical knowledge and technology argue in favour of increased rather than reduced course length, and militate against moves to create a more generalist health workforce through generic health degrees. In this latter regard, the Australian and New Zealand College of Anaesthetists said:

> Although the medical Colleges are sometimes accused of being educational 'silos', and that there should be more commonality in training, the great advances in knowledge

> and technology in medicine in the last 40 years or so have required specialisation for their safe application. A doctor entering years of postgraduate vocational training to specialise as a cardiac surgeon cannot afford much of that time to keep up with the generic knowledge and skills required of a junior doctor, a general practitioner, or an anaesthetist, and emerge a competent cardiac surgeon. (sub. 38, pp. 3-4)

And while supporting moves to reduce the length of clinical training, and pointing to some possible options for doing so in the surgery area, the Royal Australasian College of Surgeons (sub. 83, p. 5) nonetheless cautioned that there is a risk this could reduce the standard of surgical services.

Lack of access to clinical training

Current clinical training arrangements were widely seen as having failed to deliver sufficient training places for either undergraduate students or postgraduate trainees. Particular concerns were expressed in relation to allied health and some of the medical specialties — though they were by no means limited to these areas. Indeed, at a broad level, the Australian Council of Deans of Health Sciences suggested that:

> … access to quality clinical teaching placements is likely to emerge as the major rate-limiting factor in an effort to ramp up professional training programs. (sub. 67, p. 5)

Yet while there are shortages in many areas, there are also unfilled postgraduate training places in some medical specialities, especially outside the major cities.

Inadequate support from both the Australian Government (in its role as the main provider of funds for university education) and State/Territory governments (in their role as providers of training facilities and opportunities in the public hospital system) was commonly cited as a major contributor to the lack of places in many areas (see box 5.2). However, participants also pointed to a range of other contributors, including:

- a failure to properly consider the clinical training implications of policy initiatives to boost the number of university places in the health area;
- the trade-off for public teaching hospitals between service delivery and support for training, especially in an environment where overall resources are stretched, and where there is often no explicit budget allocation for training;
- changes in the casemix of public teaching hospitals which, as noted earlier, have been the main setting for much clinical training. In particular, with the shift of more elective and other non-urgent surgery to the private hospital sector, the focus of teaching hospitals is increasingly on treating more complex acute conditions. This has in turn reduced the breadth of clinical training possibilities in the public system.

Box 5.2 **Participants' comments on access to clinical training**

Difficulties in accessing clinical training were raised in relation to most areas of the health workforce. While these difficulties were seen as resulting from several factors, as the following comments from participants illustrate, lack of funding for placements was generally put at, or close to, the top of the list.

Medicine

> Owing to a lack of government funding of training facilities, training opportunities for obtaining operative and consulting skills are limited at all levels in obstetrics and gynaecology; to increase our annual intake beyond the current limit would seriously impact on the quality of training and supervision. (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, sub. 112, p. 8)

> There are plenty of surgical posts that could be accredited as specialist training positions if funding were available. The source of that funding is outside of the control of the RACS and rests with the Australian and State and Territory governments. (Royal Australasian College of Surgeons, sub. 83, p. 6)

And the Australasian College of Dermatologists (sub. 104, p. 5) similarly said that it consistently had difficulty in obtaining funding for new training positions.

Allied Health

> There is a huge amount of pressure placed on public hospital physiotherapy departments to provide undergraduates with the experience they need to be job ready. The system largely functions on the goodwill of clinicians and is unsustainable. (Australian Physiotherapy Association, sub. 65, p. 12)

Nursing

> Schools of nursing currently struggle to ensure an adequate supply of quality clinical placements to offer students the required clinical hours to adequately prepare them for registration. The current system is untenable where schools of nursing are at the mercy of the health system who have no mandate or inducement to offer the placements. Competition between schools of nursing for the placements perpetuates this problem. (Council of Deans of Nursing and Midwifery, sub. 63, p. 4)

- continued heavy reliance on pro bono provision of training services by private practitioners, especially given growing workloads and the more commercialised nature of much health care provision. In this regard, the chairman of the Committee of Presidents of Medical Colleges recently remarked:

  > Currently, pro bono work is an enormous contribution by senior fellows in all colleges; but is it sustainable? In general, people who contribute substantial time to college functions, such as examinations, education and training supervision, do so by their own choice but I am not confident this will continue for much longer. (Child 2005, MedEd Conference 2005, p. 48);

- impediments to the conduct of more clinical training in private hospitals and other private facilities — including the lack of explicit funding to pay for the use of facilities, and possible medical indemnity concerns.

Course funding relativities

Several participants commented on government funding relativities across university-based health courses, with a particular concern being that these relativities are biased against the provision of allied health courses. Synthesising these concerns, the Australian Council of Deans of Health Sciences argued that:

> … funding levels do not provide sufficient income to universities to adequately support the smaller, more specialised health disciplines such as podiatry and prosthetics, that, despite the relatively small numbers of professionals needed in comparison to medicine and nursing, are still critical to the national ability to provide a comprehensive level of health services. (sub. 67, p. 7)

More specifically, the Australian Podiatry Council commented that:

> Under the current Commonwealth Grant Scheme, universities receive just under half the amount of annual per-student funding for the education of a podiatrist, than for a student in dentistry or medicine. Yet, the cost of course delivery is comparable, particularly with regard to the integrated clinical component of training. (sub. 81, appendix 1, p. 3)

There was also commentary on the impacts of HECS fees on participation in health workforce training (see box 5.3), and on problems associated with the current arrangements for accrediting education and training programs in the health area. Accreditation issues are considered separately in the next chapter.

5.4 How could the system be improved?

In the Commission's view, it is important to put such problems in perspective. As noted above, there has been substantial change in the arrangements for educating and training the health workforce, as well as significant recent increases in funding for places. Moreover, the demands on the university and VET systems from the health care area must be considered in the context of those from a whole range of other areas.

This is not to deny that increased funding for education and training places will be an important part of the policy package for both overcoming current workforce shortages and addressing increased demand for health workers in the future. Indeed, while it will be some time before the benefits of recent measures to increase places

are realised, the additional health workers delivered by those extra places will then be available to provide services for many years to come.

Box 5.3 **HECS fees and participation in education and training**

Several participants contended that HECS fees for health workforce courses are excessive and that the resulting debts — especially for longer courses — discourage student participation.

However, as in other disciplines, income forgone rather than HECS debt will generally represent the major cost of undertaking university-based health workforce training. As such, HECS charges are likely to have a much lesser impact on overall participation levels or course choices within the health area than, say, funding arrangements under the MBS (see chapter 8).

Moreover, in the Commission's view, a contribution towards the cost of tertiary education is appropriate given the increase in earnings capacity that generally ensues. Accordingly, the Commission has not pursued this issue further.

However, there are limits on the capacity of governments to fund additional education and training places for health workers. Hence, policy attention must also be given to ways of improving the efficiency and effectiveness of the arrangements for preparing the future health workforce.

The Commission does not have the expertise to assess the many detailed initiatives for enhancing effectiveness that have been put to the study — though it is clear that the issues they are designed to address are of genuine concern to many health stakeholders, including education and training providers. Accordingly, the Commission has focused its attention on changes to institutional and regulatory arrangements and to funding mechanisms that could properly address the issues and thereby:

- deliver better value from the funding available for the education and training of health workers; and
- promote efficient and timely adjustment in health workforce education and training arrangements to the changing needs of those receiving and delivering health care services.

What are the key systemic impediments that must be overcome?

Deficient coordination mechanisms

In achieving better education and training outcomes, a pressing need is to improve coordination both within the education and training area, and between this area and the other key components of the health workforce regime. Synthesising the current deficiencies in coordination processes, AHMAC reported that:

> [State] Health Departments consider that rigidities, fragmentation and disconnects in the arrangements for funding and delivery of education and training adversely affect Australia's capacity to train and deploy the health workforce needed to meet current and future service delivery requirements. (sub. 166, p. 31)

Coordination failures are evident at several key points. The one that has attracted most attention in this study is the interface between DEST and State and Territory health authorities in regard to funding for university-based health workforce education and training. Thus, the South Australian Government remarked:

> There is no formal mechanism that engages the relevant stakeholders of DEST, the Commonwealth Department of Health and Ageing and AHMAC in the way that university places are planned and funded to better meet changing workforce supply requirements. (sub. 82, p. 34)

Similarly, the New South Wales Government observed that while protocols to provide for bilateral consultations had been established via the *Agreement between Commonwealth and States in relation to Higher Education 1991*:

> … this consultation and coordination process is no longer working. It is vital that this is remedied. (sub. 20, p. 2)

Notably, there appear to be fewer such coordination problems in the VET sector (see box 5.4), where the States and Territories both provide much of the funding for places, and are the major employers of health workers trained in the system.

Also, as alluded to above, lack of effective coordination between different components within the health workforce education and training system is causing particular difficulties in the clinical training area. Some of the consequences were highlighted by the Committee of Deans of Australian Medical Schools (CDAMS) who said that:

> The lack of consultation and planning relating to the creation of new medical school places and new schools has produced chaotic effects in the health care sector, and has threatened to undermine many effective long-term relationships between individual medical schools and their partner health units and practitioners. … Creation of new medical schools must take account of the availability of clinical placements and not continually create the need for reactive responses to political whim. (sub. 49, p. 10)

Box 5.4 **Comparing the performance of the VET and university regimes**

Some of the institutional features of the university and VET regimes have particular implications for outcomes in the health workforce area:

- VET preparation in health has parallels with a 'purchaser-provider' model. That is, State and Territory Governments, which currently fund the bulk of the training services, are also (through their health departments) the predominant employer of health graduates from that system.
- In the university sector, on the other hand, funding and policy direction are provided by one level of government to prepare health workers who will often spend at least the early part of their careers working in public hospitals for another level of government.

The VET sector is also characterised by more formalised institutional linkages to facilitate both national and state level collaborative approaches to policy and priority setting, and greater industry/employer involvement in course design and content — as exemplified by the Community Services and Health Industry Skills Council.

State Governments have argued that these characteristics of the VET system provide for effective alignment of course mix and content with their needs as employers of health workers. The contrast was drawn with the outcomes of the university system, with AHMAC arguing that those responsible for delivering services have:

> … little influence over the places in tertiary health courses, the type, content and length of the courses, where and by which institutions the courses are offered, course closures, the funding provided to institutions to deliver health courses etc. There is often considered to be a misalignment between service and client needs and the skills, knowledge and attributes imparted through existing training models and curriculum. (sub. 10, p. 7)

Indeed, in a subsequent contribution to the study (sub. 166, p. 23), AHMAC said that there could be scope to make greater use of the VET system in addressing current and future health workforce shortages, noting amongst other things that:

- delivery could be targeted to those already in the workforce;
- VET is incremental in approach which means that people can build their skills over time to match changing roles; and
- VET courses could be more readily marketed to older workers, people returning to work, or those wishing to change career while remaining in the workforce.

These views were echoed in some State Government submissions.

However, some of the apparent advantages of the VET system in the health area seemingly have as much to do with the internalisation of the training and service delivery functions within the one level of government, as to the constitution of the system per se.

Custom and practice blockers

Many mooted changes to the nature of education and training for health workers raise complex issues and trade-offs. The appropriate balance between generalist and specialist education and training, and the scope to reduce the duration of courses, are but two areas where there is considerable debate on the direction in which the regime should be moving.

Much of this debate is based on differences of opinion about the intrinsic merits of alternative approaches. But as in other aspects of health workforce arrangements, debate is sometimes coloured by a desire to preserve existing responsibilities, or to maintain or increase influence. And in some areas, longstanding practice is a barrier to exploration of better ways of educating and training the future health workforce. For example, efforts to facilitate greater private sector involvement in postgraduate clinical training of medical specialists has seemingly been impeded by the lack of transparency in the funding of that training and the consequent inability to increase contestability in the supply of training services.

Against this backdrop the Commission has looked at options directed at:

- increasing the role of health departments in the allocation of funding for university-based health workforce education and training;
- integrating university and VET funding;
- providing a vehicle for independent and transparent assessment of 'directional' change in health workforce education and training; and
- providing for a more sustainable clinical training regime over the longer term.

Changing responsibility for the allocation of university places

Responsibility for determining the overall quantum of Australian Government financial support available for university-based training of health workers resides with the Federal Education Minister and DEST. While determination of this funding quantum involves consultation with health departments and other key stakeholders, requirements in the health care area must be considered in conjunction with the needs of all of the other sectors reliant on the university system to provide core workforce skills.

However, it does not necessarily follow that responsibility for allocating available funding for health care courses across disciplines, or indeed universities, must remain with DEST. That is, while DEST continues to set the overall funding

quantum, the health area of government could assume control of allocation, through either:

- the Australian Government's Department of Health and Ageing (DOHA) — as proposed by Duckett (2005b);
- a body comprising representatives from all of the State and Territory health departments (as proposed by the Victorian Government — sub. 155, p. 45); or
- a body made up of representatives from the health areas of both levels of government.

What are the potential benefits?

Such a division of funding-related responsibilities — which has been employed in some other countries (for example, diploma level nurse training in the United Kingdom) — would have two main benefits.

- By taking advantage of the extensive linkages between health service providers and the health areas of government, it would provide for a better informed allocation process.
- More importantly, it would give greater control over the type of health workers being produced by universities to the area of government responsible for funding the bulk of service delivery, and (in the case of State and Territory Governments) delivering some of those services. Prima facie, this closer alignment of incentives would again increase the prospect that the mix of health course places is the best that can be achieved from available funding.

That said, the likely magnitude of these benefits is less clear.

- There has been little hard evidence submitted to the Commission to indicate that the mix of university-based health care places emerging from current arrangements is greatly distorted — virtually all of the argument has centred on the creation of additional places, rather than the need to train more of some workers and fewer of others.
- The extent to which the potential benefits would be reaped in practice would depend on the level of government made responsible for allocation decisions (see below).

More broadly, the question arises as to why such an approach, if soundly based, should not apply in other areas outside of health.

The Commission's view

Notwithstanding uncertainty about the magnitude of the current mix problems, the Commission considers that the approach of making the health area responsible for allocating the funds available for university-based health workforce education, has some attractions. Apart from the in-principle benefits, the present arrangements are generating considerable heat, with the ongoing debate consuming valuable policy resources.

Moreover, the Commission is not convinced that efforts to build better linkages between the health area and DEST — as canvassed by AHMAC (sub. 166, pp. 35–36) — would prove successful. This approach has been tried in the past and, on the evidence before the Commission, continues to fail. A circuit breaker is therefore needed.

Also, the Commission does not see a large tension in treating health courses differently from other university-based disciplines. The role of governments in funding the bulk of the costs of services provided by health workers sets this sector apart from many others. And there is a trend in some parts of the university sector to consolidate all health services within the one self contained unit. In these circumstances, giving the health area of government greater say in the education and training of those workers may ultimately enhance the cost-effectiveness of service delivery, and thereby reduce total public sector funding requirements.

Of the three alternatives listed above for achieving this, the Commission considers that making DOHA responsible for the allocation function would be clearly preferable.

- It would provide for single rather than collective control. Especially in the current environment of some significant workforce shortages, debate about the distribution of available funding across universities could become intractable in a multi-jurisdictional forum.
- As a portfolio shift in responsibility within the Australian Government, it would reduce the risk that DEST's loss of primary responsibility for determining how funds were spent, would lead to less favourable treatment of health-related education and training in the distribution of overall university funding.
- DOHA is already involved in the allocation process for medical places. As such, an extension of its role would be a less dramatic and potentially more workable shift in responsibilities than the alternative proposal for a multi-jurisdictional approach involving the States and Territories.

Of course, merely shifting primary responsibility from DEST to DOHA would not fully address concerns about the allocation process — especially given perceptions

that DOHA tends to focus on the medical workforce rather than the health workforce as a whole. Thus to be effective, such a shift in allocation responsibility would need to be accompanied by a formal requirement for DOHA to consider the needs of all university-based health workforce areas in its deliberations, and to consult with DEST, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.

In terms of precise functions, the Commission envisages that under such an arrangement, DOHA would focus primarily on setting the mix of places across the various health science courses and the distribution of those places across universities, in dialogue with vice chancellors as at present. However, there might also be some scope for DOHA, in consultation with the universities, to make revenue neutral changes to the course subsidies used to set overall funding levels. To the extent this were possible, it could help to address some of the previously noted concerns about current course funding relativities.

DRAFT PROPOSAL 5.1

The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- ***consider the needs of all university-based health workforce areas; and***
- ***consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.***

Establishing health colleges

A quite different way of helping to promote a better mix of university-based health workforce education and training — at least from the perspective of the States and Territories — was put forward by Professor Wayne Gibbon from the Centre for Ambulatory Care Research (sub. 48, pp. 25–26). It would involve the creation of State health colleges (effectively in competition with the universities) which could design, develop and teach new programs, or purchase and teach pre-existing accredited programs.

According to Gibbon, this approach would allow the States and Territories to tailor course mix and content to their workforce requirements, shorten the lead times

needed to make changes in curricula and student numbers, and reduce the cost of developing new degree courses and training programs.

As Gibbon noted, recent amendments to higher education legislation which permit non-university providers to offer courses if the Minister for Education in each State/Territory accredits those courses, have removed any outright barriers to the creation of such colleges. Hence, it would be open to individual States and Territories to pursue this approach were they to judge it to be worthwhile and were willing to commit funding. (Current legislative arrangements do not provide for course contributions from the Australian Government for non-university providers.)

Integrated funding for universities and VET

In proposing that the States and Territories be given responsibility for allocating funding for health workforce education and training, the Victorian Government (sub. 155, p. 45) envisaged pooling of the university and VET components. Conceptually, such a pooled funding arrangement could also operate with the Australian Government controlling purchasing decisions, or through a body involving both levels of government, along the lines suggested by the ACT Government (sub. 177, pp. 7-8).

The rationale for such pooling would again be to facilitate more integrated decision making — in this case, by allowing for the reallocation of funding between the university and VET sectors in response to changing delivery needs. Thus, the Victorian Government referred to the possibility of 'substitution' between the two sectors.

However, the Commission sees considerable problems in this approach.

- Again, it is difficult to envisage that such an arrangement would work effectively were it to be jointly administered by all of the States and Territories, or by a body involving both levels of government. And securing agreement from all States and Territories to cede responsibility for this part of the VET system to the Australian Government could be very difficult.
- All three options for administering the combined funding pool would involve significant change to a VET system which appears to be working reasonably well insofar as its health workforce role is concerned.
- The VET sector accounts for a relatively small share of both health professions and total student numbers in the health area. Hence, the opportunities for beneficial redistribution of funding between the VET and university sectors — the major efficiency reason for integrating the two funding pools — would seemingly be quite modest.

- Intrinsic differences in the nature of the two sectors — for example, the basis for student contributions — could also create difficulties were funding in this particular area to be integrated.

Accordingly, the Commission does not consider that this approach offers the prospect of benefits that would significantly outweigh the costs involved.

Facilitating change in health workforce education and training models

As noted earlier, there continues to be considerable debate about a range of issues pertaining to education and training models, the configuration of health workforce courses, and course curricula. The issues are often complex, there are inevitably trade-offs involved, vested interest concerns intrude on the debate, and longstanding practice sometimes inhibits policy innovation.

From time to time, various independent assessments of these issues have been undertaken to assist those with policy or implementation responsibilities in this area. For example, DEST is currently coordinating a study of medical education in Australia which aims to provide a body of evidence and ideas from which medical schools will be able to draw in formulating curricula.

However, there has also been recent discussion of institutional initiatives to cut through blockers to 'directional' change in health workforce education and training. In particular, there have been various proposals to create a national 'Health Education and Training Council' to provide for independent analysis of directional change issues and associated policy and other initiatives. For example:

- The National Health Workforce Strategic Framework identified such a council as a possible means to more effectively engage the health and education and training sectors.
- The most recent Medical Education Conference (2005) advocated the approach as a way to both promote collaboration between stakeholders, and to provide evidence-based policy solutions to identified problems in health education.
- Several participants in this study have similarly proposed council-style initiatives — in some cases combining an advisory role with course accreditation and other statutory functions. (See for example, the Victorian Government (sub. 155, pp. 49–50) and the ACT Government (sub. 177, p. 8).)

The Commission agrees that a health education and training council would have several benefits:

- It would be a forum to draw together the views and expertise of the various stakeholders and to secure agreement on how worthwhile new directions in

education and training of health workers (including vocational and clinical training) would be best implemented.

- With appropriate governance structures, including a balanced membership, it could act as an 'honest broker' on divisive issues and those where existing interests might unduly influence outcomes under a more informal and less transparent process.
- It would facilitate consideration of education and training issues on an integrated rather than profession-by-profession basis. Amongst other things, this could provide greater scope to identify common education and training requirements across particular professions, and consequent opportunities to further develop inter/multi-disciplinary training approaches.

And given that such a council would be formalising and consolidating current discussion of these issues, the Commission does not give weight to concerns that this would represent just another layer of bureaucracy.

Such a council should be purely advisory. In particular, it should have no formal role in the accreditation of health-related education and training courses. Though the Commission considers that a single national accreditation body should be introduced (see chapter 6), combining that role with the advisory role outlined above could give rise to conflict of interest issues, and thereby undermine the effectiveness of both arrangements.

That said, an advisory council could nonetheless provide a valuable bridge between the proposed health workforce improvement and national accreditation agencies (see chapters 4 and 6). In particular, it could be a source of advice to the latter on some of the implications for courses, curricula and clinical training requirements of job design proposals emanating from the workforce improvement agency. As such, it would be a mechanism for helping to ensure that all of the cogs in the health workforce apparatus are meshing together properly.

Like the workforce improvement agency, the effectiveness of such a council would depend critically on its composition and the accompanying governance mechanisms. Indeed, without effective arrangements in this regard, the council could well become an impediment to, rather than a facilitator of, desirable change. Some key requirements would include:

- balanced membership — encompassing all broad professional areas (medicine, nursing, dental and allied health), the university and VET sectors, health care providers and consumers; and
- an independent chairperson, and the appointment of members as individuals rather than as formal representatives of the various stakeholder groups.

Also, to increase the likelihood that the council's analysis and advice was properly considered by policy makers, it would be desirable for it to report to AHMAC.

With these requirements met, the Commission considers that a health workforce education and training council would be of considerable assistance in facilitating further change and innovation in the preparation of Australia's future health workers. In its view, the council's assessments should cover all forms of health workforce education and training, including vocational and clinical training. However, in regard to health-related vocational training, consideration would need to be given to the council's relationship with the VET sector's Community Services and Health Industry Skills Council.

DRAFT PROPOSAL 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- ***opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and***
- ***their implications for courses and curricula, accreditation requirements and the like.***

A more sustainable clinical training regime

While several participants characterised the current state of play on clinical training as one of crisis, in the Commission's view, the pressures are neither uniform nor such as to suggest that the system will become dysfunctional in the near future.

- Though access to both undergraduate and postgraduate clinical training is becoming increasingly difficult in some key areas, in others there is reasonable balance between demand and supply, or even unfilled training places (eg, geriatric medicine, psychiatry, renal medicine, GPs).
- Notwithstanding increasing service delivery pressures, a large amount of clinical training continues to be provided to students, often on a pro bono basis.
- Reflecting its increasing importance in the provision of hospital services, the private sector is undertaking somewhat more clinical training than in the past.

Also, some of the current problems have stemmed from recent increases in undergraduate places. While indicative of lack of coordination within the education and training system, to some extent they are cyclical problems that will be resolved over time. Moreover, various responses to the undergraduate 'bulge', including by

State and Territory Governments, are likely to ameliorate the consequences in the short to medium term.

Equally, however, there are clearly systemic problems in current clinical training arrangements:

- There is a dearth of accurate, consolidated information on such things as available clinical training capacity (professional and site) and the numbers of undergraduate and graduate students seeking clinical placements.
- Funding for clinical training comes from a variety of disparate sources and is not always separately identified. This lack of transparency makes it more difficult to mobilise training resources in a coordinated way.
- The lack of explicit payment for many clinical training services — whether to the entities providing the infrastructure or to those providing the training — makes such training vulnerable to competing service delivery needs. It also inhibits the emergence of alternative competent training providers. Indeed, clinical training for General Practitioners under the GPET arrangements (see box 5.5) is the only area where funding and training delivery occurs within an explicit, transparent and contestable framework.

The last of these characteristics of the current arrangements is proving to be a particular impediment to greater clinical training in the private sector. In the absence of a dedicated funding pool, there has been an ongoing debate (see below) about who should pay for training in private hospitals. Thus, while private hospitals are providing an increasing share of hospital services, growth in their training activities appears not to have been sufficient to offset reduced training capacity and activity in the public system.

Against this backdrop, and in what is intended to be a forward looking study, the Commission has therefore assessed what is required to help ensure that over the *longer term* the clinical training regime is able to:

- offer adequate clinical training capacity at any point in time;
- respond in a timely manner as those needs change; and
- deliver training in the most cost-effective way — including, as appropriate, by competing providers.

To achieve this, effective coordination within the education and training sector is essential. Making DOHA primarily responsible for allocating government funding for university-based health workforce education and training, as canvassed above, could potentially assist in this regard. The proposed workforce improvement agency could also play a role by drawing the attention of governments to the clinical

training ramifications of job redesign. So too could the proposed health workforce education and training council in advising on the ramifications of new approaches to the delivery of clinical training.

But the Commission also sees the need for a better information base and some changes of emphasis within the broad clinical training framework. Some of these matters may well be encompassed by the current Medical Specialist Training Taskforce exercise aimed at putting specific proposals to AHMAC in the first half of 2006 (DOHA, sub. 159, p. 52). However, they are equally relevant to the clinical training regimes for allied health professionals and nurses.

A better information base

There is a clear need for those with policy responsibility in this area to have more accurate and complete data on how the clinical training regime (and in particular specialist medical training) is actually working. It is telling that the policy areas of governments do not have a complete picture across the health workforce of who is providing clinical training; where it is being provided; and how its cost is distributed across the various players.

This will not be an easy task — especially determining precisely how costs and contributions to those costs are distributed (see section 5.2). The extent to which negotiated remuneration for Visiting Medical Officers working in public hospitals includes an implicit allowance for the provision of pro bono training services, is just one of the issues that arises in this context. However, the lack of transparency is hampering efforts to develop structures better able to provide for longer term clinical training needs.

Explicit payment for clinical training services

In the Commission's view, greater use of explicit payments to those providing infrastructure support for clinical training, and for the training services themselves, is likely to be necessary if the system is to remain sustainable over the longer term. Importantly, a dedicated revenue stream for both training providers and the institutions in which training is conducted would reduce the vulnerability of clinical training to competing demands on those resources.

Explicit funding could be particularly helpful in encouraging the private sector to take on a larger clinical training role. In this regard, the Australian Private Hospitals Association commented:

> If Australia is to have a well-rounded health workforce, there is a pressing need to ensure that medical, nursing and allied health practitioners receive training in both the

> private and public hospital sectors. In order for this to occur, a coherent and equitable model of delivering and funding such training must be developed and implemented. (sub. 109, p. 2)

Also, explicit payment would provide a means to make funding for clinical training more contestable. In turn, competition to provide training services is likely to enhance the efficiency of service delivery, and facilitate the emergence of new training approaches. The Commission notes that, as well as underpinning the arrangements for the training of GPs in Australia (see box 5.5), initiatives to make funding explicit and transparent have been part of clinical training reforms in countries such as the UK and New Zealand.

However, there is clearly some resistance to moving in this direction. Notwithstanding its concerns about the longer term sustainability of pro bono training provision, the Committee of Presidents of Medical Colleges (sub. 47, p. 1) said that there is little 'enthusiasm' for greater reliance on explicit payment models within the colleges. Also, the Victorian Government (sub. 155, p. 43) expressed concern that if an explicit payment model led to higher charges for trainees, existing financial incentives for those completing training to practise in the private system would be reinforced.

But in the Commission's view, such concerns, of themselves, do not support continuation of an approach dependent on implicit funding and quid pro quos. For example, the issue of explicit payment to those providing training services is entirely separable from the question of how the costs of that training should be distributed across the various parties.

That said, the Commission emphasises that greater reliance on explicit funding and payment for clinical training services would not, and should not, preclude a continuing important role for pro bono training services. Indeed, notwithstanding the previously noted doubts about their sustainability over the longer term, for the foreseeable future, pro bono services will remain a key component of Australia's clinical training regime.

How should costs be distributed?

Several submissions to this study have called for those who employ health workers to make a contribution to the costs of their clinical training. For example, AHMAC observed that while not every private service is in a position to provide clinical training, all benefit from the availability of trained staff. It went on to note that:

> Other industries have addressed the need for equitable contribution to industry training through a scheme that enables employers to contribute by providing training or by paying a levy towards the costs of training provision. (sub. 166, p. 33)

Box 5.5 The GPET clinical training model

General Practice Education and Training (GPET) was established in 2001 to develop, oversee and fund postgraduate training for medical graduates seeking entry to general practice. Prior to its introduction, this training was provided exclusively by the Royal Australian College of General Practice (RACGP).

There are presently around 1800 trainees undertaking a three year program, Australian General Practice and Training, which leads to RACGP fellowship. The cost of the program is around $60 million a year, which is fully met by the Australian Government.

The program is delivered through 22 regional training providers (RTPs) across Australia, which are chosen through a competitive tender process. Supervision of trainees is provided by practising GPs, contracted by the RTPs.

RTP boards, which are appointed by the Minister for Health and Ageing, variously comprise representatives from medical colleges, universities, divisions of general practice, community organisations, consumers and other relevant bodies. Devolution of program delivery to the regional level is intended to provide scope to recognise diversity in needs and priorities in the training program, including in regard to preparation for work in rural and remote areas.

Though providing an example of an alternative to the predominant way of providing clinical training in Australia, the GPET arrangements have not been problem free. According to GPET itself, the fact that training continues to be organised according to RACGP standards and requirements has impeded consideration of issues relevant to determining appropriate competencies:

> Tensions may arise when professional organisations define training requirements, determine the qualifications for practice, determine entry to the profession and define the scope of practice. It seems inherent that a regulatory system controlled by professional interests will emphasise role delineation. This impedes the incorporation of a broader range of expert input into defining professional competence. (sub. 129, p. 6)

Moreover, GPET remains the only way in Australia of training to become a GP. Hence, though employing a tender process to allocate funding within the program, it makes no provision for competing forms of training delivery. As discussed in the text, the Commission considers that one of the primary reasons for making funding for clinical training explicit is to allow new delivery models to emerge.

A review of the cost-effectiveness of GPET is currently in progress.

However, in the Commission's view, it is far from clear that private health care providers receive a sizeable 'free lunch'. That is, competition between health care providers (public and private) to acquire the services of qualified workers is likely

to eliminate any excess returns that private providers might otherwise garner from training provided at the public expense.

It is true that public hospitals currently suffer a competitive disadvantage relative to their private counterparts because of the greater onus on them to *fund* clinical training from service delivery budgets. But this is a reflection of the lack of explicit government funding for clinical training, rather than of an inherent and differential benefit to private providers ensuing from government support for clinical training. As such, the disadvantage would be best addressed by making government support explicit and transparent, rather than through second best and blunt instruments such as training levies that do not account for the differing circumstances of individual service providers.

Accordingly, in the Commission's view, the key cost distribution issue to be addressed is the relativity between the private benefits accruing to trainees from the increase in their earning capacity, and the wider public benefits of having ready access to a well trained health workforce. In broad terms, the former should be reflected in charges levied on trainees, and the latter funded from the public purse. This delineation already underpins undergraduate clinical training through the mix of public funding and student contributions towards course costs. And though there may well be a larger private benefit component in postgraduate clinical training, current HECS charges could still provide a useful starting point to determine an appropriate split.

The Commission acknowledges the previously noted concern of the Victorian Government that were such delineation to lead to higher charges for trainees, it could reinforce the disincentives for practise in the public sector resulting from factors such as generally lower remuneration levels. Again, however, this is not of itself a reason to forgo opportunities to achieve a more efficient distribution of clinical training costs across the various parties. Ultimately, the causes of recruitment and retention difficulties in the public system are best tackled directly, including through competitive remuneration structures.

The Commission also acknowledges the concern that higher student charges for clinical training could reduce the attractiveness of health careers more generally. Given current excess demand for most places, this seems unlikely to be a major issue in the short term. Nonetheless, if moves towards a more efficient distribution of clinical training costs led to significantly higher charges, consideration could be given to concurrent introduction of a student loan scheme, similar to the HECS arrangements.

Finally, the Commission observes that clinical training often embodies a service delivery function. Indeed, for hospital interns and resident doctors prior to their

entry to a specialist program, a sizeable part of training is service-based. While not negating the thrust of the general observations above, it means that in many situations, a portion of clinical training costs should continue to be met from service delivery budgets.

Public funding to follow the trainee

The Commission sees general merit in the approach where the government contribution towards the cost of clinical training in lieu of wider public benefits follows the trainee, rather than being directed to particular institutions or service providers. In combination with charges levied on trainees, this would provide a consolidated and contestable funding pool which could be accessed by new as well as existing service providers. Moreover, unlike GPET, such competition would be possible without the need for a centralised competitive tendering process.

It is important to recognise that such competition would not greatly alter many of the core components of the current clinical training regime. Professional bodies and their members would still have an important role to play in providing input to the proposed national body that would accredit training programs (see chapter 6). And notwithstanding the potential for greater use of clinical simulators (see box 5.6), the delivery of training would still rely heavily on the existing group of trainers.

However, those trainers would be working in a potentially wider range of settings and receiving explicit payment for their services. Universities in particular have advised of their interest in assuming a greater role in managing the delivery of clinical training services (see box 5.7).

That said, the Commission acknowledges that practical considerations mean that there will be less scope to apply the 'public funding follows trainee' principle in the health workforce area than in many other sectors:

- While the Australian Government's contribution to undergraduate clinical training is of this nature, unbundling that funding from support for other aspects of undergraduate education is unlikely to be practical or efficient.
- As noted above, training of interns and resident doctors in public hospitals prior to their entry to specialist programs is interwoven with a service delivery role. Again, attempting to unbundle the training component and fund it according to this principle is unlikely to be feasible.

Nevertheless, in regard to the bulk of postgraduate clinical training, the Commission sees the approach as potentially having a useful role to play in putting clinical training on a more sustainable footing. Like explicit payment for the use of training

facilities, it could be particularly helpful in boosting specialist training in the private hospital system.

Box 5.6 **Simulated clinical training**

Clinical simulators can both substitute for, and complement, clinical training involving patients. Over the last decade, a number of simulation laboratories have been established in Australia on a collaborative basis between medical colleges and universities and, in some cases, State health departments.

Several participants pointed to the intrinsic benefits of simulated training. For example, the Urological Society of Australasia observed:

> A number of surgical skills laboratories are being set up throughout the country which eventually should provide virtual models, cadaver and live animal practice opportunities before supervised surgery on human patients is undertaken and competency to operate independently determined. (sub. 130, p. 4)

And Professor Peter Brooks said that overseas evidence indicates that simulated training delivers better outcomes in some areas:

> … in the training of laparoscopic cholecystectomy techniques, simulator trained residents performed the procedure 30% faster and made six times fewer errors while standard trained subjects were nine times more likely to fail to make progress and five times more likely to injure the gall bladder ... Simulators are now used extensively for training in cardiac endoscopy and interestingly the Federal drug administration in the USA has mandated simulator training for some of the newer cardiac stents. (sub. 13 (attachment), pp. 9–10)

And in regard to the contribution of clinical simulators in promoting more efficient workforce outcomes, the South Australian Government said that:

> In QLD, a Skills Laboratory has been developed which can be used for competency testing in relation to the medical workforce. For example, testing of hand eye coordination early in medical training would enable the students to be assessed for their capacity to undertake certain specialisations that require high levels of hand/eye coordination (eg surgery). This could lead to earlier preselection for certain types of specialisation and reduce wastage. (sub. 82, p. 37)

However, others such as the HCPA (sub. 70, p. 10) cautioned that 'computer-based learning experiences can enhance but not substitute for hands-on training in a hospital or other clinical environment'. It noted that simulators are costly and still require clinicians both to devise and supervise workshops in a laboratory setting, and develop the competencies which form the basis of assessment.

Changes to regulatory and indemnity insurance arrangements

For there to be greater contestability in clinical funding, the regulatory arrangements would need to facilitate rather than impede competition between potential providers of these training services.

Box 5.7 **What role for universities in clinical training?**

The current role of Australian universities in the clinical training of health workers is quite modest, being mainly limited to on-site training in certain allied health areas such as dentistry and podiatry, and involvement in consortia delivering postgraduate training to GPs under the GPET arrangements. In contrast, universities in countries such as the USA and Canada play a significant role in postgraduate clinical training across the full spectrum of medical specialities. This was also the case in Australia during the first half of the last century.

University interests submitting to this study wished to explore opportunities to increase their current level of involvement in the clinical training area. For example, CDAMS argued:

> As expert educational providers universities could, if properly funded to do so, provide the necessary education and training programs which could then link with and inform the certification processes managed by the Colleges. (sub. 49, p. 14)

However, it went on to say that this would require a process of unbundling of the education component of State-based hospital funding, as happened several years ago in the UK to create the 'Service Increment for Teaching'.

The Committee of Presidents of Medical Colleges (sub. 47, p. 1) expressed some scepticism about this approach, claiming that it has not been widely successful in other countries, and that there is little support for it within the Australian medical colleges. Nonetheless, collaborative initiatives between the colleges and the universities are currently being canvassed, which would see universities providing the more academic-related components of clinical training programs such as in basic sciences, communication and ethics modules.

Some have suggested that clinical training could occur within universities outside of the college system. In this regard, during the recent ACCC authorisation process for the Royal Australian College of Surgeons' (RACS) training program, the Hunter Area Health Service submitted that:

> … an opportunity now exists to establish a new, innovative, high-quality medical graduate training program — to be accredited by the Australian Medical Council and to complement the training program undertaken by the Colleges … For example, a surgical training program could be designed and implemented by the University of Newcastle, in partnership with the College and Hunter Health. Such a program could stand-alone (without the College's involvement, if the College were not prepared to participate) and be independently accredited by the AMC … (ACCC 2003, p. 121)

Hunter Health also contended that the program could be funded on a user pays basis without any need for government funding — though the Commission understands that no progress has been made in implementing the proposal due to funding constraints.

As discussed in box 5.5, regulatory issues have arisen in relation to the operation of GPET, where the RACGP has continued to exert tight control over the content and conduct of the training program. It is partly to address such potential conflict of

interest issues, that the Commission is proposing the staged introduction of an independent national accreditation agency (see chapter 6).

There may also be some issues to resolve in regard to indemnity insurance for those supervising training in the private sector. The Medical Indemnity Industry Association (sub. 62) said that access to indemnity insurance should not be a barrier to private sector training in the medical area, with 'affordable' cover available to both supervising practitioners and trainees. However, others expressed the view that there are still impediments in this area — though at least some of the concerns may reflect a reluctance to meet any additional insurance premiums to cover training activity in a situation where that training is being provided on a pro bono basis. Medical indemnity issues are discussed further in chapter 12.

Some wider considerations

In developing a more sustainable clinical training regime for the health workforce, consideration could also be given to consolidating responsibilities for providing the government component of funding. The current division of funding responsibility between the Australian and State and Territory Governments is essentially the legacy of a system where the bulk of postgraduate clinical training has been provided in the public hospital system, with the government contribution coming from general funding for hospital services.

However, in an environment where the private sector will inevitably play a more significant training role, and with a likely greater emphasis on explicit payment for training services, the question arises as to whether one level of government should be responsible for providing all, or the majority of, public subsidies for the non-service delivery component of that training. Such consolidation of funding responsibility would in turn make it easier to introduce initiatives such as 'funding follows the trainee' for aspects of postgraduate clinical training. That said, this is a matter on which the Commission does not yet have a firm view.

DRAFT PROPOSAL 5.3

To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- ***improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;***

- ***examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;***
- ***better linking training subsidies to the wider public benefits of having a well trained health workforce; and***
- ***addressing any regulatory impediments to competition in the delivery of clinical training services.***

6 Accreditation

Key points

- *Accreditation* assesses and evaluates education and training courses and institutions to 'guarantee' standards and consistency of health professional education and training.
  - It is complemented by *registration* which gives professionals the legal right to practise.
- Current accreditation arrangements can inappropriately reinforce traditional professional roles and boundaries, and thus impede job innovation. Inconsistent requirements imposed on educational institutions and trainers by different agencies create further inefficiency.
- A national across-profession approach to accreditation would:
  - facilitate more timely and objective consideration of job substitution and redesign options; and
  - provide uniform national standards on which to base professional registration.
- Governments should establish a single national accreditation agency for health workforce education and training. Its implementation should be in a considered and staged manner. It would draw on the expertise of health and education professionals as needed.
  - Possible extension to VET should be assessed at a later date, in the light of experience with the new accreditation agency.
- The new agency should develop a national approach towards the assessment of overseas trained health professionals.

Accreditation stands at the interface of between what the community and employers need from the health workforce, and the education and training that provides the workforce with the skills and competencies to meet those needs (see figure 4.1 in chapter 4). Its primary role is to assess and evaluate education and training courses to effectively provide 'guarantees' of standards and consistency of health professional education and training. Accreditation has an important influence on such matters as job design, the division of work between professions, and interdisciplinary and multidisciplinary approaches, on the one hand, and educational and training curricula and facilities on the other.

The process of accreditation is complemented by registration — this legally recognises practitioners' qualifications, experience and 'character' as being suitable for practice. Its purpose is to help overcome the information asymmetry between health professionals and their patients, and to provide assurances of quality and safety.

In practice, most registration boards currently have considerable discretion as to the qualifications they recognise and the conditions they impose on registration. In this respect, much of the commentary from participants about accreditation or registration ranged across both functions, while focusing more frequently on the registration boards themselves (see box 7.1 in chapter 7).

This current chapter covers accreditation, given its central role, while chapter 7 covers registration issues.

6.1 Existing accreditation arrangements

With the notable exception of nursing (which is working towards a national approach), much of the accreditation task within Australia for university based training and beyond is undertaken on a national basis, sometimes extending to New Zealand. However, it is undertaken by over 20 different bodies and there are considerable differences in approaches across professions (table 6.1). Some of these bodies have explicit statutory functions, while in other cases they may fulfil responsibilities delegated from registering authorities. In some professions, accreditation bodies were established in cooperation with, or as an initiative of, the respective peak professional associations.

In contrast to most other professions, the accreditation arrangements for the medical professions are complex and diverse, reflecting in part the multi-tiered education and training arrangements. Thus they involve not only the Australian Medical Council, but also a number of Postgraduate Medical Education Councils as well as the specialist medical professional colleges. In regard to the latter, some recent work of the Australian Competition and Consumer Commission (ACCC) is relevant:

- In June 2003, the ACCC granted authorisation to the Royal Australasian College of Surgeons in regard to a number of its processes in relation to the training of surgeons and the assessment of overseas trained doctors. This was subject to the College implementing a number of reforms, broadly relating to transparency, accountability, stakeholder participation and procedural fairness (ACCC 2003).

Table 6.1 **Accreditation bodies and functions**

Profession	*Agency*	*Scope*
Medical	Australian Medical Council	Undergraduate education (Australia and New Zealand) Specialist medical colleges (by agreement)
	Postgraduate Medical Education Councils (state based)	Intern posts
	Specialist medical professional colleges	Learning plans, training posts, facilities
Nursing	State nursing registration boards	Undergraduate education (moving to national approach)
	Specialist nursing groups	Specialist nursing professions
Dental	Australian Dental Council	Courses
Optometry	Optometry Council	Courses (Australia and New Zealand)
Other allied health examples	Australian Council of Physiotherapy Regulating Authorities	Courses
	Australasian Podiatry Council	Courses

Source: Various, including AHMAC (sub. 166) and Victorian Government (sub. 155).

- Subsequently, the ACCC reviewed, jointly with the Australian Health Workforce Officials Committee, the extent to which those principles were followed by other specialist medical colleges. The recommendations arising out of that July 2005 report (ACCC 2005b) were agreed by Australian Health Ministers (ACCC 2005a).

At the VET level, accreditation often proceeds through the development and approval of competency-based training packages on a national basis. Many of those of relevance to health are progressed through the Community Services and Health Industries Skills Council, a tripartite national body representing relevant governments, employers and unions. This council operates across traditional professional-based boundaries.

Accreditation can take place at a number of levels, including: courses and curriculum; teaching processes; assessment processes; approval of facilities; training plans for individual students and training positions. Accreditation does not usually involve the actual examination or assessment of students and trainees. The complexity of accreditation can vary, but major exercises can be broad in scope (for

example, assessment of a medical school), lengthy (18 months or more), and require the input of expert resources.

6.2 Issues and proposals

Many participants outlined the role of existing accreditation agencies in relation to the various health professions, without raising any major concerns or problems. These agencies are seen to be performing a necessary and worthwhile role in an adequate fashion, at least from the viewpoint of individual professions. For example, the Royal Australasian College of Surgeons considered there were 'no stiffer tests in Australia' than the accreditation standards of the Australian Medical Council, and hoped that 'this issue [of accreditation of surgeons] had finally been put to rest' (sub. 148, p. 5).

However, some participants, with a perspective of the operation of accreditation arrangements across the health professions, expressed concern about the efficiency and effectiveness of the regime as a whole. In the view of the Australian Government Department of Health and Ageing:

> The separate, complex and profession-based regulatory provisions currently operating State by State adversely affect health workforce capacity. A nationally consistent approach to regulatory arrangements for health care professionals which is centred on individual competencies would encourage portability, workforce flexibility and help address workforce distribution issues. Agreement has recently been reached on introducing nationally consistent arrangements for the medical profession, but not for any of the other major health professions. (sub. 159, p. 32)

Two broad areas of concern were identified by some participants. The first centred on the effect of current accreditation arrangements in reinforcing traditional professional roles and boundaries and thus impeding job substitution and redesign. The second was the lack of consistency in the requirements different accreditation agencies impose on educational institutions and trainers (box 6.1).

The solution to these problems was seen as involving consolidation of the accreditation functions for the various professions within the one national framework.

For example, AHMAC considered that the adoption of a cross-profession national model would:

- support the development of a more responsive system by reducing inconsistencies and inefficiencies within current arrangements;

Box 6.1 **Participants' concerns with accreditation arrangements**

Reinforcing traditional roles; stifling job development

> [Accreditation bodies] reinforce traditional workforce roles, rather than focusing on evolving service and client needs. The single-discipline focus is opposed to current policy directions that encourage inter-disciplinary approaches, optimal use of workforce skills and workforce adaptability. (Victorian Government, sub. 155, p. 48)
>
> … current accreditation processes do not fit easily with the expansion of scopes of practice or new workforce roles, particularly roles which might combine aspects of two or more existing professions eg a generic allied health professional. (AHMAC, sub. 166, p. 38)

Costs imposed by multiple agencies and/or lack of consistency

> If a coordinated approach to the accreditation of hospitals in relation to education and training was developed this would provide a significant improvement to hospitals and would cut down on a great deal of administration and save time. (Postgraduate Medical Council of NSW, sub. 153, p. 5)
>
> Currently, a range of professional self-interest groups is responsible for course accreditation. The process is cumbersome, long — up to two years — and is relatively costly. Accreditation standards and the methods of inspection also vary significantly between professions and can be applied inconsistently across jurisdictions. The ACT requires a greater range of health courses but current accreditation processes appear to be an insurmountable obstacle to course growth. (ACT Government, sub. 177, p. 11)
>
> The process of accreditation is unacceptably variable across different professions and in different States. Using hours as a fundamental yardstick, e.g. in Radiography and Physiotherapy, is inappropriate in a work environment where processes and practices have changed radically in the last 20 years, and which is also fundamentally inhospitable to the trainee. (Monash University, Faculty of Medicine, Nursing and Health Sciences, sub. 89, pp. 6–7)
>
> As this fragmentation of organisation suggests, some rationalisation in relation to accreditation and certification should be considered. (Committee of Deans of Australian Medical Schools, sub. 49, p. 17)
>
> The different specialist medical colleges assess hospitals and other providers of clinical training placements using different sets of accreditation criteria. There are several common elements in those criteria, such as: education facilities and support for students/trainees; the quality of supervision; administrative systems; communication; and performance management. There are also overlaps with requirements of other accreditation processes, in particular those of the Postgraduate Medical Education Councils. … However, standards that must be met in relation to these criteria differ between colleges and other accrediting bodies. Also, information about the accreditation criteria and processes is not always widely available (if developed). Criteria are not sufficiently objective, and clear, to enable accreditation outcomes to be anticipated or understood, constraining training providers' capacity to plan training arrangements and prepare applications. (AHMAC, sub. 166, p. 39)

- remove or substantially reduce the complexities with multiple accreditation across multiple jurisdictions; and
- through development of core competencies on a national basis facilitate curriculum development, identify common clinical education requirements,

> avoid duplication of effort and resources and underpin a national registration system and mobility of the workforce (sub. 166, p. 40).

Moreover, it considered that the potential of national arrangements to constrain 'innovative solutions to workforce issues locally' could be 'easily overcome by constructing the national accreditation standards, principles and processes to support such innovation' (sub. 166, p. 40).

However, AHMAC cautioned that, to achieve these benefits, the new system would need to 'substantially replace, not add on to' existing accreditation systems (sub. 166, p. 40). It suggested a number of objectives that would provide the basis for a staged move towards a national accreditation model.

- In the short to medium term: developing improved mechanisms for collaboration within and between professions, employer bodies and education and training providers to ensure consideration of workforce requirements in accreditation processes.
- In the medium term: developing a national framework of principles and process guidelines, to be progressively implemented across the different accreditation processes. This framework would be adopted as the standard for development of any new accreditation requirements and progressive review of existing criteria and processes.
- In the medium to longer term: establishing a single national health education and training accreditation body, responsible for revising the accreditation framework to apply across health occupations and managing related accreditation arrangements.

The Victorian Government was somewhat more specific in its proposal. It suggested the Australian Government and the States and Territories work together towards the establishment of a National Health Education and Accreditation Council which would be a 'multidisciplinary model for national course accreditation, curriculum leadership and the assessment of international practitioners' (sub. 155, p. 51) — the functions proposed are listed in box 6.2.

And the Queensland Government considered that a national review was called for:

> Australia would benefit from a national review including regulation of competency-based qualifications that potentially cross professions and facilitation of the regulation of new roles as required. (sub. 171, p. 18)

6.3 The Commission's assessment

In the Commission's view, the question of whether to consolidate accreditation

nationally is one of benefit and cost. On the benefit side of the equation, a national approach to accreditation would bring three main advantages.

- Together with the formation of a national workforce improvement agency (chapter 4), it would represent a significant movement of health workforce policy away from the current profession-based approach, while still drawing on health and education professional expertise as needed. It would give much needed impetus to more timely and objective consideration of job substitution and redesign options to improve the efficiency and effectiveness of the health workforce. And, except for the transitional costs, it is likely that most of the potential downsides could be addressed through intelligent design of the national arrangements.

Box 6.2 **The Victorian Government's proposed National Accreditation and Education Council**

According to the Victorian Government, a National Health Accreditation and Education Council should be established to:

- Identify competencies required for both entry level and more specialised practice across the health workforce, based on common core competencies.
- Assess and accredit courses for health practitioners seeking to enter (or re-enter) the health workforce.
- Maintain and publish a list of approved courses of study.
- Develop and publish standards and guidelines on the criteria and processes for course accreditation and assessment of international practitioners following consultation with key stakeholders such as educational institutions, professional bodies, consumers and government. This would include mandatory minimum requirements for safe practice assessments prior to entering the workforce.
- Assess courses and determine equivalence of overseas courses for accreditation purposes.
- Assess qualifications of international practitioners and determine additional requirements for purposes of registration in all categories.
- Provide leadership on national reforms and implement policy directions that allow the education and training system to respond to emerging health industry needs.

In the Commission's view, with the possible exception of those listed in the last dot point, these functions are appropriate for inclusion in a national accreditation agency (see text).

Source: Sub. (155, p. 51).

- It would, in effect, facilitate uniform standards for professional registration to be adopted on a national basis. (Of course, such uniformity of standards does not

imply that curricula need to be uniform or that teaching should be regimented.) This would remove those current jurisdictional barriers to efficient and effective deployment of practitioners which still remain, despite the operation of mutual recognition (see chapter 7) — currently differences in standards, professional practice requirements and the necessary educational preparation hinder the movement of practitioners across borders.

- And there would be administrative and compliance cost savings and efficiencies from greater uniformity in requirements imposed on education and training institutions by accreditation.

To some extent, the benefits of national accreditation have already been recognised — within professions, a national approach to accreditation is widespread, although sometimes with division of functions across a number of agencies. There is also a degree of consolidation within these national approaches, as evidenced by the role that the Australian Medical Council now undertakes for a number of specialist medical colleges.

In terms of cost, some disruption and other transitional costs would inevitably follow from overhauling present arrangements which, judging from submissions, are working reasonably well in many cases, albeit in the context of particular professions.

On balance, the Commission considers that the current multiplicity of the more than 20 accreditation bodies and their functions should be consolidated into a national approach for university education and postgraduate training (see below). As discussed in chapter 7, the Commission also considers that registration boards should be required to register health professionals on the basis of the national standards developed through the national accreditation process.

The planning and implementation process will be critically important to the likely success of consolidated national accreditation. As recognised by both the Victorian Government and AHMAC, the move towards a national accreditation system will need to be approached in a considered and measured manner, involving cooperation between the Australian, State and Territory Governments and other stakeholders.

Indeed, there will be many issues to be resolved through intergovernmental and consultative processes in relation to a new national agency including its coverage, functions, governance arrangements and funding, as well as the implementation and transitional arrangements required. To assist such consideration, the Commission has set out below its preliminary views on some important design and institutional features.

Coverage of professions

A national accreditation agency should cover the existing mainstream medical, registered nursing, dentistry and allied health professions (including optometry). Boundary line issues will arise — for example, as to the inclusion of 'new' professions and of occupations for which professional registration is currently not required.

One approach would be to include those occupations/professions where their scopes of work actually or potentially overlap or substitute for existing mainstream professions. Of course, even if not covered by the national agency, new professions, alternative therapies, etc. will still generally require some form of accreditation of their relevant education and training courses.

Functions

The national body would exercise statutory powers across the full range of 'traditional' accreditation functions including, where necessary and appropriate, accrediting courses, facilities and institutions. It would cover academic teaching as well as clinical and other forms of practical education and training, including postgraduate education and training. It would also be advantageous for the national agency to specify requirements for continuing professional development and education across the range of professions. However, functions such as the selection of students and certification would generally remain with education and training providers themselves.

So that its role is clear, and to avoid duplication with other agencies (for example the proposed workforce improvement agency), its functions should be clearly set in an education and training context. Thus, in the Commission's view, the accreditation agency itself should not be charged with such functions as developing new scopes of work and redesigning jobs. It should, however, cooperate with other bodies, advising on the educational and training implications of such proposals and, where necessary, develop relevant accreditation procedures to respond to those changes, as well as to clearly identified community health services needs. And it should have the power to facilitate education and training changes on its own initiative and to refer proposals with broader implications to the workforce improvement agency and other relevant bodies.

The Commission considers that the functions proposed by the Victorian Government are largely appropriate for inclusion in a national accreditation agency. The one exception concerns the last dot point in box 6.2 — while a national accreditation agency should clearly have a role in assisting the education and

training sector to respond to emerging health industry needs, this would need to be complementary to the roles of other agencies, including those proposed by the Commission — the workforce improvement agency and the health education and training advisory council (discussed in chapter 5).

Overseas trained professionals

Overseas-trained professionals are an important part of the Australian health workforce. For example, the Department of Health and Ageing noted that overseas trained doctors now constitute around 25 per cent of the overall medical workforce and a significantly higher percentage of doctors in rural and remote areas (sub. 159, p. 27). Recognising the skills and competencies of overseas professionals, and allowing them to practise in areas appropriate to their competencies, supports good workforce deployment (see the discussion about 'national self sufficiency' in chapter 3.)

However, in the wake of recent incidents, there have been widespread concerns about the current arrangements for assessing and recognising the competencies of overseas-trained doctors (box 6.3). In particular, the rigour of the different assessment procedures for temporary resident doctors has been questioned. While there is recognition that removal of the existing alternative assessment paths for this group would take time and could lead to major short term disruption to service delivery (particularly in rural areas), several participants questioned whether current controls are sufficient to protect patients and whether there would be value in a more uniform approach.

Indeed, participants were generally supportive of introducing national assessment processes and criteria for overseas-trained doctors (box 6.4). For example, in its submission, the South Australian Government (sub. 82, p. 39) recommended the development of 'national guidelines to ensure consistency around the supply, appointment and support of overseas trained professionals'. Similarly, the Victorian Government considered that standards and assessment procedures for international practitioners should be functions for its proposed National Accreditation and Education Council (box 6.2).

But, while recognising quality and safety issues, the Queensland Government warned against restricting the inflow of overseas trained doctors:

> The special purpose registration for medical practitioners in designated areas of need must not be used as a mechanism to restrict the inflow of overseas trained doctors, but must ensure that the quality and safety of medical practice equals that expected of Australian medical school graduates. (sub. 171, p. 18)

Box 6.3 **Assessment of overseas trained doctors**

The assessment path for overseas trained doctors depends on whether the practitioner is seeking general/unconditional registration (required for permanent residency) or conditional registration in Australia.

Overseas trained medical practitioners who have trained in medical schools that have not been formally reviewed and accredited by the AMC and who are seeking to practise medicine in Australia under *general* registration must sit a national examination administered by the AMC. This exam assesses whether practitioners are at the same or a better standard than newly qualified graduates of Australian medical schools who are about to go into intern training. Practitioners must also complete a period of supervised training approved by the State or Territory registration board (usually of 12 months duration).

However, sitting and passing the AMC exam is not a requirement for overseas doctors seeking *conditional* registration. For example, practitioners who wish to enter Australia as temporary resident doctors (TRDs) to work in medical positions designated as 'areas of need' by a State or Territory health authority, undergo a different assessment process. These practitioners have employment sponsorship, and their qualifications and credentials are assessed against the specific requirements of the sponsored position by either the State or Territory Medical Board or the relevant specialist college (with college recommendations forwarded to the relevant registration board). Other groups taking up conditional registration include TRDs entering Australia in order to undertake training, teaching or research, OTDs working towards the AMC exam, and OTDs seeking specialty-specific registration.

The Commission considers that implementing a national approach to the assessment of overseas-trained doctors, and indeed for all overseas trained health professionals, has considerable merit. Development of criteria and processes on a national basis would bring greater transparency and contribute to greater consistency in treatment. Importantly, it would also encourage dialogue between jurisdictions and within jurisdictions as to the appropriate requirements for these practitioners in different work settings.

In the Commission's view, the proposed national accreditation agency would provide a suitable institutional mechanism through which to pursue a national approach towards assessment of overseas-trained health professionals.

Coverage of VET

The current VET system appears to respond reasonably flexibly to the changing needs of the community and employers, without undue emphasis on a profession-

specific approach. Indeed, the system may well provide some object lessons for the new national arrangements for university education and post-graduate training.

Box 6.4 **A national approach to OTDs — participants' views**

Many participants supported the idea of national standards for assessing overseas-trained doctors.

> Assessment is a critical issue. The AMC pathway is highly regarded but there are a number of alternative routes to registration and employment for IMGs [International Medical Graduates] in Australia and no uniformity about the minimum standards of assessment for entry point to clinical practice. This is of major concern to CPMEC and its State and Territory PMCs as the majority of IMGs are working in Australian hospitals and IMGs are a mobile workforce. (Confederation of Postgraduate Medical Education Councils, sub. 85, p. 3)
>
> A single national assessment process of the qualifications of overseas trained doctors is required to ensure that doctors entering Australia with the same qualifications are assessed in the same manner around the country. … Given the different State and Territory requirements, it is feasible for a doctor to fail our assessment processes, but obtain employment in another State or Territory where requirements or assessment processes may be less stringent. A national streamlined and coordinated approach to assessment across the various categories of OTDs including permanent and all categories of temporary residents is to be encouraged. (Rural Workforce Agency Victoria, sub. 146, pp. 17–18)
>
> ARRWAG supports a nationally consistent approach to OTD assessment processes in order to achieve safe, high quality primary health care for the Australian community. (Australian Rural & Remote Workforce Agencies Group, sub. 136, p. 8)
>
> Insurers must be confident that the registration authority has rigorously assessed the qualifications of the doctor to practice in the area into which they are to be placed, and the expectation would be that the medical boards would be undertaking a nationally consistent, timely, rigorous and effective assessment of the qualifications of each doctor who applies for registration, irrespective of the geographic need. (Medical Indemnity Industry Association of Australia, sub. 62, p. 9)

It would be appropriate to exclude VET from the new arrangements, at least for the short to medium term, particularly in view of the other significant changes currently occurring in that sector. Possible extension to the VET areas should be reassessed at a later date, in the light of experience with the new accreditation agency.

Governance

The Commission broadly agrees with the views of the Victorian Government that the new body should be structured to allow for a:

> … balanced representation from professions, universities and training providers, educational experts, government and consumers to ensure the public interest remains paramount. (sub. 155, p. 50)

The comments on governance made in chapter 4 in relation to the national workforce improvement agency and in chapter 7 to registration boards are equally relevant here. In summary, it is important that membership collectively contain the necessary knowledge and expertise required across the health and education and training sectors and that members seek to further the public interest rather than the more narrow interest of particular stakeholders.

Operation

As envisaged by the Commission, such a national body would progressively take over *responsibility* for the range of existing accreditation functions carried out by such bodies as the AMC, Postgraduate Medical Education Councils, the Australian Dental Council, the Optometry Council, and the allied health accreditation agencies, although not necessarily all their existing work. As well, it would limit the direct responsibility of professional associations in the accreditation function (see below).

The proposed areas of responsibility of the new agency are extremely broad. It would need to operate through, and probably in many instances delegate particular powers to, a range of subcommittees and expert working panels — in practice, the experts may be currently supporting the existing accreditation agencies and their working groups. Such procedures should not, however, be allowed to detract from the advantages of drawing together statutory responsibility for health workforce education and training accreditation into the one agency. Thus, while subsidiary bodies may well include experts from various fields, they too should be structured (or restructured as necessary) so as to represent the broader public interest.

Implementation

As noted, participants have recognised the advantages of a staged approach towards introducing a national accreditation agency. This would allow time for discussion and negotiation directed at building support for the new arrangements, as well as help minimise transitional costs. While there is a danger that a protracted discussion and negotiation process would give those opposed to change time to undermine the proposal, the Commission considers, on balance, that a staged approach would be appropriate.

DRAFT PROPOSAL 6.1

The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- ***It would develop uniform national standards upon which professional registration would be based.***
- ***Its implementation should be in a considered and staged manner.***

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

DRAFT PROPOSAL 6.2

The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.

7 Registration

Key points

- In licensing health professionals, registration aims to protect the community by assuring the quality and safety of health services provision.
- The adoption of the uniform national standards for registration that would effectively be set by the national accreditation agency (chapter 6) would leave registration boards primarily responsible for the administration of registration and for enforcing professional standards and related matters.
  - During the implementation phase, jurisdictions should consider moving to uniform national standards on a profession-by-profession basis where the current costs of non-uniformity are high.
- Mutual recognition arrangements should be improved through implementing fee waivers for mobile practitioners and streamlining processes for short term provision of services across jurisdictional borders.
- Issues of extension of regulation need to be considered in a national benefit-cost framework and take account of alternatives such as self-regulation, credentialing and delegation.
  - Registration Acts should be amended to provide a sound legal basis for delegation.
- The merits of consolidation of registration boards, across jurisdictions and/or across professions, can only be assessed on a case by case basis.
  - With the adoption of uniform national standards for registration, the issue hinges on administrative and compliance cost savings and the transitional costs of change.
- Where necessary, membership of registration boards should be reconstituted to better reflect the public interest.

As noted in chapter 6, registration is the process of legally recognising practitioners' qualifications, experience and 'character' as being, and continuing to be, suitable for practice. Its purpose is to provide assurances of quality and safety, and to help overcome the information asymmetry between health professionals and their patients.

As they currently operate, most registration boards have discretion as to the qualifications they recognise and the conditions they impose on registration. Thus, at present, the registration process is a key factor affecting the efficient and effective deployment of the health workforce.

Potential changes to registration processes must be considered in the context of the more central role of accreditation. In the previous chapter, a national accreditation agency was proposed that would set, in effect, uniform national standards for health workforce education and training. Adopting such standards as the basis for national uniform registration would leave registration boards primarily responsible for administration of registration and for enforcing professional standards and related matters.

Nevertheless, during the transition to such a national accreditation body, registration boards will continue to have considerable influence on job design and workforce flexibility. And even with uniform national standards, there will be ongoing issues relating to the operation of mutual recognition, the extension of registration, potential consolidation of registration boards, and their composition.

This chapter first outlines the current roles of registration boards across the range of health professions. It then briefly reviews the arguments for a national approach to registration standards; explores possible improvements to mutual recognition processes; outlines options for the extension of registration; considers consolidation of administrative processes across jurisdictions and/or professions; and discusses the composition of registration boards.

7.1 Current roles of registration boards

Registration of health professionals is a State and Territory function, with over 90 boards currently operating (see appendix B, box B.5). Many health professions are subject to registration requirements, although some (such as occupational therapists) have registration in only some jurisdictions. Other professions, such as clinical perfusionists, lie outside formal registration and rely on self-regulation.

Boards take responsibility for setting standards for registration, maintaining registers of practitioners, collecting data, overseeing continuing professional development requirements, and administering disciplinary procedures. In many cases, responsibility for setting appropriate standards is effectively transferred to accreditation agencies (chapter 6). Some professional groups are working towards common approaches to registration standards (for example, the Australian Nursing and Midwifery Council's competency standards for nurses), and some jurisdictions (such as the ACT) have established multi-professional registration acts. However, for the most part, the standards and administrative processes for registration currently differ both between professions and between jurisdictions.

Mutual recognition arrangements apply within Australia (and between Australia and New Zealand) to allow practitioners who are registered in one jurisdiction to be

registered in an equivalent occupation in other jurisdictions, without the need for further assessment of their qualifications and experience. These arrangements are intended both to facilitate the mobility of practitioners across borders and to encourage the development of national standards. As part of their activities, registration boards handle applications for registration under mutual recognition.

7.2 National standards

While State-based registration arrangements have formed the cornerstone of much occupational regulation of the health workforce, there are increasing concerns that existing arrangements not only impose high administrative costs but also hinder workforce innovation.

Many participants considered that the current fragmented and uncoordinated multiplicity of bodies reduces workforce flexibility and leads to unwarranted administrative costs (box 7.1). In particular, it was suggested that jurisdictional standards set up barriers to the efficient and effective deployment of practitioners — differences in standards, professional practice requirements and necessary educational preparation across jurisdictions hinder movement of practitioners across borders, despite the operation of mutual recognition.

Prima facie, uniform national standards for registration have merit in terms of supporting better workforce deployment. More broadly, some argued that national standards are intrinsically more appropriate than jurisdictionally-based approaches — that Australians, no matter where they live, should have their health care delivered by people who are registered as meeting a nationally agreed level of competency. And while state-based standards allow for tailoring to state-specific conditions, there are other mechanisms through which particular requirements can be met, for example, credentialing by employers (see below).

If implemented, the national accreditation body proposed in chapter 6 would effectively provide national standards which registration boards could utilise. Indeed, the Commission considers that boards should be required to adopt such standards.

DRAFT PROPOSAL 7.1

Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

In the interim, however, jurisdictions should jointly review current arrangements on a profession by profession basis and, where the costs of current non-uniformity are high, consider moving to uniform national standards. This would require agreement on common categories of registration and uniform registration requirements for the existing professional groups concerned. AHMAC could take a lead coordinating role in this process.

Box 7.1 **Participants' views on national approaches to registration**

Many submissions commented on the problems associated with the current State-based registration systems and noted the potential for national registration systems to improve workforce deployment, generate efficiencies and promote consumer protection.

> … current registration processes are sufficiently dissonant between jurisdictions as to impede free movement of professionals between States and Territories. This is of particular importance for practitioners located in border regions who may be required to practise in more than one jurisdiction. (Australasian College of Dermatologists, sub. 104, p. 5)
>
> The registration process is costly, with limited consistency across the nation. … create an Australian Health Registration Board. (NSW Government, sub. 20, p. 5 and sub 178, p. 6)
>
> If they practice near State or Territory borders, they are required to be registered (and pay registration fees) in two or more places and are subject to scrutiny by multiple medical boards. (AMA, sub. 119, p. 8)
>
> … there would be benefits to both consumers and health professionals through developing nationally consistent regulation and consolidating responsibility for registration of health professionals. (Professions Australia, sub. 31, p. 2)
>
> The objective of national registration should be to:
>
> - Remove constraints on the development of a national market for the supply of individual professional services and provide a platform for other efficiency-enhancing reforms (including the reduction of compliance costs for individual professionals/professional firms);
> - Provide for a national regulatory system through uniform/consistent State and Territory legislation;
> - Enhance consumer protection and end inconsistent protection of consumers, with the implementation of national standards where necessary; (Professions Australia, sub. 31, att. 3, p. 3)
>
> Individual professions must have uniform regulation across Australia to ensure that clients and consumers are not exposed to possible harm. (Health Professions Council of Australia, sub. 70, p. 6)
>
> … national registration of doctors [must] be introduced as a priority to facilitate more flexible movement of the medical workforce across state boundaries. (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, sub. 112, p. 11)
>
> A major barrier to efficiency in recruiting nurses into aged care (and other areas of the health system) is the current state-based registration system. ACAA believes that nursing registration should be centralised nationally to facilitate national standards and reduce the duplication of administration. (Aged Care Association of Australia, sub. 115, p. 9)

Improving mutual recognition

There is a strong case for seeking to remove administrative impediments that currently stop mutual recognition arrangements from working smoothly and that would continue to be problematic even if uniform national standards were introduced and administered by the individual States and Territories. Waiving of registration fees for mobile practitioners is one such initiative. Streamlining of processes to allow the short term provision of services across jurisdictions without formal re-registration could also be beneficial.

Some initiatives along these lines have begun to emerge. For example, all States and Territories have agreed, through the Australian Nursing Council, to waive fees where a nurse is required to have registration in more than one jurisdiction as a result of working across jurisdictional borders (PC 2003a, p. 88). And the recently endorsed approach by Health Ministers for medical registration has the potential to overcome a number of problems with the current State-based administrative system. In this approach, registration in one jurisdiction will allow national practice, with no additional fees or applications required (AHMC 2004a). Standard and consistent registration categories will also be adopted.

DRAFT PROPOSAL 7.2

States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

7.3 Extension of registration

A number of participants argued for extension of the scope of registration to additional jurisdictions and professions (box 7.2). This question, and that of how to deal with 'new' professions, raises the broader issue of whether registration is the best way to ensure public health and safety without impeding effective workplace deployment.

Extending registration requires careful benefit-cost analysis case-by-case, preferably on a national basis. Protecting public health and safety and providing consumer protection must be weighed against the potential for reducing workforce flexibility and supporting anti-competitive behaviours, as well as the administrative and compliance costs involved. The balance is likely to differ across professions, in concert with differences in the level of risk and information asymmetry between patient and provider — the key rationales for legislated requirements.

Box 7.2 **Calls for extensions of registration**

Participants put forward several arguments to support wider registration of current health professionals. Some claimed that while there is a degree of self regulation of existing professions through professional societies, formal regulation is required to ensure service quality and safety:

> Perfusion is one of those groups where there is no minimum qualification required to practice and Australian hospitals are under no obligation to hire appropriate qualified personnel. The ASCVP [Australasian Society of Cardio-Vascular Perfusionists] and ABCP [Australasian Board of Clinical Perfusion] both believe that there is an issue of public safety if hospitals are not using appropriately qualified Perfusionists.
>
> … we propose (a) that the Commonwealth Government recognise the ABCP training regime and Diploma and (b) that State Governments establish Registers of Diploma-qualified clinical perfusionists. (Australasian Society of Cardio-Vascular Perfusionists, sub. 37, pp. 1–2)
>
> A nationally consistent process of statutory regulation or registration for occupational therapists is required. The status quo of partial regulation of the profession poses unacceptable levels of potential harm to the Australian public. This is especially significant as the workforce is growing rapidly and the profession is advancing into non-clinical or consultancy based services in the private sector. (OT Australia, sub. 54, p. 2)

Some also argued that introducing registration confers benefits to a profession. The Royal Australian and New Zealand College of Psychiatrists considered that as well as improving the recognition and status of Aboriginal and Torres Strait Islander Mental Health Workers, registration via Commonwealth or State mechanisms would assist in the development of a career structure (sub. 79, att. 2, pp. 2, 5).

Within this framework, where it is deemed desirable to register 'new' professions, or to extend currently limited registration across the jurisdictions more generally, the Commission considers it likely that national standards would provide the best approach. This would not preclude short-term experimentation with new roles at the jurisdictional level. However, should such roles be adopted on a permanent basis, agreement on national registration standards should then desirably be reached.

In considering the benefits and costs of extending registration, the protections provided by other features of the service delivery environment should also be considered. These features may provide an alternative method of ensuring appropriate quality and safety standards and include, for example, the discipline exerted over professions through self regulation activities, the rules imposed by employers and health funds, and the demands of other practitioners. In the case of clinical perfusionists, for instance, there appears to be a fairly robust regime underpinning the delivery of perfusion services, particularly given the close collaboration with the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists (who, together with the perfusionist and specialist nurses, are the key members of the surgical team for cardiac surgery) on

training and recertification of clinical perfusionists (sub. 37, p. 2). Indeed, standards defined by the Australasian Society of Cardio Vascular Perfusionists and the Australasian College of Surgeons recommend that cardiopulmonary bypass may only be conducted by specialists who have undergone recognised training and certification in perfusion science (sub. 37, att. 1, p. 4). In this instance, the case for registration may be less pressing, as the responsibility for quality and safety has already been accepted by the surgeon.

Similarly, greater involvement by employers, professional bodies and colleagues, via credentialing and delegation processes (box 7.3), may sometimes be an effective and less costly approach than formal registration. For example, such arrangements offer the potential for advanced practice health professionals to expand their scope of practice in a safe and controlled manner without requiring formal registration.

The benefits of credentialing received mixed support in submissions (box 7.4). While employer credentialing was seen as one way to better tailor scopes of practice to the work environment, some argued that 'credentialing' by professional bodies potentially 'locked in' current workforce roles and arrangements and was, in many respects, little different from statutory requirements.

In contrast, delegation was generally viewed favourably by participants, being seen as a useful way of supporting greater workforce flexibility (box 7.5). Indeed, rural interests noted that task delegation already operates and works well in rural and remote areas.

While delegation guidelines have sometimes been spelt out by registration boards, they do not always appear to have legislative backing. Hence, Duckett (2005b, pp. 6–7) has argued that the introduction of formal powers of delegation within registration Acts would facilitate the delegation of tasks to appropriately trained staff:

> … by extending the reach of a health professional registration board to cover the work of any person to whom a professional registered with that board has delegated tasks … [this] would establish a regulatory framework for health professionals' delegating to other professionals or assistants, and would allow professionals to delegate tasks, knowing they were doing so within an accepted regulatory framework.

The Rural Doctors Association similarly suggested an expansion of delegation could provide recognition and regulatory protection to rural practitioners who are 'forced by circumstances into work beyond their formal scope of practice' (sub. 161, p. 10).

In the Commission's view, giving formal legal backing to delegation, and supporting this through clear guidelines on the circumstances under which

delegation may take place, would encourage a more appropriate distribution of tasks across health professionals. However, changes to funding arrangements would also be required to provide an incentive for appropriate delegation to occur. Chapter 8 proposes changes to the MBS specifically to address this requirement.

Box 7.3 Credentialing and delegation

Credentialing is a formal process used by employers to verify the qualifications, experience, professional standing and other relevant professional attributes of health practitioners, for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Service providers may use credentialing as a base to *define the scope of clinical practice*, where the extent of an individual practitioner's clinical practice within the organisation is delineated, based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the practitioner's scope of clinical practice. This is also sometimes called 'clinical privileging'. In effect, by undertaking credentialing processes as part of their clinical risk management, employers are taking on some of the responsibility and accountability for determining the limits of practice.

The Australian Council for Safety and Quality in Health Care has published a national standard for credentialing and defining the scope of practice of medical practitioners, for use in public and private hospitals. The standard was developed in response to the rapid increase in the availability of new and complex clinical services, procedures and interventions and the increasing mobility of practitioners, and is intended to enhance the rigour of credentialing processes.

Delegation of tasks occurs when practitioners request another health care worker to provide treatment or care on their behalf. In making the decision to delegate, practitioners make the judgment that the person to whom they are delegating tasks is competent to carry out the procedure or provide the therapy involved.

Delegation procedures are relatively informal, with guidance for practitioners often contained within registration boards' guidelines or codes, but often without legal backing.

Source: Draws from ACSQH (2004).

In sum, the Commission considers that credentialing and delegation will sometimes be better approaches than formal registration requirements for providing assurances about the quality and safety of services delivered by health practitioners. In rural areas, particularly, these approaches may allow a faster and more effective response to changing scopes of practice and job redesign initiatives.

Accordingly, those responsible for assessing whether registration requirements should be extended should give consideration to alternatives such as self-regulation,

credentialing and delegation arrangements. Where formal registration is deemed to be desirable, this should be on a national basis with uniform national standards.

DRAFT PROPOSAL 7.3

Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

Box 7.4 **Participants' views on credentialing**

The Royal Australian and New Zealand College of Radiologists argued:

> … credentialling should be an integral aspect of a modern health workforce, and should explicitly recognise that the scope of practice for each practitioner be considered in conjunction with the capacity of the practice environment to provide the required infrastructure and related clinical services. (sub. 78, p. 19)

And the Medical Training and Education Council of NSW said:

> There are many doctors working in senior roles in public hospitals but who do not have specialist qualifications. It is often difficult for these doctors to access structured or formal training and professional development.
>
> … There are plans in NSW to develop a hospital training program which will be specifically designed to enhance and credential the skills of doctors not in a specialised training program. (sub. 154, p. 3)

However, employer credentialing was considered to have workforce mobility implications:

> One distracter that has impacted upon the ambulance profession is the fact that the employers are the credentialing authority. This affects the portability of ambulance qualifications between states. (Australian College of Ambulance Professionals, sub. 145, p. 3)

Some concerns were also expressed about credentialing by professional bodies:

> … while Australia retains this plethora of organisations that 'register and/or credential' individuals, and while these are focused on narrow professional categories, their concentration will remain on delineating roles and protecting patches rather than on creating an environment in which more effective team structures can evolve. (Australian Healthcare Association, sub. 151, p. 6)

7.4 Consolidation of registration boards

As noted above, several participants considered that there was merit in moving to a national approach to registration, at least through the adoption of uniform standards

on a profession-specific basis. Some also advocated a consolidated approach to administration, across jurisdictions and/or across professions.

Box 7.5 **Participants' views on delegation**

A number of submissions suggested delegation of tasks would encourage workforce flexibility:

> … the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner … has a number of attractions: clear clinical governance in diagnosis, investigation and technical management; greater likelihood of uptake and acceptance by the medical profession; less regulation, red-tape and external constraint on scope of practice; opportunities for participation by a broad range of health professionals …; easier uptake by the private sector; Medical Practitioners able to focus on complex and technically difficult cases; and simpler indemnity arrangements.
>
> To formalise 'delegated' practice arrangements, State and Territory Medical Act Regulations need amendment to provide a clear legal framework for responsible delegation of tasks by registered Medical Practitioners. While 'guidelines for good medical practice' that have been developed by most Medical Boards contain guidance on delegation and represent an interim solution, they lack legal weight. This should be identified as an area for early action by COAG. (James Cook University Faculty of Medicine, sub. 106, p. 3)
>
> RDAA sees new models already evolving through greater flexibility in the delegation of care by rural doctors to an expanding range of other health care professionals at the local practice level. Practice nurses have been employed in rural practices for several generations and RDAA strongly supported the introduction of the Commonwealth Practice Nurse subsidy to support and expand their work. This practical incentive to employ registered and enrolled nurses and Aboriginal Health Workers in general practice has been followed by access to new Medicare item numbers for wound dressings, immunisations and pap smears performed by practice nurses on behalf of the medical practitioner. RDAA supports extending this access to other services and procedures to enhance the holistic care a general practice can offer a community … (Rural Doctors Association of Australia, sub. 161, p. 9)
>
> The AMA … supports task delegation to appropriately trained nursing and allied health colleagues. This approach would build on the long history in health of providing health services in clinical teams. (Australian Medical Association, sub. 119, p. 5)
>
> A Radiologist is often required to check a patient's suitability for contrast, consent patient to receive contrast, insert cannula for venous access, inject contrast and monitor for possible contrast reactions. Most, if not all of these functions could be delegated to a nurse, radiographer or 'physician's assistant' so that the radiologist can concentrate on reporting/consultation functions etc. Although some sites already allow such multi-skilling it requires greater formalisation and expansion for universality and appropriate training and credentialling systems put into place. Safeguards should include suitable training and back-up, agreed protocols, participation in regular audit and formal arrangements for delegation. (Professor Wayne Gibbon, sub. 48, att. 1, p. 8)

Some participants expressed concern that current profession-specific board arrangements are becoming increasingly inflexible in the face of evolving

workforce trends. In particular, it was argued that current registration arrangements inhibit proper consideration of cross-profession issues, such as job redesign:

> Whilst it is essential that each profession takes responsibility towards regulation of its members, the jurisdictional and siloed approach to regulation undermines the capacity for the development or expansion of roles that might best, flexibly provide the health care of the future. Role expansion will certainly include some work practices moving from one occupational group to another. … the current system will not provide for this change. (Queensland Government, sub. 171, p. 8)

Administrative inefficiencies are also an issue — the Victorian Government considered that duplication of board administration is inefficient and costly, and discourages sharing of important expertise across boards and the establishment of consistent processes for managing common statutory functions (DHS 2005, p. 3).

Several participants suggested the creation of a single *national* registration board to cover all health professions, as one mechanism to help overcome concerns about workforce silos and administrative inefficiencies (box 7.6). AHMAC envisaged a staged approach, starting with a national framework for registration implemented at jurisdictional level, moving to a multi-jurisdictional system for each profession, and ultimately establishing a single national registration system (sub. 166, pp. 45–46).

However, not all groups supported consolidation across professions. For example, the Queensland Nursing Union stated:

> There is certainly a need for improvements to regulatory processes but it is essential that these occur in a manner that does not compromise the professional autonomy of different health professional groups. Nursing, for example, is a separate and distinct professional group that has struggled for years to be free from the 'medical model'. The QNU would strongly oppose any action that would see nursing lose its autonomy and professional status. (sub. 80, pp. 4–5)

National accreditation (as proposed in chapter 6) and the adoption of uniform national standards for registration (as proposed above) should largely eliminate the barriers to job design and innovation arising from a profession specific approach to registration. In this case, the issue becomes largely one of the administrative and compliance costs of the differing approaches, as well as the transitional costs of change.

On one side, duplication of processes with multiple boards increases administrative costs and thus imposes an increased financial burden on practitioners, especially on mobile practitioners who often must pay multiple registration fees under current jurisdictionally-based arrangements (but see above proposal about mutual recognition). On the other, some groups argue that monitoring and disciplinary processes are best conducted at the State and profession level. And the transitional

costs of supplanting the existing State-based registration regimes could be large. This tradeoff cannot be assessed except on a case by case basis.

Box 7.6 **A single national registration board for health professionals**

A number of submissions supported the creation of a single national registration board to cover all health professions. For example, the ACT Government suggested:

> In the longer term a national regulatory body which undertakes the process of registering health professionals and licensing workers should be considered. This would reduce the boundaries between jurisdictions and establish one national registration system which would determine common categories, qualifications and training requirements as well as ongoing competence. Membership would comprise a mix of professional, legal, government and consumer representation to ensure the public interest remains paramount. (sub. 177, p. 2)

In advocating transition to a national registration scheme, AHMAC said that:

> … the benefits that could be achieved through a national registration scheme … include:
>
> – system simplicity and clarity;
> – consistent requirements across all states and territories …
> – improving efficiency …
> – facilitating mobility of practitioners between jurisdictions or occupational roles in response to changing workforce needs;
> – reducing confusion among practitioners and consumers …
> – the opportunity to build a registration model which reflects and supports the multi-disciplinary nature of health service delivery;
> – the opportunity to build a registration model which facilitates the consideration of issues which cross health professions, such as new roles, expansion of scope of practice, core competencies; … (sub. 166, p. 44)

And the Victorian Government set out its vision for a national board:

> This scheme would take the form of a National Health Practitioners Registration Council to:
>
> – Establish and maintain a national register listing members of each regulated profession.
> – Determine the common categories of registration.
> – Establish national codes of guidance governing the regulated health professions, including any mandatory requirements for assessment by health services prior to commencement of practice.
> – Determine:
>
> - Qualification and training requirements for registration …
> - Requirements for establishing that applicants are of good health and character ...
> - Requirements regarding maintenance of professional competence.
>
> – Receive notifications and delegate to locally-based processes, investigations into the performance/competence, health and conduct of registered health practitioners. …
> – Explore … alternative models of regulation for those occupations not subject to statutory registration. (sub. 155, pp. 52–3)

Nevertheless, as a first step towards possible consolidation of administration more broadly, States and Territories should consider opportunities to progressively consolidate registration administrative arrangements across health professionals at a jurisdictional level.

7.5 Composition of boards

Regardless of whether registration boards can be effectively consolidated, it is important that their membership supports decision making in the public interest. For example, if those representing particular interests are given excessive say, desirable workplace change may be slowed or even blocked.

There are claims that some boards may indeed compromise the broader public interest. The Victorian Government commented:

> In the Victorian experience, this occurs most commonly where new roles (such as support workers) have been proposed and/or introduced. However there are instances where the standards set for entry (and re-entry) to practise also appear to reflect professional interests, rather than those of the broader public. (sub. 155, p. 52)

In response to its concerns, the Victorian Government has reviewed its health practitioner registration Acts and is considering a number of reform options, including changing the balance of membership on boards to increase the proportion of non-practitioners (sub. 155, p. 52).

In general, in the Commission's view, it is desirable that boards have:

- clear specification of roles and responsibilities of members;
- robust accountability mechanisms;
- an independent chair; and
- appointment of members in their own right, rather than as representatives of particular organisations, via transparent appointment processes.

It is not necessarily appropriate for practitioners from the profession in question to comprise the majority of the board's membership — a minority may well be sufficient to ensure access to relevant profession-specific expertise. Further, as consumer protection is the main aim of registration, boards should include appropriate consumer representation.

To the extent that the current composition of boards is causing concern, or where pursuit of particular board functions is hindering necessary workforce change, the immediate solution lies with the States and Territories. It is within their power to

make changes to board composition and the functions of registration boards as the circumstances dictate.

8 Funding mechanisms for health care services

Key points

- Health care funding and payment arrangements affect demand for health workers, the career choices of those workers, where they locate and whether they practise in the public or private sectors, professional boundaries between health workers, and work practices generally.
- Many funding issues affecting the health workforce are 'higher level' and cannot adequately be addressed in a study into the health workforce. They require a broader review of the health system itself.
- However, some improvements can be made within the confines of current arrangements and levels of government funding to support the provision of health workforce services.
- The operation of the Medicare Benefits Schedule (MBS) may not always facilitate the provision of health services by the most appropriate health professional.
  - There should be a transparent formal mechanism for advising the Australian Government on whether changes to the range of services covered, referral rights for diagnostic and specialist services, and prescribing rights under the PBS, would improve health care outcomes and/or provide more cost-effective service delivery for the same level of outcome.
  - And to progressively encourage more efficient deployment of the workforce, MBS rebates should be payable for a wider range of delegated services.
- Multiple expenditure control mechanisms which contain the costs of government subsidies for the delivery of health services can detract from the effective deployment and training of the health workforce. Some streamlining may be possible, based on the minimum and least distortionary set of mechanisms that would be consistent with achieving appropriate fiscal discipline.

8.1 A pervasive influence on the health workforce

A common theme in previous reviews and in submissions to this study has been the need for more government funding to overcome shortfalls in health workforce numbers or skills. With governments meeting nearly 70 per cent of total health care costs (see box 8.1), the level and nature of such support is clearly a major influence

on both the demand for health services and the capacity of the system to meet that demand.[1] Indeed, several recent workforce-related initiatives have involved additional public funding for service provision, or for the training of prospective health workers.

But equally important to the health workforce is the efficiency and effectiveness of funding and payment arrangements. For example, they can affect:

- decisions by consumers about what sort of health care services to consume and from whom they acquire them;
- the career choices of health care workers — both as to fields of study and to the extent of specialisation within chosen fields;
- the location decisions of those workers and whether they practise in the public or private sectors;
- the boundaries between health professions; and
- methods of practice, including referral patterns and the willingness to assess different models of service delivery, or to countenance changes in scopes of practice.

Moreover, while the mechanisms for disbursing public funds are clearly influential in such decisions, the instruments used to mobilise the other 30 per cent of expenditure, including patient co-payments, private health and compensation insurance arrangements, are also germane. So too are the variety of expenditure control measures attached to the broad funding instruments to contain budgetary risk for governments and private health insurers.

Getting funding and payment arrangements 'right' poses enormous challenges for policy makers. Ensuring that the reasonable health care needs of those with limited capacity to pay are met, while at the same time minimising wasteful consumption of health care services, is a challenge that virtually all developed countries struggle with.

An overarching difficulty is that, because third parties (government and private insurers) meet the majority of health care costs, the incentives on patients and practitioners to exercise due restraint on the demand for, and supply of, health care services are muted. This is exacerbated by the opaque and indirect nature of the impact of over-consumption of health care services on costs for taxpayers and those who pay private health insurance premiums.

[1] The House of Representatives Standing Committee on Health and Ageing commenced an inquiry into Health Funding in March 2005.

Box 8.1 **Funding of health care in Australia**

In 2002-03, expenditure on health care in Australia totalled $72 billion, or over $3600 per person. It represents 9.5 per cent of GDP, up from 9.3 per cent in 2001-02 and 8.2 per cent a decade ago. Governments funded 68 per cent of this expenditure (or about $50 billion), with the rest funded by patient contributions ($14.2 billion), private health insurers ($5.3 billion) and others such as compulsory motor vehicle, third-party and workers' compensation insurers ($3.7 billion).

Government funding is split between the Australian Government (about 46 per cent of total health care expenditure) and State and Territory Governments (about 22 per cent). The Australian Government's contribution includes:

- direct expenditure on health programs (including Medicare, the PBS, residential aged care, and programs designed to improve access to health services in particular areas — eg rural and remote — and/or for particular groups — eg Indigenous Australians);
- payments through the Department of Veterans' Affairs for the treatment of eligible veterans and their dependants;
- health-related specific-purpose payments (SPPs) to the States and Territories;
- rebates and subsidies under the *Private Health Insurance Incentives Act 1997*; and
- taxation expenditures — for example, rebates to individuals or families incurring high out-of-pocket costs in any particular tax year.

State and Territory government expenditure, in combination with SPPs from the Australian Government, funds the public hospital system, community-based health care services and a range of other health care services, including for remote and Indigenous services.

- Funding of public hospitals is largely governed by the Australian Health Care Agreements. Over 90 per cent of all funding of public hospitals comes from governments — 49 per cent from SPPs from the Australian Government and 43 per cent from the States and Territories, which have the major responsibility for operating and regulating public hospitals.

Private health insurance provides the bulk of funding for private hospitals and for private patients in public (non-psychiatric) hospitals. Funding for private hospital services accounted for 48 per cent of the $5.3 billion provided by health insurance funds in 2002-03. Other major areas of expenditure were dental services (13 per cent) and medical services (9 per cent).

Of the $14 billion out-of-pocket expenditure by individuals, about one-third was spent on pharmaceuticals, 21 per cent on dental services, 15 per cent on aids and appliances and 10 per cent on medical services. In the case of dental services, individuals contributed two-thirds of the total expenditure of $4.1 billion.

Sources: AIHW (2004a; 2004b).

Moreover, judgments by health professionals will be influenced to varying degrees by a range of 'external' considerations such as rules governing the referral of patients to more specialised services, limitations on access to certain diagnostic tests, remuneration arrangements (fee-for-service or salary) and medical indemnity considerations.

One of the significant complexities in Australia's funding and payments arrangements is the division of government responsibility for health care. This was a common theme in many individual submissions. In the communiqué issued after the June 2005 meeting of CoAG, all governments agreed that:

> … there is room for governments to discuss areas for improvement, particularly in areas where governments' responsibilities intersect. … Further, governments recognised that the health system can be improved by clarifying roles and responsibilities, and by reducing duplication and gaps in services. (CoAG 2005)

In a health workforce contest, divided responsibility can have a range of undesirable outcomes. For example, the New South Wales Government said that:

> The joint funding responsibilities of the Australian and state governments in the provision of health care services affect how those services are delivered in Australia. … Sometimes care is delivered to the community in a way that is based on the source of funding for the care and not what is clinically the most appropriate way to deliver the care by the most appropriate health care provider. (sub. 20, p. 6)

It also noted that many distortions arise from existing funding arrangements, citing the 'strictly hospital based' Australian Health Care Agreements (and their 'rigid funding and performance regime'), the MBS and its safety net arrangements, private health insurance, and the PBS. It further argued that the control of program budgets by different fund holders:

> … does not encourage horizontal integration of services across the primary, secondary and tertiary provision of care, or for specific care areas such as mental health and aged care. (sub. 178, p. 20)

From the above, it is evident that a wide range of 'high level' funding arrangements determine the broad incentives framework facing the health workforce. Among other things, they affect how much emphasis is given to particular institutional arrangements or models of care, and the extent to which variations from the status quo are encouraged or hindered. They can also lead to similar services being funded differently — particularly at program boundaries, where different incentive structures become evident (and cost shifting becomes an issue). Examples include funding for salaried hospital staff and VMOs; emergency departments and after-hours GP clinics; and MBS-supported GPs and dentists and other allieds dependent on private sources of funding.

However, altering these high level funding arrangements would significantly change the overall structure of the health system. It would not be appropriate to propose major changes based on workforce considerations alone. The parallel Senior Officials Group review is examining some of these broader issues, with the CoAG communiqué recognising that responsibilities between levels of government may need to change.

Consistent with the Commission's terms of reference for this study, the remainder of this chapter looks at reform options within the confines of current funding and payment arrangements. The focus is on improving broad institutional and procedural frameworks, rather than on the potential role of more specific programs and approaches. The latter include the Practice Incentives Program, which provides a range of financial incentives to general practice to: encourage use of computer-based information systems; provide after hours care; better manage diseases such as asthma and diabetes; and increase screening for cervical cancer. Nor does the chapter examine the effect of additional payments to GPs to encourage bulk billing, incentives for services provision in areas of need or in aged care facilities, higher rebates for after-hours GP attendances and so on. However, some of these are considered in later chapters that look at rural and remote issues, areas of special need and after-hours care.

8.2 The MBS and the health workforce

Medicare subsidises access by patients to, mainly, medical care. The key services covered are shown in table 8.1. Among other things, the Medicare program provides benefits, as listed in the MBS, to patients who use the services of general practitioners and specialists. It also provides benefits for the use of diagnostic services such as pathology tests, X-rays and ultrasounds.

Total spending by the Australian Government on the MBS was $8.6 billion in 2003-04, of which about a third was for GP services. In the case of GPs, MBS benefits accounted for about 90 per cent of income derived from consultations (Department of Health and Ageing, sub. 159, p. 34). About 75 per cent of all GP services are bulk billed.

For the most part, the MBS does not cover non-medical services — such as those provided by nurses and allied health professionals. The few exceptions include: optometry consultations; a very limited range of dental services; and some delegated services provided by practice nurses under the direction of medical practitioners in whose name the MBS claim is made. In addition, some allied health

services are covered where the patient has been referred for a program of care by a medical practitioner (for example, under the Enhanced Primary Care Program).[2]

Table 8.1 **MBS benefits and services, by broad type of service, 2003-04**

	Benefits	*Services*	*Average number of services per capita*
	$m	*'000*	
GP attendances	2 855	97 467	4.8
Pathology	1 408	73 762	3.7
Specialist attendances	1 120	20 313	1.0
Diagnostic imaging	1 331	13 458	0.7
Operations	840	6 590	0.3
Optometry	197	4 786	0.2
Anaesthesia	209	1 956	0.1
Obstetric services	77	1 418	0.1
Other	566	6 632	0.3
Total MBS	8 600	226 382	11.3

Source: DOHA (sub. 43 to House of Representatives Standing Committee on Health and Ageing inquiry into Health Funding, p. 9).

8.3 What are the key workforce-related concerns?

Aggregate funding levels aside, there are several aspects of the operation of the MBS that have important implications for the efficient deployment of the health workforce. They involve:

- access to the MBS by other than medical practitioners;
- the structure and relativities of MBS rebates;
- the scope for delegation of MBS-supported services; and
- referral and prescribing rights under the MBS and the PBS.

Access to the MBS by other than medical practitioners

The MBS is primarily a mechanism for facilitating access (by way of subsidies) to services that are 'personally provided' by medical practitioners. Differences in the extent to which it subsidises various medical and health care services affect

[2] Eligible services include those provided by Aboriginal health workers, audiologists, chiropractors, chiropodists, diabetes educators, dietitians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists. There are limits on the number of MBS-funded services per patient per year.

incentives facing both patients and providers and thus have significant implications for the performance and supply of the current and future health workforce, and consequently for the provision of health care.

A particular concern for many participants was the exclusion of a range of health services from the MBS. At a broad level, this was seen as undermining equity of access objectives and detracting from health care outcomes for certain groups. For example, mention was made of long waiting times for public dental services (which has major implications for the health care of lower income groups) and the financial disincentive for greater use of allied health services, such as podiatry and physiotherapy — in some instances as a substitution for GP services.

More specifically, participants contended that restricted coverage of the MBS inhibits the effective use of the health workforce and thus exacerbates workforce shortages. For example, the Queensland Nurses' Union argued for consistency of approach between the various health professional groups, noting that:

> … nurse practitioners, midwives and many other health professionals are not able to obtain a Medicare provider number under the MBS. … If we are to truly examine appropriate extension of roles within the health care team then this must also involve an examination of remuneration arrangements and a consistent approach must be taken. (sub. 80, p. 7)

The New South Wales Government noted that while greater emphasis on integrated or multidisciplinary models of care will be required in the future, the involvement of some health professionals in such teams may be discouraged by the current structure of MBS rebates, particularly in rural areas (sub. 178, pp. 21–22).

Some, such as the Australian Physiotherapy Association (sub. 16, p. 4) and the Victorian Government (sub. 155, p. 32) said that the current restrictive MBS coverage may induce some patients to opt for treatment by a GP simply because an MBS rebate is not available for what in some cases may be an equally effective service delivered independently by an allied health professional. They went on to point out that, in such cases, unnecessary costs may be incurred, and the GP's time may be diverted from the provision of more beneficial services (and at times the patient is subsequently on-referred by the GP to an allied health professional in any case). In this regard, the Victorian Government argued that costs may be increased:

> … by generating avoidable duplication of effort, delaying initiation of treatment and impeding the optimal deployment of available workforce skills. (sub. 155, p. 32)

Specifically, it noted that:

> … approximately 50 per cent of the caseload of general practice involves counselling, emotional support and mental health assessment. Social workers or psychologists could handle much of this. (sub. 155, p. 32)

The Department of Health and Ageing also noted that a number of primary care health services carried out by GPs could be carried out by other qualified health professionals, thereby freeing up GPs to focus on more complex clinical tasks (sub. 159, p. 29). It added that:

> Allied health professionals such as dieticians, diabetes educators, podiatrists, psychologists and physiotherapists can provide a number of primary care services currently being met to a lesser or greater extent by GPs. (sub. 159, p. 31)

The Commission also received a number of submissions arguing that there is considerable scope for greater use of technicians and other health professionals to undertake and report on routine diagnostic tests in their own right, with provision to refer more complex cases to medical specialists in the usual way. For example, in regard to radiography, Professor Wayne Gibbon contended that:

> No plain film reporting is occurring within many hospitals due to the absence of sufficient radiologist resources to formally read and report these. It is imperative that radiographers are trained to read and report plain films, particularly films that require rapid reporting such as those within an emergency department. International evidence substantiated through meta-analysis and published in February 2005 indicates radiographer competence as being equivalent to radiologists in this function, if appropriately trained. (sub. 48, pp. 5–6)

Duckett (2005b) gave other examples of where some substitution is now occurring or could occur (table 8.2), but argued that progress in this area is being hindered by restricted access to the MBS, as did the Queensland Government (sub. 171, p. 9).

Table 8.2 **Areas of potential or current task substitutions**

Task[a]	*Traditional professional*	*Substitute professional/assistant*
anaesthesia	anaesthetist	nurse anaesthetist
clerking of new hospital patients	hospital medical officer	nurse
closure of wound	surgeon	nurse
foot care	podiatrist	foot care assistant
foot surgery	orthopaedic surgeon	podiatric surgeon
laryngoscopy/naso-endoscopy	ENT surgeon	speech pathologist/nurse
maternity care	obstetrician	midwife or GP
mobilisation assistance	physiotherapist	physiotherapy assistant
patient management	medical practitioner	nurse practitioner
plain X-ray	medical imaging technologist	X-ray assistant
refraction	optometrist	orthoptist
reporting pathology	pathologist	scientist
reporting X-rays	radiologist	medical imaging technologist

[a] Performance of the substituted tasks will generally require additional training and clear protocols, and will also depend upon the complexity of the condition and the comorbidities of the patient.

Source: Duckett (2005b).

Going further, the Victorian Government argued that the MBS should be explicitly configured to provide incentives for task delegation to suitably qualified practitioners (such as nurses and/or allied health providers) in areas of workforce shortage (sub. 155, pp. 33, 34). A different approach was advocated by the Australian Physiotherapy Association, which proposed an assessment committee that would operate somewhat like the Pharmaceutical Benefits Advisory Committee, an independent statutory body that recommends which drugs should be added to the PBS schedule. Some other observations from those supporting wider access to the MBS are provided in box 8.2.

However, the AMA cautioned that an emphasis on substitution of tasks away from medical practitioners to other health staff could lead to diminished quality and safety outcomes:

> Many of the proposals for substitution would have a marginal impact on the availability of medical practitioners and create very significant quality and safety issues at first consideration. … there are significant limitations on the extent to which tasks can be taken out of the hands of medical practitioners or away from their supervision. These limitations include the inability of lesser trained groups to appreciate the complexity of medical decision making and treatment options. (sub. 119, p. 4)

Similarly, the I-MED/MIA Network, which operates 240 radiology clinics and accounts for about one-third of the private radiology market, expressed concern about proposals to extend the roles of radiographers and sonographers, arguing that:

> Such role extension will exacerbate existing staff shortages of radiographers and sonographers, have a cost impost for training and require the development of appropriate protocols for supervision by radiologists. We would not support radiographers and sonographers being given direct access to Medicare Benefits because of the significant impacts this would have on the Diagnostic Imaging outlays. (sub. 176, p. 2)

The scope for delegation of MBS-supported services

As touched on above, one way of encouraging a more effective deployment of the workforce is by way of delegation. Under current arrangements, the high cost and limited time of highly trained practitioners can be taken up with tasks that may be able to be undertaken by others. Delegation of more routine tasks could help to ensure that their expertise, and that of those to whom such tasks are delegated, is used to its best advantage. This would be consistent with the principle, enunciated by AHMAC, that ‘wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care (sub. 166, p. 9).

Box 8.2 **Support for extending MBS service coverage**

The Centre for Midwifery and Family Health argued that new and evolving models of maternity care are being hindered in part because women do not have access to Medicare funding for midwifery services (sub. 41, pp. 2, 5).

The Australian College of Midwives said that the restriction of MBS maternity payments to doctors:

> … creates a strong incentive to over-servicing of healthy pregnant women by specialist obstetricians. … Midwives have no access to relevant MBS rebates despite having the professional expertise to provide an equivalent service to healthy pregnant women. (sub. 99, pp. 20, 21)

The Australian Psychological Society said that psychologists are highly skilled and qualified to provide psychological interventions for mental health problems, but do not have access to Medicare rebates.

> Many patients have little choice but to use the funded (and hence cheaper), less well-trained practitioner. … Enabling psychologist access to the Medicare items for Focused Psychological Strategies would … provide access to best practice psychological interventions in specialised areas of great need, such as youth and aged mental health. (sub. 118, pp. 19–20)

Australian Society of Anaesthetists said it has been attempting over the past 15 years to have anaesthesia consultations (as distinct from the provision of anaesthesia services) recognised by both Medicare and private health insurers to provide appropriate incentives for best practice.

> Medicare funding for services should be subject to review and a more outcome-based approach must be adopted and not one solely based on direct impact on health expenditure. (sub. 40 to House of Representatives Standing Committee on Health and Ageing inquiry into Health Funding, p. 3)

The Australian Physiotherapy Association argued that an MBS rebate should apply to physiotherapy services in cases where the patient is referred by a medical specialist.

> In many cases the specialist refers the patient for physiotherapy instead of undertaking a surgical procedure. In such cases physiotherapy intervention is the best available care for the patient, it is substantially cheaper than surgery, and places less pressure on the health workforce. … If physiotherapy management is available to substitute for surgical management, clearly there are workforce advantages and cost savings. (sub. 65, p. 10)

The National Rural Health Alliance and College of Medicine and Health Sciences said that, while amputation of a diabetic foot is covered under the MBS, its treatment by a podiatrist is not (sub. 126, p. 10).

The Australasian College of Podiatric Surgeons said:

> There are no Medicare rebates for podiatric surgeons even though an identical service provided by an orthopaedic surgeon will attract a Medicare rebate. [There are also] no rebates to medical practitioners (eg. anaesthetists, pathologists, radiologists) who provide services to the patients of podiatric surgeons and are integral in the surgical care of patients. (sub. 131. pp. 3, 7)

There is currently some limited provision for MBS funding of delegated services undertaken by, for example, practice nurses acting on behalf of a medical practitioner (box 8.3).

The Commission has received submissions arguing that there are other instances where patients could be provided with services of appropriate quality and safety by another health care professional, with consequent efficiencies from a workforce viewpoint.

Box 8.3 **MBS items for practice nurses**

In 2004, the Government introduced new MBS rebates for a practice nurse — an RN or EN employed by, or whose services are retained by, a general practice.

A GP can claim for an immunisation or wound management service provided by a practice nurse on behalf of the GP. For these items, the schedule fee is $10.

In 2005, MBS items were introduced for pap smears taken by a practice nurse in regional, rural and remote areas. The schedule fee for these items is $10.20.

As these services are provided on behalf of, and under the supervision of, the GP, the GP retains responsibility for the health, safety and clinical outcomes of the patient. The practice nurse must be appropriately qualified and trained to provide these services. This includes compliance with any state or territory requirements.

However, to claim these items, the GP is not required to see the patient first, or be present with the practice nurse while the service is being provided. It is up to the GP to decide whether they initially need to see the patient. If so, the GP is eligible to claim a Medicare item for that consultation. The time the practice nurse spends with the patient is claimed separately under the practice nurse items.

Source: www.hic.gov.au.

To this end, Duckett suggested increasing the number of services which a medical practitioner can delegate to another health professional and still claim the appropriate MBS item.

Supporting an approach along these lines, James Cook University Faculty of Medicine argued that:

> The greatest expansion in the delivery of clinical care is likely come through the devolution of 'medical' tasks to other members of the health team under the local supervision and delegated authority of a Medical Practitioner. (sub. 106, p. 3)

It went on to say that it would have a range of attractions, namely:

> … clear clinical governance in diagnosis, investigation and technical management; greater likelihood of uptake and acceptance by the medical profession; less regulation, red-tape and external constraint on scope of practice; opportunities for participation by

> a broad range of health professionals … easier uptake by the private sector; Medical Practitioners able to focus on complex and technically difficult cases; and simpler indemnity arrangements. (sub. 106, p. 3)

And the New South Wales Rural Doctors Network saw delegation as 'the heart of any skills mix system', and argued that, where private practice and fee-for-service arrangements operate, the key issue is delegation in a manner which continues to attract a fee (sub. 110, p. 6).

Notably, the Australian Medical Association, which rejected extension of MBS rebates to substitute providers in their own right, supported delegation under the control of medical practitioners, noting that:

> … pressure to deliver health care in a timely, effective and safe manner in complex environments, requires new models of care to be investigated. … The key to safe practice in new models of care is that non medical health professionals work in an interdependent, co-operative and supervised relationship with medical practitioners. (sub. 119, pp. 4–5)

The structure and relativities of MBS rebates

The structure of the MBS and the relativities between Schedule fees can affect how services are provided, and in what institutional settings. They influence whether practitioners provide particular services personally or delegate to another health care practitioner (and hence whether the services are being provided in the most cost effective manner). They also influence the extent to which services are provided at a surgery or on a home visit, in business hours or after hours. The career choices of graduates are also affected. Consequently, these incentives can affect health care outcomes generally.

The Commission received many submissions arguing the inadequacy of particular MBS rebates. For example, the Brotherhood of St Laurence reported the views of GPs and GP organisations that:

> … current levels of MBS rebates discourage them from providing services to residents of aged care facilities … (sub. 45, p. 2)

But other participants also commented on the relativities between MBS rebates for different services. Several referred to the impact of current relativities on the 'value' placed on particular professions, and consequently on the career choices of graduates. Indeed, some called for increased rebates to increase the career attractiveness of particular medical areas, and thereby to help overcome workforce shortages in those areas. For example, the Royal Australian and New Zealand College of Psychiatrists argued that the MBS rebate for psychiatric consultations

should be increased to the levels recommended in the Relative Value Study, to increase the incentive for doctors to enter the speciality and reduce the cost to patients (sub. 79, p. 11).

Similarly, the Royal Australian College of General Practitioners argued that the relative value of GP rebates does not reflect the value that general practice brings to the health system, nor the relative cost of the real inputs for patient care. As a result:

> … the rebate system does little to encourage appropriate … use of the medical workforce. Addressing the problem of inappropriate relativities would assist by sending a signal to patients about the value of general practice, and may also have an impact on the attractiveness of general practice as a career choice … (sub. 143, p. 11)

However, such funding level issues are beyond the remit of this study.

The relative value of procedural items

Several participants advised the Commission that the structure of MBS fees gives an unduly greater weight to *procedures* over non-procedural services such as *consultations*, in part because of inertia in the MBS schedule in the face of changing technology and productivity gains.

Such differences can, for example, make certain clinical specialties more attractive as a career choice than others, as remuneration for procedural specialties has been said to be more generous than those for generalist specialties (box 8.4). In this way, the overall MBS fee structure can underpin large differences in income between different professional groups, thereby affecting the career incentives facing those entering medicine.

The Department of Health and Ageing agreed that the MBS structure acts as a disincentive in attracting medical graduates to some consultation-based specialties, because the relative weights given to the various procedures in consultations no longer appropriately reflect current clinical practices. It drew particular attention to geriatric medicine, rehabilitation medicine, psychiatry and renal medicine (sub. 159, pp. 34–35).

Limits on referral and prescribing rights

Under Medicare, access to most subsidised specialist services is subject to a referral from a GP. Similarly, pathology tests must generally be ordered by medical practitioners. Such referral restrictions aim to minimise the inefficient use of more specialised and high cost services, and to contain budgetary costs for government.

Box 8.4 **Relative value of procedural items**

The Royal Australasian College of Physicians said that the cognitive aspects of a physician's work are now considerably less valued than the procedural aspects because, notwithstanding advances in technology, the fee relativities originally established within the MBS have remained relatively unchanged:

> Throughputs of procedures are proportional to income generated given the open-ended nature of MBS funding … the time to undertake a procedural item of physician practice relative to that of cognitive consultative practice has decreased markedly without there being any recognition of this element in the fee for Medicare benefit quantum. (sub. 108, p. 5)

The Australasian College for Emergency Medicine argued that the MBS is heavily weighted in favour of procedural medicine:

> … with a not-surprising maldistribution of trainees and specialists to those specialties that have a number of profitable procedures as part of their practice, particularly some surgical subspecialties. … Both the [MBS] and most salary structures for medical practitioners and specialists provide insufficient incentive to encourage work outside of traditional business hours. (sub. 76, p. 7)

General Practice Education and Training (GPET) observed that lower remuneration for GPs relative to specialists is one reason for the difficulty of attracting graduates to general practice (sub. 129, p. 27).

The Royal Australasian College of Physicians said:

> Given that the MBS is a major driver for fees charged by and hence income of the College Fellows, it thus has had a major influence on the way the medical workforce has been distributed both between specialties and geographically. (sub. 108, p. 5)

The Victorian Government said that the present structure of MBS payments makes certain clinical specialties more attractive than others, as remuneration for procedural specialties is more generous than those for generalist specialties. In its view:

> The system of payments should be reviewed to ensure that remuneration does not discourage entry to the more generalist professions. (sub. 155, p. 34)

It gave as an example remuneration rates for paediatric orthopaedic practice, which it said are poorer than those for adult orthopaedic practice, notwithstanding that:

> … the time spent in private practice and the remuneration rate for surgical interventions is far greater for adult orthopaedics than for paediatric orthopaedics, which has a heavier consultative load. (sub. 155, p. 34)

The New South Wales Government argued that:

> Some areas of specialisation offer significantly higher financial rewards, through MBS reimbursements, which can lead to imbalances in supply. Such imbalances can become particularly acute when there is an overall shortage of qualified staff. (sub. 20, p. 6)

But referral restrictions have their own set of costs. In particular, a requirement to consult with a GP prior to visiting a specialist will entail time and usually monetary costs for patients — sometimes for little more than confirmation that a visit to the

specialist is required. And the capacity of the GP to service other patients is simultaneously reduced.

Commenting on these costs, the Australian Physiotherapy Association argued that the inability of physiotherapists to directly refer patients for diagnostic imaging results in 9500 hours of unnecessary GP consultations each year, at an annual cost to the taxpayer of $1 million, as well as additional time and monetary costs for patients (sub. 16, p. 18). It argued that there are efficiencies to be gained by granting physiotherapists the right to refer patients for MBS-supported consultations with specialists such as orthopaedic surgeons and obstetricians and gynaecologists.

Similarly, the Australasian College of Podiatric Surgeons referred to the lack of MBS rebates for the services of medical specialists in cases when a patient is referred by a podiatric surgeon (sub. 131. p. 7). The Victorian Government said that data collected by the Optometrists Association Victoria:

> … suggest that approximately one out of eight patients who required a script were referred to a medical practitioner in order to be eligible for PBS subsidies, and that any increased costs associated with making PBS available to suitably qualified optometrists would be offset by savings to Medicare. (sub. 155, p. 33)

It recommended a trial to provide limited access to MBS and PBS entitlements for non-medical practitioners in areas of designated GP shortage (sub. 155, p. 33).

The Victorian Government also cited Halcomb et al (2005), which suggested that the potential value of making MBS benefits available to non-medical providers would be compromised unless also accompanied by a (limited) extension of PBS prescribing rights (sub. 155, p. 33). Similarly, the Australasian College for Emergency Medicine argued that regulatory arrangements may make substitutions or new roles difficult, citing:

> … barriers within Medicare and the PBS that prevent staff other than medical practitioners ordering investigations, or prescribing medication. While there are good reasons for some of these restrictions, they do limit the ability to transfer roles to other staff members. (sub. 76, p. 4)

8.4 What can be done to address these issues?

There are aspects of the MBS that warrant wider examination if the health workforce is to be efficiently used and the objectives underlying Medicare are to be effectively met.

However, extending the scope and coverage of the MBS would have much wider implications and hence could not be justified on the basis of workforce

considerations alone. It would change the incentives facing providers of newly included services and, as the costs could be very significant, a careful analysis of the costs and benefits of change would need to be made, particularly in view of competing calls from within the health sector and elsewhere for public funding.

Moreover, it needs to be recognised that, while any change to the scope of the MBS might ameliorate some problems, it would create others — that is, the boundary that separates services that are subsidised from those that are not, and hence the area of inconsistency, would simply shift. As the Royal Australasian College of Physicians noted:

> … whenever MBS item numbers are introduced or revised, there is a risk of distorting relativities between health practitioners. A more recent example has emerged from the Co-ordinated Care Trials with the enhanced primary care (EPC) items in the MBS … The level of benefits has been struck … so as to almost obliterate the relativity between primary care and consultant practice. (sub. 108, p. 5)

Detailed issues concerning what services ought to be covered by the MBS, who should be able to refer patients to other health practitioners for MBS-supported services, and the appropriate relativities between MBS fees for procedural and consultative services are not matters for this study.

However, there are some institutional changes that could be made to progress these matters in a considered way. In particular, the Commission sees benefits in bringing greater transparency to the assessment of policy issues raised by participants during this study. And, as discussed below, it sees scope within the current MBS structure to encourage greater delegation of tasks in appropriate circumstances.

An ongoing evaluation mechanism

While the MBS is amended from time to time to reflect, for example, the availability of new medical technologies and procedures, changing medical practice and the implementation of new government policies, there is no formal independent mechanism by which arguments for inclusion of a wider range of services (such as those provided by allied health professionals) can be evaluated transparently against some form of public net benefit criteria.

There are two main ways by which changes to the MBS may be made (box 8.5). One is though addition of new medical items. The Medical Services Advisory Committee (MSAC) advises the Minister as to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures and whether new MBS items should be provided to support them (MSAC 2004, p. 2).

Changes to the MBS are also made through periodic reviews of professional services already listed on the MBS. This is undertaken by the Department of Health and Ageing in conjunction with the medical profession, through the Medicare Benefits Consultative Committee (MBCC). These arrangements:

> … ensure that the medical profession plays a key role in ensuring that the MBS reflects current and appropriate medical practice. (MSAC 2004, p. 2)

The MBCC may, for example, review current MBS items in terms of adequacy of descriptions, fees and the existing structure of the Schedule 'but not so as to involve a general review of the overall fees throughout the Schedule'.

Box 8.5 **Changes to the MBS**

There are two main procedural routes by which changes are made to the MBS:

- One route involves the Medical Services Advisory Committee (MSAC), which advises the Minister for Health and Ageing on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures (for example, a new technique in an existing surgical procedure). This advice informs government decisions on public funding for new and in some cases existing medical procedures. The Committee includes people with a mix of clinical expertise covering pathology, surgery, specialist medicine and general practice, plus clinical epidemiology and clinical trials, health economists, consumers, and health administrators and planners.
- The second route relates to reviews of existing items on the General Medical Services Table of the MBS. The Medicare Benefits Consultative Committee (MBCC) provides an informal forum for consultation between medical practitioners and the Minister/Department of Health and Ageing to review particular services, including consideration of new items (referred to MSAC for independent evaluation) and appropriate fee levels. It operates on a cost neutral basis, except for genuinely new items where consideration is given to additional funding.

Separate committees operate when items covering optometrical or certain dental services (such as those relating to cleft lip and palate conditions) are being reviewed, and there are separate consultative arrangements for the Diagnostic Imaging and Pathology Services tables.

If the Minister endorses a recommendation for public funding of a new medical procedure, an MBS listing and fee will be negotiated through the MBCC (or the Consultative Committee on Diagnostic Imaging or the Pathology Services Table Committee as appropriate). Following the introduction of new items or major amendments, it is usual for a review of the changes to be made after two years.

Sources: MSAC (2004); Department of Health and Ageing (sub. 34 to Productivity Commission study into Medical Technology, p. 8).

Importantly, the deliberations of the MSAC and the MBCC are broadly confined to new medical technologies or current MBS items — that is, they operate within the limits of the current, essentially medical services-based, scope of the MBS. Requests for broader changes to the MBS of a kind made during this study are not scrutinised by these arrangements. Where such changes are made, they generally flow from the development within government of new policies or programs, in consultation with key stakeholders, rather than through a standing assessment body process. Recent illustrations include new MBS items for practice nurses and for chronic disease management, and extensions to the Practice Incentives Program.

In the Commission's view, the lack of a formal and transparent process for assessing such requests against broad public interest criteria is an important deficiency in current arrangements. Lack of such a mechanism does little to promote consistency in decision making and may also make closure difficult in cases where requests to government to extend coverage are denied.

Evidence presented to the Commission by participants (section 8.2) suggest that there are instances where access to the MBS for some services by new providers may improve quality for patients, maintain safety, lead to a more efficient use of the mix of skills in the workforce, and increase job satisfaction. While extending the coverage of the MBS would involve some increased budgetary outlays, it could also lead to better health outcomes (and in some instances, some cost offsets could arise).

For such reasons, the Commission sees a need for a more transparent process to allow requests to extend the coverage of the MBS to be assessed within a benefit–cost framework. It sees merit in an approach broadly similar in concept to the model used to assess whether pharmaceutical benefits should be made available for certain drugs, whereby all proposals are assessed via the one review mechanism (essentially, the Pharmaceutical Benefits Advisory Committee — box 8.6). Such an approach was also advocated by the Australian Physiotherapy Association, with the caveat that funding should be limited to interventions for the management of specified conditions by specified practitioners where it can be shown that they are effective and cost effective (sub. 65, p. 11).

Specifically, the Commission proposes that a single, broadly-based and independent body replace, and have a broader role than, the committees that now advise the Australian Government on the coverage of the MBS (primarily, the MSAC and the MBCC). Its function should be to recommend on the coverage of the MBS (and also referral rights under MBS and prescribing rights under the PBS).

Box 8.6 **The Pharmaceutical Benefits Advisory Committee**

The PBAC makes recommendations to the Minister for Health and Ageing about whether pharmaceutical benefits should be made available for certain drugs and medicinal preparations. No new drug may be made available as a pharmaceutical benefit unless the Committee has recommended it.

It considers the effectiveness, cost-effectiveness and clinical place of a product compared with other products already listed in the PBS for the same, or similar, indications. Where there is no listed alternative, the Committee compares the product against standard medical care or the benefits for patients compared to the cost of achieving those benefits. The Committee may also recommend maximum quantities and repeats and restrictions on the circumstances where PBS subsidy is available.

When recommending listings, the Committee also provides advice to the Pharmaceutical Benefits Pricing Authority regarding comparison with alternatives or their cost-effectiveness.

Sources: DOHA (Role of the PBAC, www.health.gov.au).

Early tasks for this body could include proposals of a kind raised with the Commission during the present workforce study, such as investigations of:

- proposals from a wide range of health care professionals for new MBS items; and
- the scope to allow a wider range of health professionals to refer their patients for MBS-supported specialist and diagnostic services, and to be accorded prescribing rights under the PBS.

The independent body should be required to evaluate the benefits and costs of change. It should be required to make formal recommendations to the Minister for Health and Ageing, and to report publicly on the reasons for its recommendations.

DRAFT PROPOSAL 8.1

The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- ***the range of services (type and by provider) covered under the MBS;***
- ***referral arrangements for diagnostic and specialist services already subsidised under the MBS; and***

- ***prescribing rights under the PBS.***

It should report publicly on its recommendations to the Minister and the reasoning behind them.

Extension of delegation arrangements

As noted earlier, delegation of services is not well-supported by the MBS. To help ensure that current arrangements encourage the provision of health care services by the most appropriate health professional, the Commission see benefits in changing the MBS regime to facilitate greater delegation of less complex tasks to other, suitably qualified but more cost-effective, health workers.

It sees current arrangements whereby practice nurses carry out services on behalf of medical practitioners as a useful model that should be extended where it can improve the efficient and effective utilisation of the health workforce, provided it is consistent with patient safety and quality of care outcomes.

A mechanism to achieve this has been mapped out by Duckett, who suggested increasing the number of services which a medical practitioner can delegate to another health professional and still claim the appropriate MBS item.

> In this way, for example, an anaesthetist would be able to bill for the work of a nurse anaesthetist using the anaesthetic items of the Schedule. Assuming salary costs for the substitute professional are lower than the medical specialist, this would then put a financial incentive on medical practitioners to utilise other health professionals for service delivery. (2005b, p. 8)

In his view, this could be done by increasing the list of MBS items which do not require 'personal provision' by the medical practitioner (as applies, for example, with pathology tests in the current MBS) to cover all procedural items. He added that it might also be appropriate to allow some consultation items to be billed without personal provision, for example, if provided by a practice nurse. Importantly, however, the services would still be provided under the authority of the medical practitioner, who would bill Medicare.

The Commission sees benefits in such an approach. However, as cost savings may be made on the provision of individual services when they are delegated to staff with the most cost effective training and qualifications, there should be scope for government and the community to share in these savings. To achieve this, the rebate should be set at a lower level than would have applied if the delegating practitioner had provided the service. (This already happens for some of the limited range of delegated services for which MBS rebates are payable.)

But establishing what discount should apply would be difficult. If the MBS rebate for the delegated service was similar to that applying to the same service provided by the delegating practitioner, it would provide a strong financial incentive for that practitioner to delegate, freeing them up to provide other services that are more medically valuable. However, this would increase the volume of services, possibly significantly, and hence overall government funding requirements would also increase. That said, facilitating additional service provision in this way would be less expensive than increasing the number of GPs.

On the other hand, while setting a very low MBS rate for delegated services would lessen the fiscal impact, it would also reduce the incentive for the delegation of services. In this case, the benefits that many see arising from delegation would be much reduced.

A further difficulty is that the discount rate for services that are delegated would need to take account of the apparent bias in current MBS rebates towards procedural medicine. Any such bias may discourage delegation of better funded but straight-forward procedures if the alternative for the practitioner is to undertake consultations that are less financially rewarding (notwithstanding that this reallocation of tasks may make better use of available workforce skills).

The choice of a delegation discount rate involves balancing these competing concerns. But, ultimately, the 'appropriate' level of discount will depend on the extent to which the government is prepared to finance the provision of the additional services that would result from greater delegation. To achieve major task delegation without significant expenditure increases would most likely require more fundamental change to MBS rebate structures — a matter well beyond the remit of this study.

However, the Commission considers that the underlying relativities in the MBS do need examining, both in this context and more generally. While such matters were the subject of considerable analysis and debate during the Relative Value Study of the MBS, undertaken during the late 1990s and early 2000s, several participants said that little came of that process. Nevertheless, the issue is important, as acknowledged by the Department of Health and Ageing, which said that the relative weight or values given by the MBS to the various procedures in consultations do not always reflect current clinical practice. The Department said it is:

> ... reviewing the payment methodologies used under the MBS and is obtaining information from a range of sources, with a view to better aligning these with contemporary clinical practice. (sub. 159, p. 35)

New arrangements to facilitate delegation could be implemented in various ways. The AMA argued for a single MBS item number for all clinical tasks carried out by

general practice nurses under the direction of a GP (AMA 2005). Another approach would be to indicate which MBS services may be undertaken on a delegated basis. As noted, several participants argued for an increase in the number of MBS items that do not require 'personal provision' by a medical practitioner.

The Commission does not have a firm view on which of these or other possibilities would be preferred. However, in its view, it is important that such delegation be supported by a clear legal framework, operating through professional registration arrangements (as argued by Duckett 2005b, p. 8; the Victorian Government, sub. 155, p. 32; and James Cook University Faculty of Medicine, sub. 106, p. 3). In chapter 7, it has proposed that the AHMC take steps to provide a formal regulatory framework for task delegation in this way (draft proposal 7.3).

There would also be a need for measures to deter any fraudulent use of delegation arrangements. While the Commission received no information on this matter, it understands that this was a concern when delegation arrangements operated more widely at the time Medicare and its predecessor arrangements were set in place.

Finally, to the extent that this proposal is implemented so as to significantly increase the incentive for the delegation of services, the Commission reiterates that it would have significant budgetary implications. In view of this, the proposed change should be introduced progressively, and its effects reviewed after three years.

DRAFT PROPOSAL 8.2

For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- ***the service would be billed in the name of the delegating practitioner; and***
- ***rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.***

This change should be introduced progressively and its impacts reviewed after three years.

Streamlining expenditure control mechanisms

Given the extensive public subsidisation of health care costs, measures designed to limit governments' budgetary exposure will be an ongoing feature of the health workforce environment. There are many 'fiscal gatekeeping' restrictions, ranging from limits on university places and MBS provider numbers, through to GP

referrals to specialists and pharmaceutical dispensing rights. Examples of such measures in the primary medical care area are given in box 8.7.

Box 8.7 **Multiple expenditure control measures for health care**

Measures in place at least partly to contain the Australian Government's budgetary exposure on health care services include:

- limits on the number of training places at universities;
- restrictions on the number and type of providers eligible to claim public funding via the MBS and the PBS;
- restrictions on the range of subsidised medical and diagnostic services and drugs;
- dollar limits on rebates for subsidised items;
- the system of referrals to specialists;
- the authority given to Medical Colleges with respect to specialist numbers;
- limitation to regional areas of the provision of subsidised services by some Overseas Trained Doctors;
- monitoring by the HIC of servicing and prescribing patterns;
- restrictions (via location controls) on the number of pharmacies eligible to dispense subsidised PBS drugs; and
- limits on the scope for private health insurers to cover patients' residual out-of-pocket costs for publicly subsidised items.

Viewed in isolation, there may well be a sound rationale for each of these measures — recognising that, in several cases, these measures are also in place to pursue other goals. However, such expenditure control measures will often have adverse implications for efficiency and effectiveness, including in a workforce context. For example, as noted earlier, constraints on the coverage of the MBS, PBS and other subsidies can lead to inefficient substitution between health care providers. While government fiscal controls are warranted, not all controls seem well-aligned in terms of supporting a common set of objectives.

In the future, it will therefore be important to ensure that, as far as possible, expenditure control mechanisms are consistent with the objectives of health workforce policy, and that the instruments employed in the health care area are well coordinated with those used in education and training. The Commission's proposal to bring the finance and central policy coordination areas of government within the purview of the NHWSF is partly directed at this end.

9 Workforce planning— projecting future workforce needs

Key points

- Projections of the numbers of health workers required in the future, such as those currently provided by AMWAC/AHWAC, are planning tools.
- The role of such workforce projections should be to assist governments and other stakeholders in their considerations of the supply consequences — particularly in relation to education and training — of various health services demand scenarios.
- Governments and other relevant stakeholders should retain responsibility for integrating that advice into their broader health policy frameworks.
- Given their inherent imprecision, projection methodologies should:
  - be kept as simple as possible;
  - be based on a range of demand and supply scenarios;
  - concentrate on the major health workforce groups: ie undergraduate entry into medicine, nursing, dentistry and the larger allied professions, recognising that projections for smaller workforce groups may be required from time to time; and
  - be updated regularly, consistent with education and training planning cycles.
- Current institutional structures for this workforce planning should be rationalised, with the secretariat reporting to AHMAC.
  - This would result in some small administrative savings, and address residual concerns regarding inappropriate influence by particular stakeholder groups.

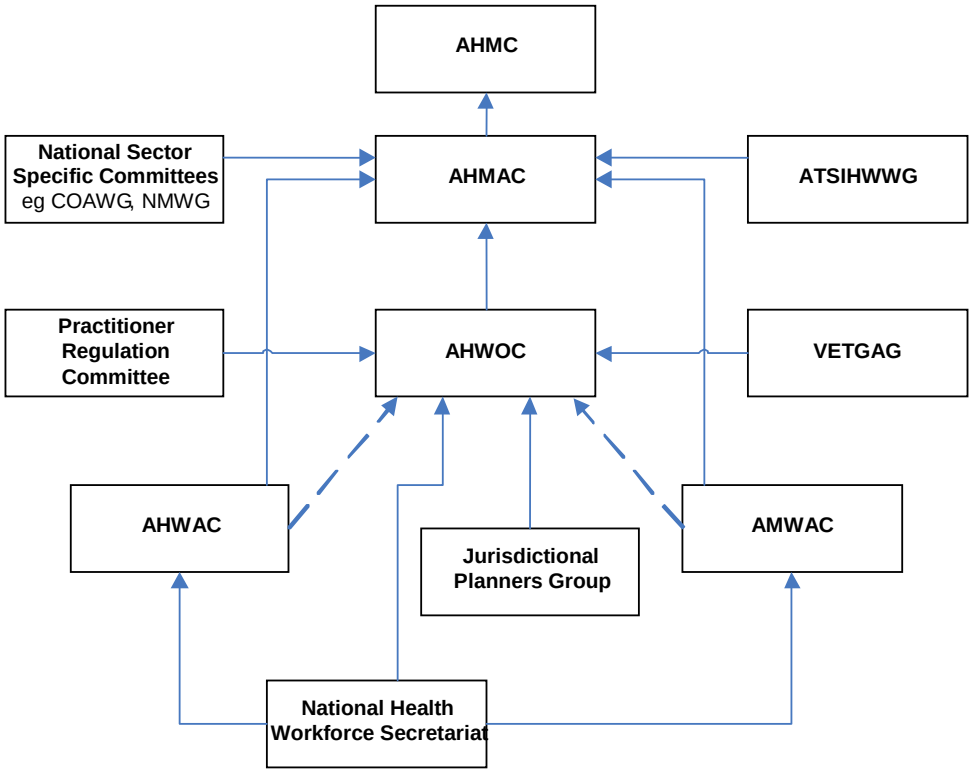
This chapter concerns the processes currently adopted by the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) in their consideration of the *numbers* of health workforce professionals of various descriptions likely to be required to sustain health services delivery into the future. Thus, throughout this chapter, the term 'workforce planning' has a narrower interpretation than elsewhere in the paper.

AMWAC was formed by the Australian Health Ministers' Advisory Council (AHMAC) in 1995, followed by AHWAC in 2000. They are both ultimately under the control of the Australian Health Ministers' Conference (AHMC) (figure 9.1). Under the existing framework, AMWAC is responsible for medical workforce planning and has undertaken planning reviews on general practice and most of the

medical specialties. AHWAC is responsible for non-medical workforce planning and has to date conducted planning reviews for specific nursing fields (for example, midwifery and critical care nursing). It has also foreshadowed, but not yet undertaken, planning projections for the allied health professions.

States and Territories also undertake some workforce planning activities, at the jurisdictional level — according to the Victorian Government, their scope and complexity vary significantly, as do the datasets and assumptions used (sub. 155, p. 38).

Figure 9.1 **National health workforce planning reporting structure**



Source: Victorian Government (sub. 155, p. 37).

9.1 The role of workforce planning

Governments intervene in the provision of health services for reasons of equity and market failure (chapter 1). They heavily subsidise service provision and, at the State and Territory level, are major employers of health workers. In doing so, they have a particular interest in ensuring that health services are neither under supplied nor over supplied — under supply would deny the community some of the health

services it requires, whereas over supply would waste expensive resources, not only in the direct provision of health services (including through any supplier induced demand), but also through the education and training system. Thus, governments have a clear need for health workforce planning.

For several reasons, planning exercises are far from trivial. There can be lags of 10 years or more in the supply of some health professionals after their first entry into education/training. This introduces considerable uncertainty into the projection process, as does making allowance for likely future workforce participation trends (box 9.1). It is in this context that AMWAC/AHWAC were established.

Box 9.1 **The inherent difficulties of workforce planning**

A range of factors present sizeable challenges for workforce planners, rendering projections of future workforce requirements an inherently imprecise activity.

A complex environment

Planners face a multitude of uncertainties in relation to factors influencing the demand for, and supply of, health workers. On the demand side these include the impact of:

- increased demand for health services, due to higher incomes and expectations;
- changes to the types of health services needed, for example, arising from technological change and population ageing; and
- policy changes that may alter 'prices' paid for health services by consumers or the uptake of private health insurance.

And, on the supply side, they include the impact of:

- broad economy-wide pressures that affect the general strength of the labour market, and thereby entries and exits to the health workforce and participation levels;
- structural pressures, like workforce ageing, lifestyle balance and increased feminisation, which are contributing to reductions in average hours worked; and
- enhancements to labour productivity (mainly through technological advancements and improved work practices) that affect future requirements for health workers.

Long lead times for education and training

The lead times required to train many types of health workers (and especially medical specialists) are lengthy. There is uncertainty regarding the level of workforce need that will exist at the completion of training programs, and the number of students that will satisfactorily complete the necessary training, year by year.

Data problems

There are often considerable 'gaps' in required data, terminology is inconsistent and available information is frequently dated.

Participants put forward a number of differing views about the appropriate role for AMWAC/AHWAC's work — in particular, some expressed disappointment that its advice was not 'automatically' put into effect. For example, the Committee of Deans of Australian Medical Schools (CDAMS) stated that:

> [An] urgent priority is the creation of a coordinating mechanism to implement the specific recommendations of AMWAC as they become available from each of the detailed studies on individual components of the medical workforce. CDAMS therefore strongly supports the continued funding of AMWAC but also recommends the creation of mechanisms to ensure that its recommendations are effectively implemented. (sub. 49, p. 9)

A disconnect between the conduct of planning and the implementation of advice by government was also raised during the 2002 review of AMWAC (AHMAC 2002).

Many participants argued that greater engagement of the Commonwealth Department of Education, Science and Training (DEST) in the planning process would be helpful in improving the translation of workforce needs to education and training places. While DEST is currently a member of the Australian Health Workforce Officials Committee (AHWOC), its involvement is commonly viewed as nominal only. AHMAC noted:

> Engagement of DEST on health workforce issues through State and Territory Education and Training agencies has had limited success … (sub. 10, p. 7)

However, in the Commission's view, the role of those bodies undertaking technical projections of future workforce needs is to provide advice to governments on the numerical workforce requirements for meeting particular levels and structures of health services demand. That advice should centre around the numbers of students required, over time, at various points along the undergraduate education, clinical training and vocational and higher training pathway.

Responsibility for decisions that draw on that advice must necessarily remain with governments, their appropriate agencies (such as their health and education departments) and high level coordinating bodies such as the AHMC. Responsibility for decisions on such matters as health and education expenditure levels, the acceptable degree of reliance on overseas trained professionals, the number of education and training places for the various professions, and health workforce distribution across Australia cannot be readily ceded to technical bodies.

9.2 Methodological issues

Projections of health workforce numbers, and the associated implications for education and training, can be made at varying degrees of sophistication. The broad

methodology currently used is briefly described in box 9.2.

Box 9.2 **AMWAC/AHWAC approach to workforce planning projections**

National health workforce planning agencies, AMWAC and AHWAC, adopt similar methodologies to estimate the workforce numbers required to meet future health care needs. The broad stages of the approach are outlined below, with predictive elements typically calculated using a spreadsheet based model (usually over a 10 year period). Notably, the approach requires some fundamental judgments (which usually input directly as parameters into the calculation model) about demand and supply for particular health professions. Perhaps the most critical of these involves determining an appropriate 'baseline' level of service *need* (as distinguished from the demand by consumers for subsidised health services) on which to base workforce projections.

Requirement analysis Future workforce needs are projected by applying a growth factor to the baseline level of need. This growth factor reflects expected changes over the projection period in a range of parameters, including: demographic changes (eg population growth and ageing); technological advancements; and disease trends.

Supply analysis Future supply is generally projected using a 'stocks and flows' method, based on five year age and gender cohorts. Current (baseline) supply is estimated and then projected over future years by adding in new entrants to the workforce, subtracting losses, and accounting for the impact of changes in the age and gender balance of the workforce, and in hours worked.

Gap analysis Following projections of the two key analytical elements — workforce needs and supply — an analysis of the remaining 'gap' is undertaken, with options proposed to remedy any imbalance. These most often focus on adjustments to education and training intakes, but also sometimes note that overseas trained health workers might be needed to completely fill a gap.

Sensitivity and scenario analyses Some sensitivity analyses of projections is often conducted through modifying key modelling assumptions — such as disease incidence and workforce participation trends. More recently, a wider array of key workforce need and supply assumptions have been varied to generate a series of scenarios. Such scenario analyses can highlight the range of variability and uncertainty within the judgments and assumptions adopted.

Sources: AHWAC (2004a); AMWAC (2003).

Since its inception, workforce planning has been subject to various refinements (box 9.3). Some concerns, however, still remain — including, for instance, that broader factors that influence supply and demand have yet to be sufficiently accommodated. Participants' views about methodology are given in box 9.4. Of course, possible methodological changes and 'advances' need to be considered in a cost–benefit framework — with some more 'sophisticated' proposals possibly

involving considerable additional effort for only marginal gains in 'accuracy' or usefulness.

Box 9.3 **Some improvements to health workforce planning methods**

Since the adoption of formalised planning in 1995, there have been significant refinements in method, within the context of the broad approach outlined in box 9.2.

Some of these refinements were made in response to criticisms of particular planning exercises. For example, AMWAC's 2000 review of the general practice workforce was criticised on the basis that it adopted rather rudimentary assumptions concerning the utilisation of GP services; did not sufficiently account for price and income information as a supply indicator; relied too heavily on MBS data that failed to account for many of the activities undertaken by GPs; and consulted inadequately with the profession.

Many of these concerns were also echoed in the 2002 external review of AMWAC. While that review provided broad support for AMWAC's role, structure and methodology, it also identified some specific areas where planning methods could be improved. For instance, it recommended that:

- there be more transparent use of indicators or benchmarks to gauge the adequacy of the workforce, so as to avoid any ambiguous interpretation; and
- more dynamic scenario modelling and sensitivity analysis be undertaken to frame projections that would, for instance, take into account both likely and desirable changes to health services delivery (AHMAC 2002).

Most of these concerns have now been addressed, with almost all methodological recommendations made in the 2002 AMWAC review having been adopted.

Other changes have been driven from within the planning bodies. In particular, there has been a transition from using a single 'off the shelf' approach to more tailored planning assessments. This recognises that the considerable variations across the health workforce (eg the size of the different professions) mean that a methodology that may be effective for one area of the workforce may not necessarily be the most appropriate for others.

The extent of the changes made since the inception of formalised planning are evident in AMWAC's most recent review of the general practice workforce. The review departed from a benchmarked approach to demand and adopted a disaggregated 'bottoms up' method to measure service utilisation and project demand. Extensive consultations were also undertaken with stakeholders, including on methodology issues.

Factoring in demand

Assumptions made about the future health care requirements of the community are of central importance to the usefulness of workforce number projections, as are the

assumptions concerning the models of care and service delivery, levels of subsidy and the like.

In terms of the associated demand for the health workforce, two broad approaches can be taken:

- A single 'best guess', or benchmark, approach can be used. In the past, such benchmarks have often been developed from the advice of committees or working parties, drawing on input from a range of stakeholders and technical experts.
- A number of differing demand scenarios can be modelled — indeed, scenario planning is a specific inclusion in AMWAC's terms of reference.

The first approach runs a number of risks including a possible lack of realism, and greater risk of undue influence from particular stakeholder groups. Further, as illustrated by Australia's experience with health workforce benchmarks, point estimates are difficult to get 'right' (box 9.5).

The second approach has the advantage that it can be used to illustrate the workforce consequences — in particular, for education and training — of different policy responses to the community's fundamental health needs and burdens of disease, nationally and on a regional basis, in an environment where demand is so heavily dependent on the level of government support. In this way, it would help meet AHMAC's concern that 'health workforce planning and health service planning are better linked' (sub. 166, p. 12).

Workforce participation and productivity trends

On the supply side, information about likely future workforce participation trends is of prime importance. Of course, this will depend on a whole range of somewhat unpredictable factors, including fee structures and remuneration relativities across professions. Nevertheless, an adequate foundation of data about current trends is an essential starting point (see section 9.3).

Another central supply side influence is the productivity of the workforce. In its submission, the AMA recommended a study into its impact:

> … organisations with expertise in workforce modelling in Australia and overseas [should] be canvassed to determine if there are available methods to predict the impact of productivity improvements in workforce modelling in Australia. (sub. 119, p. 12)

Box 9.4 **Participants' views about methodology**

Participants provided a range of comments regarding planning projection methodologies. In relation to factoring in demand for health services, the Committee of Deans of Australian Medical Schools (CDAMS) stated:

> There is currently no agreed statement of overall medical workforce needs which could serve as the basis for future planning. Provision of such a statement by AMWAC should be an urgent priority. (sub. 49, p. 9)

The Australian Divisions of General Practice (ADGP) emphasised the importance of recognising more localised factors influencing demand:

> ADGP suggests that Australia's health workforce planning, certainly in respect of general practice, has been inadequate. In particular there is poor articulation between the AMWAC 'top down' national approach and the particular circumstances and needs of different regions.
>
> There is wide diversity of need across different regions of Australia driven by factors such as the geography of the area, the age structure of the population, other demographic factors and the pattern of morbidity.
>
> … it would be unfortunate if the focus remains on 'getting the workforce numbers right'. ADGP suggests that it may be fallacious to think in terms of 'solving' workforce issues by just responding to abstract estimates of demand and that what is needed are established processes and structures that facilitate on-going management. (sub. 135, p. 24)

Similarly, the Medical Training and Education Council of NSW said:

> While AMWAC was established ten years ago to advise government on the future medical workforce requirements at a national and state level, there has never been an agreed method or best practice model for linking national requirements with local medical workforce planning activities. The latter tends to be historically based and driven by hospitals' reliance on specialist trainees for delivery of 'front-line' acute medical care rather than the community's requirement for trained specialists. (sub. 154, p. 1)

The Royal Australasian College of Physicians raised a number of concerns:

> Current modelling tools used to guide decision making to address future workforce needs tend to be deterministic and static — with little or no capacity to anticipate changes in key determinants. 'Ideal' workforce numbers are typically based on historical doctor to population ratios or utilisation rates with little consideration given to examining the relationship between:
>
> 1) models of care and service delivery;
> 2) type, skill-mix, number and distribution of health professionals required to staff such service delivery models; and
> 3) health outcomes expected from service implementation (health production).
>
> AMWAC, for example, uses a simple 'stock and flow' model to generate predictions on future workforce imbalances within the specialist medical workforce. The utility of its current recommendations rests ultimately on simplistic assumptions that workforce needs can be modelled by matching the projected population health needs of Australia with current service utilisation rates. (sub. 108, p. 25)

(Continued next page)

Box 9.4 (continued)

The Australian Medical Association raised issues about both the demand and supply sides of the projections:

> The AMWAC methodology has been particularly weak on the demand side and used crude doctor visits per population ratios (themselves affected by shortages) to calculate medical workforce requirements. AMWAC recently sought to improve its demand side capability in its most recent GP workforce modelling and to us, this is a welcome development.
>
> Although their supply side modelling was better, it did not take the vital issue of remuneration into account. It is not always possible to do econometric modelling of the medical workforce as some specialist groups are small and clustered around hospitals and other institutions and require large minimum populations for their existence. But it is possible in relation to General Practice in our view. That said, workforce modelling is still relatively crude and underdeveloped, with much room for improvement. (sub. 119, p. 6)

It also commented on the relevance of allowing for productivity change:

> Without implying any criticism of AMWAC, their methodology is not good at factoring in the impact on workforce projections from productivity increases from various sources including technological change. (sub. 119, p. 12)

In the usual course of events, improvements in productivity would reduce workforce requirements. However, there is some evidence that productivity improvements in health services provision are typically captured as quality enhancements, rather than as cost reductions.

More generally, the Commission reiterates that the benefits arising from greater modelling sophistication need to be set against the costs of making those improvements. Further, the routine use of demand scenarios should lessen pressure for enhanced supply side precision. (See further discussion in section 9.3 below.)

Coverage issues

Some participants argued that planning projections should be undertaken across the whole of the health workforce, including the allied health professions, rather than just for the medical and nursing fields as presently occurs. Other participants criticised what they perceived as a profession-centric approach to this workforce planning (box 9.6).

The Commission has assessed these views against what it considers should be the main purpose of workforce numbers projections — that is, to advise governments of the education and training implications, over time, of meeting various possible future levels of health services demand. More precisely, the projections should help

governments plan (after factoring in the portion of demand to be met by overseas trained professionals) the required numbers of:

- undergraduate students who should enter universities and VET institutions, over time;
- students/graduates who should enter the various forms of clinical training; and
- students/graduates who should enter the various forms of vocational and higher training.

Box 9.5 **Benchmarking problems**

- AHMAC set a benchmark of 200 practitioners per 100 000 population in 1992. AMWAC 1996a (p. xxi) commented that this lacked 'an empirical foundation' — in particular, it was unclear whether this was to represent all practitioners or FTEs.
- In 1996, the AIHW established benchmarks per 100 000 population for 1994 of 222.0 FTE practitioners or 205.1 FTE practising clinicians (AIHW 1996). These were lower than the number of practising clinicians of 229.0 per 100 000, suggesting practitioners were oversupplied at that time.
- The 1996 methodology was jointly reviewed in 1998 by AMWAC/AIHW. The review concluded that the benchmarking methodology was 'fundamentally sound' (AMWAC 1998, p. xiii). However, the setting of new benchmarks was deferred pending an AMWAC review of the GP workforce.
- AMWAC, in 2000, found that on the basis that 'the situation in large rural centres, as a whole, was acceptable as a benchmark for use in metropolitan and other rural/remote comparisons' (p. 1) the GP workforce in total was oversupplied in 1998 (AMWAC 2000).
- Access Economics, commissioned by the AMA, published its estimates of GP demand and supply in early 2002, based on econometric analysis of demand (Access Economics 2002). It considered that there was an overall shortage of GPs in Australia, as well as maldistribution.
- A review of AMWAC in 2002 called for increased transparency about the benchmarking system (AHMAC 2002, p. 39). It noted that 'there is generally no correct ratio [of practitioners to population], but rather the most suitable ratio has to be derived on the basis of available information'.
- No further aggregate benchmarks have been published since 1996, although a series of studies into particular medical workforce areas have been undertaken.

These estimates might be provided at a number of levels, for example, on a national, state and regional basis.

In the Commission's view this, in turn, suggests that focus should be accorded to those groups of professions which have the greatest impact at the education and

training level, namely, medical practice in the broad, nursing, dentistry and some of the larger allied professions. Further, because of their importance, those numerical projections might justify frequent updating, in accordance with education and training planning cycles.

Some of the smaller professions (including some of the medical specialties and the smaller allied health professions) could be handled less frequently without major modelling exercises — either to feed into the estimates of undergraduate entry, or to plan for their particular clinical and advanced training requirements.

Box 9.6 **Participants' views on scope of modelling**

Many participants considered planning projections should extend into the allied health fields. For instance, Services for Australian Rural and Remote Allied Health (SARRAH) stated:

> … planning processes need to be improved — across whole of workforce and crossing the Federal/State divide. In order for future workforce planning to meet the needs of the community and to enable a responsive adaptation to changing needs … There has been minimal planning for future allied health needs. (sub. 71, p. 12)

Others stressed the limitations of the current profession-based approach. In this respect, the Australian Healthcare Association stated:

> Fragmentation of health system planning impedes … planning. It 'locks in' established structures and impedes innovation. Any workforce planning that does occur reflects the historical 'silo' approach to service provision based on a structure characterised by professional monopolies (dominated by the medical profession), with strong protocols delineating work boundaries between professionals. (sub. 151, p. 6)

Further, General Practice Eduction and Training (GPET) said:

> … health workforce planning in Australia analyses and makes recommendations about individual specialties. There has been little attempt to develop processes that look at the needs of all professions required to deliver specific health services.
>
> For example, there has been little consideration in Australia of the relationship, from a medical workforce perspective, between requirements for general practitioners and requirements for specialists. AMWAC considers each specialty, including general practice, quite separately. While the case could be overstated, there are significant interdependencies. (sub. 129, p. 26)

The need for a broader perspective was also argued by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG):

> The College has found that AMWAC have had a very limited role in assisting and advising in workforce planning. Workforce information has been fragmented rather than acknowledging the interdependence of the various specialties and health workforce; AMWAC needs to be able to take a broader view of the health workforce … (sub. 112, p. 2)

(Continued next page)

Box 9.6 (continued)

Similarly, the Royal Australasian College of Physicians remarked:

> Most planning currently takes place within narrow professional silos, with little modelling of future needs as to the right balance of professions and skill-mix within service delivery models that have been shown to improve health outcomes. AMWAC, for example, is concerned solely with the medical workforce, which is kept separate from any other planning of the broader health workforce; and indeed, no planning of the health administration workforce occurs at all. (sub. 108, p. 26)

The Committee of Deans of Australian Medical Schools (CDAMS) also emphasised a service-based approach was required:

> … there is a need to consider planning based on service needs rather than as silos of discipline-based planning efforts conducted in isolation. Flexibility in patterns of service delivery can be factored into future care delivery and planning and therefore should incorporate the opportunity for some role substitution around the edges of traditional job demarcations. (sub. 49, p. 10)

9.3 Data and research issues

A sound information base is as important for workforce numbers projections as it is for effective reform and good policy formulation more generally. In this regard, the Australian Institute of Health and Welfare pointed to some considerable deficiencies in available health workforce data (box 9.7). Similar concerns were echoed by many other participants, particularly in regard to the allied health area. And AHMAC listed data limitations as follows:

- lack of comprehensive coverage of the full range of professions and support workers in the health system;
- the need for existing data sets eg human resources, education and training, to take better account of health workforce needs;
- variations of data items and definitions, and response rates between jurisdictions;
- timeliness of processing and supplying information;
- difficulties in drilling down into the data to get useful detail;
- lack of information on specialised areas such as oncology or aged care; and
- a need for an ongoing research program to inform how people make decisions on careers and locations of work and other factors affecting workforce supply. (sub. 166, p. 11)

Box 9.7 **Australia's health workforce data**

The AIHW considered that a comprehensive information base regarding Australia's health workforce would include measures such as:

- the demographic characteristics of the health workers, such as age, sex and birthplace;
- qualifications, such as type, where obtained, when obtained etc;
- workforce characteristics, such as labour force status, job tenure, specialty area, classification level, hours worked, hours spent in patient care, industry and sector of employment, earnings etc; and
- geographic location.

It added that, for analyses of changes in the health workforce, it is desirable to have measures such as:

- entrants to the workforce (contemporary and projected) — student completions of health courses in higher education and VET institutions — migration data for health workers into and out of Australia (short- and long-term visitors; permanent and temporary migration); and
- exits from the workforce (contemporary and projected) — retirement, death, career change — temporary leave for travel, family responsibilities, training, sabbatical, and so on.

And for analyses of the supply of and demand for services provided by health workers, it is desirable to have measures such as:

- demography, including geographical distribution of the subpopulations who need various health services;
- health needs, dissected by subpopulation and geographical area; and
- the characteristics of service delivery entities, both public and private.

In AIHW's view, currently available data sources provide information on many of these features. But it saw the information base as far from ideal because:

- it must be patched together from a variety of sources, which are not based on consistent concepts — so judgment or synthetic methods must be invoked to construct the data needed for policy design and evaluation;
- some key segments of the workforce are unmeasured or poorly measured or suffer from significant problems of data quality; and
- some data that are important for policy design and evaluation are available only with a long time lag.

Source: AIHW (sub. 58, p. 4).

AHMAC also considered that improvements are needed in the information required to support productivity analysis within the sector and comparisons between the

health sector and other sectors of the economy. And in arguing that 'improved data collection for the health workforce is a priority', the Department of Health and Ageing noted particular problems with health workforce data for the community based aged care sector (sub. 159, pp. 54–5).

However, information collection and compilation is not costless. Hence, though there are significant gaps in the health workforce data base, it is far from certain that some of the proposals for additional data collection put to this study would pass a benefit–cost test.

Clearly, it would not be possible in this study to undertake analysis to determine which particular date enhancements would deliver a net benefit. But the Commission considers that, subject to benefit–cost assessment, strategies to give effect to the commitment in the *Strategic Framework* that 'health workforce policy and planning must be informed by the best available information' are important. Among the strategies identified in the framework to achieve this are: encouragement, support and leadership for health workforce research; the continued development of information sharing; and ongoing improvement in health workforce data collections through 'putting in place common language, minimum data sets; and consistent collection and processing arrangements.'

Indeed, AHMAC noted that, over the last five to ten years, there has been an improvement in the 'collection of nationally consistent data and an increased understanding by all stakeholders of the need for quality and timely data' (sub. 166, p. 11). It commented that it is currently undertaking work on a 'minimum health workforce data set and common terminology' (sub. 166, p. 11).

The Commission supports such current initiatives to improve data collection and commends ongoing assessment of the benefits of improving data availability still further. In the particular context of workforce planning, the Commission suggests that AHMAC, in conjunction with the AIHW, could sponsor development of formal data exchange protocols between jurisdictions, registration bodies and relevant agencies. Such protocols would be designed to build on existing linkages between these bodies and could help to overcome current difficulties in accessing data and other relevant information, as well as facilitating cost efficient improvements in the data base.

However, these initiatives, while useful, will not necessarily enhance the *quality* of the information available for decision making and productivity analysis. For this to occur, such information needs to be collected and organised in an appropriately rigorous conceptual framework. The Commission has been undertaking its own analysis of the availability and quality of data that would enhance research into health workforce productivity. It has been informed during this process through

consultation with the AIHW and the ABS. The Commission's final report in December will comment more definitely on this issue.

9.4 Institutional arrangements

Rationalise the workforce planning structure

As outlined above, a relatively substantial institutional framework has been established to undertake formalised health workforce planning — comprising various planning bodies, AMWAC and AHWAC, as well as a secretariat and supporting committees and working parties. Total expenditure for AMWAC and AHWAC and the supporting secretariat in 2003-04 was approximately $1.6 million.

The Victorian Government proposed a rationalisation of this current structure, effectively combining the role of AMWAC, AHWAC, the Jurisdictional Planners Group and national sector specific committees into the one 'National Health Workforce Planning Council'. It considered that membership of the council 'would include experts in health economics and workforce planning and representatives from DOHA, DEST and jurisdictional health departments', with subcommittees comprising 'relevant health professionals and key stakeholders' in pursuing its work program (sub. 155, pp. 38–9). The suggested functions would appear to centre on workforce numbers projections and associated methodological and data issues, although there could be some overlap with the functions for the Commission's proposed health workforce improvement agency (chapter 4).

Particularly given its views about the role of workforce planning expressed above — that is, as a tool to aid government decision making — the Commission agrees that rationalisation of existing arrangements is called for. However, it questions whether establishment of a new high level council as proposed by the Victorian Government is necessary. In its view, it would be preferable for the workforce secretariat simply to report to AHMAC.

Such a rationalisation would also largely address any residual concerns regarding inappropriate influence on the projection process by particular stakeholder groups. In this respect, a report prepared for the ACCC on AMWAC's planning process recommended that practising medical practitioners should not comprise more than one third of the members of any review working party (Borland 2001).

The 2002 external review of AMWAC concluded that concerns about domination of the planning process by professional groups were largely unfounded. That said, the review did recommend the addition of new non-practitioner members to planning working groups (for example, from jurisdictions and consumer groups) that would

effectively reduce the influence of professional interests (AHMAC 2002, recommendation 3.3).

Moreover, while this recommendation has been implemented by AMWAC, jurisdictions have at times appointed clinicians as their representatives on reviews. Such appointments may be a factor in continuing concerns of excessive professional influence in the health workforce planning process. For instance, the Victorian Government stated:

> Membership of many [planning] committees comprise a majority of professional members, often solely from the profession under analysis, which can reinforce existing professional norms, militate against cross disciplinary comparisons and prevent exploration of more innovative workforce models. (sub. 155, p. 38)

Finally, while AMWAC and AHWAC would cease to exist under the Commission's proposal, the secretariat would obviously need to continue to consult with stakeholders (including professional associations) to draw on their knowledge and expertise as required, and establish working parties to assist with particular exercises.

Transparency and other issues

A number of transparency issues were canvassed by participants. For example, the Australian Association of Occupational Therapists commented:

> Despite their achievements to date on national coordination of workforce issues, current arrangements such as … AHWAC and … AMWAC lack independence and transparency. (sub. 21, p. 3)

In this context, some participants particularly raised the lack of connection between the output of modelling exercises and the implementation of that advice by government. However, as noted above, governments should be free to consider such advice within their broader health policy frameworks.

But there are a number of changes which, in the Commission's view, would improve the transparency and usefulness of the projection process:

- The proposal (as detailed in chapter 3) for wider endorsement of the National Health Workforce Strategic Framework (NHWSF), including by those areas of government responsible for eduction and training, could be helpful in better improving the linkages between health planning and education planning — the ultimate goal of these numerical projections.

- A requirement for those responsible for undertaking numerical planning projections to conduct analysis against both alternative demand and supply scenarios could be made more explicit and given greater emphasis.
- And as noted above, there is a role for AHMAC in facilitating access to, and improvements in, data.

Finally, there may be some merit in providing funding for the planning entity on a three or five-year basis rather than the current annual funding arrangement. This would give the entity greater surety and provide it with more scope to undertake longer duration planning-related tasks.

DRAFT PROPOSAL 9.1

Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

DRAFT PROPOSAL 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- ***be based on a range of relevant demand and supply scenarios;***
- ***concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and***
- ***be updated regularly, consistent with education and training planning cycles.***

10 Rural and remote issues

Key points

- Health service providers in rural and remote areas face particular challenges.
  - For patients, access to primary and emergency care services can be difficult and impact on health outcomes. And access to more specialised services, only available in major population centres, involves even longer travel times and greater costs.
  - For health workers, there are concerns regarding remuneration opportunities, professional demands and, more generally, lifestyles and isolation.
  - However, the health workforce outlook in rural and remote Australia is far from universally negative.
- While there are limits on the degree of improvement possible, rural and remote areas will benefit from general health workforce reforms, especially if these reforms make explicit provision for rural and remote issues.
  - For instance, the proposed health workforce improvement agency should consider the rural and remote impacts of generally applicable changes to job design, as well as job redesign opportunities specific to these areas.
- Many of the specific initiatives (mooted or already in train) to improve health workforce services in rural and remote areas may provide a way forward:
  - further widening scopes of practice and greater use of innovative technologies to make the best use of the available workforce;
  - changes to funding structures, such as rural loadings or block funding for a package of care services; and
  - a strong focus on regionally-based education and training — which may be particularly beneficial over the longer term.
- However, lack of rigorous program evaluation means that there is still considerable uncertainty about which broad approaches deliver the best value for money.
  - The Australian Health Ministers' Conference should initiate 'cross-program' evaluations to ascertain which approaches, or mixes of approaches, are likely to be most cost-effective in improving access to, and the quality and sustainability of, health workforce services in rural and remote Australia.

A major theme in submissions to this study has been that access to health services in rural and remote Australia is inferior to that available in the major population centres, and that problems are worsening. In a health workforce context, the major concerns relate to the relative lack of general practitioners, medical specialists and

some allied health workers. However, a variety of more specific concerns about skills mix, scopes of practice and recruitment and retention have also been raised.

This chapter explores these concerns and looks at some possible broad approaches for reducing the gap in overall health workforce outcomes between metropolitan and rural and remote Australia. It also looks at some ways in which the processes for formulating policies and programs for health workforce services in rural and remote areas might be improved.

10.1 The rural and remote health workforce

The provision of care in rural and remote Australia

Particular access concerns for rural and remote Australia

There are several access issues which confront rural and remote patients to an extent that usually exceeds those in metropolitan areas.

First, a characteristic of some health services is that a delay in the time taken to access them can critically affect the ultimate health outcome. Given the distances involved, the time taken to access care is a particular issue for those in rural and remote Australia.

Second, in addition to the time factor, significant travel to health services can have sizeable financial costs, both directly in the form of travel and accommodation costs, and indirectly, in terms of lost income and potential interruptions to individuals' careers, education and general quality of life. Requirements to travel long distances may also have intangible costs in the form of disruption to family (and social) life, placing a burden on other family members.

Finally, a high frequency of care — for example several times a week — may make it unreasonable for the patient to travel for each individual treatment. As such, patients can end up temporarily relocating, with all the costs and disruptions to work and family life that this entails. With the rise of chronic conditions in the overall disease burden of an ageing Australia, the numbers of patients in rural and remote areas facing such costs and disruption will increase in the future.

The hierarchy of care impacts on the location of services …

Access concerns play a central role in determining the hierarchy of care in rural and remote Australia, as the Department of Health and Ageing noted:

> Most rural people expect to travel some distance for specialist and major hospital services. However, reasonable regional access to primary care, such as general practice and dentistry, and emergency treatment, is very important in ensuring adequate rural health profiles. (sub. 159, p. 13)

In the majority of cases, the general practitioner, or the accident and emergency department of the local hospital, will be a rural or remote patient's first point of contact with the health profession. Public hospitals in rural towns represent the next tier in this 'pyramid'. These hospitals are designed to be able to provide a broader range of care, including acute and surgical services, to a wide area, often beyond the community in which they are located, drawing on visiting medical officers and other health care and support staff.

Many rural communities do not have the 'critical mass' necessary to support resident specialists, not only in terms of population, but also in meeting related infrastructure requirements:

> There are good and cogent reasons why many specialists are located in larger regional centres and major cities. Access to support, infrastructure, caseload and training opportunities are all important factors. (AMA, sub. 119, p. 15)

> … surgical services require much more than just the presence of a surgeon. The infrastructure requirements are an insurmountable barrier to providing services to all but the largest remote centres such as Mt Isa and Broken Hill … some services, which because of their technical nature require a modern tertiary hospital (e.g. neurosurgery, cardiothoracic surgery) or need high population levels for adequate demand (e.g. paediatric surgery), will be difficult to establish in even regional settings. (Royal Australasian College of Surgeons, sub. 83, pp. 10–11)

As such, specialist services — particularly those relating to elective procedures — are usually located only in larger regional or metropolitan centres, and provided on an 'outreach' basis to those in outlying communities.

… and institutional arrangements are tailored to local needs

In addition to the broader structures applicable to the health workforce as a whole, several arrangements apply more specifically or, indeed, solely, to the rural and remote health workforce. These arrangements have been put in place by the Australian and State and Territory Governments, as well as by private organisations such as specialist colleges.

Australian Government

The Australian Government plays a large part in the provision of health services in rural and remote areas through its role in funding general practitioners. In addition to general funding through the MBS, it provides a range of financial incentives, such as rural retention payments, incentives delivered through the Practice Incentives Program, as well as bulk-billing incentives for rural and remote practices. Beyond general practitioners, the Australian Government also funds the provision of other health services through, for example, the More Allied Health Services (MAHS) Program.

Additionally, the Australian Government affects the number and distribution of overseas trained doctors not only through immigration policies, but also by restricting access to the MBS to those practising in districts of workforce shortage. This is aimed at attracting these doctors to rural and remote areas:

> … in remote areas of Australia, overseas trained doctors with restricted Medicare provider number approvals now account for more than 30% of the general practice workforce. On 30 June 2005, there were a total of 2557 overseas trained doctors Australia-wide with restricted access to Medicare approvals, allowing them to work in areas of workforce shortage. … and 1713 (66%) of these had approvals to work in rural and remote areas. (DOHA, sub. 159, p. 37)

The Australian Government also plays a significant role in the education and training of health practitioners for rural and remote Australia, particularly through the university system. It provides programs to increase education and training opportunities for students with rural backgrounds, as well as encouraging the location of more education in rural areas (see below).

State and Territory Governments

As in the broader health workforce, State and Territory Governments have a significant role in the rural and remote health workforce. Of particular note is their responsibility for public hospitals. These hospitals play an important role in providing emergency treatment, acute care, after hours care and access to visiting medical officers. They are also centres for the performance of more complex procedures, often servicing wide regions beyond their immediate community. Additionally, the presence of a nearby hospital may ease isolation concerns for GPs in rural towns, as it provides medical infrastructure and important ‘back up’ for primary care services.

State and Territory Governments fund a variety of incentive and training programs for rural and remote health professionals, including professional development programs for a range of health practitioners, scholarships and training. The

jurisdictions also work in collaboration with non-government entities and the Australian Government. One example is the work of Rural Workforce Agencies, which exist:

> … in each State and the Northern Territory (NT) to recruit and retain doctors for rural and remote communities, through the Australian Government's Rural and Remote General Practice Program (RRGPP). RWAs also work closely with their respective State and Territory Governments to support recruitment, retention and professional development of rural doctors. (Australian Rural & Remote Workforce Agencies Group, sub. 136, p. 3)

The VET sector has a strong presence in many rural and remote areas, providing training for selected health professions, including skills enhancement courses.

Private organisations

Many private organisations are active in supporting the rural and remote health workforce. Several broadly based health workforce organisations (including medical colleges such as the Royal Australian College of General Practice) provide tailored services such as education, training and professional support.

Other organisations have a primary focus on rural and remote health, including the Australian College of Rural and Remote Medicine, the Council of Remote Area Nurses of Australia, and Services for Australian Rural and Remote Allied Health.

Many organisations (such as Divisions of General Practice, through the GPET process) are active in training and even directly in service provision (see, for example, the involvement of the NSW Rural Doctors' Network in the 'Easy Entry, Gracious Exit' model in box 10.2).

Models of care differ…

While there is broad similarity with urban areas, circumstances in rural and remote Australia have necessitated some variations in models of service provision. These include support for patients who need to travel to major health facilities, specialists and other health professions visiting communities on a 'fly in/fly out' basis, and the increased use of 'telehealth', using communications to transfer health records and medical imaging and to conduct consultations.

The necessity and urgency of some types of health care, combined with the limited range of health professionals in rural and remote areas, has meant that professional boundaries have been less rigid and that scopes of practice have been broader. As the AMA has noted:

> The further away the rural practitioner is from major hospital facilities and professional support, the greater the need for a wider skill set and the exercise of independent clinical judgement and decision-making. (AMA 2004a, p. 1)

… as does education and training

Education and training arrangements are also progressively recognising the needs of rural and remote Australia. There is a range of courses for rural practice, both to 'top up' existing skills, or as entire courses specific to rural and remote requirements. Additionally, some training is located in rural and remote areas, either permanently, or as part of course rotations. The variety of Australian and State and Territory government programs designed to increase education and training in rural and remote areas have been well documented by a number of participants (see sub. 159, pp. 72–75 and, for example, programs in Victoria, sub. 155, p. 30).

Distribution of the health workforce

The distribution of health workers varies considerably across Australia. There are differences in access to health services in outer metropolitan areas compared to the inner suburbs. And, in the major regional centres, access to both general practitioners and specialists is, on average, only slightly lower than in the major cities (see table 10.1).

Table 10.1 **Health professionals per 100 000 population, 2001**
(by industry and remoteness)

Occupation	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*
General practice	351	280	228	198	109
Specialist medical services	147	105	59	26	15
Nurses	1059	1109	1056	1034	959
Dental services	168	127	104	71	35
Physiotherapy	48	37	27	22	7

Sources: AIHW (2003a; 2003b).

However, as table 10.1 shows, apart from nurses, the relative number of health professionals diminishes for communities located further away from major centres. Thus in 'remote' areas, the GP to population ratio is over half of that in the cities, for physiotherapists it is less than a half and for specialists it is under one-fifth.

Additionally, many Indigenous communities are in remote areas. Despite the poor standards of health in those communities, health practitioners are almost always under-represented there. Indigenous health issues are discussed further in chapter 11.

In the absence of major policy reform or other initiatives, workforce shortages in rural and remote areas will become more acute over the next few years. As in metropolitan areas, the health workforce in regional areas is ageing, with age-related exits expected to rise over the next decade. However, difficulties in recruiting new workers are likely to be more significant in rural and remote areas (see below).

That said, the severity of access problems is far from uniform across rural and remote areas. For example 'mining towns' are often well serviced by resident general practitioners, and have significantly better access to specialist and other health services, often on a 'fly in/fly out' basis. For example, one study (Rankin et al 2002) canvassed four rural towns in Western Australia in 2000. One town, a mining town some 1500 km from Perth with a population of 800, had access to four visiting specialists, while an agricultural town with a population of 2500, only 400 kms from Perth, had access to one visiting specialist.

10.2 Underlying causes of workforce maldistribution

There are a range of factors which contribute to the relative underrepresentation of the health workforce in rural and remote areas. In particular, when deciding where they will practise, health professionals will take account of factors such as remuneration, professional and career development and lifestyle in making their choice. Education and training opportunities for health workers in rural and remote areas also have an important impact on workforce availability.

Remuneration

There are concerns amongst many health professionals that practising in a rural or remote area may adversely affect their remuneration opportunities. First, remuneration levels in rural and remote areas are perceived as lower than those in metropolitan areas for the same professions. Second, rural and remote areas present fewer opportunities to advance to more highly specialised and financially rewarding positions. Several participants raised such issues:

> Many practitioners believe that they will receive less remuneration and become professionally isolated as a consequence of moving to a rural and remote area to work with Indigenous people. (DOHA sub. 159, p. 45)

> ... the potential income for [rural] proceduralists is considerably lower than that of their city based colleagues. This naturally impacts on recruitment: who will join a rural practice when they can earn much more doing the same sort of work in a large city? (Rural Doctors Association of Australia sub. 161, p. 32)
>
> Low levels of remuneration related to the low socio-economic status of many rural and outer urban areas is frequently identified as a disincentive to private practice in these areas. (Royal Australian and New Zealand College of Psychiatrists, sub. 79, p. 10)

Professional demands

A variety of professional and lifestyle considerations can discourage practise in rural and remote locations:

- Hours of work tend to be longer than in the cities, and the pressure greater due to an expectation that practitioners will be able to perform a wider range of services, and be available to do so at any time, often resulting in a heavier load of after hours care. This is often compounded by a lack of locum services. Another concern, particularly among new practitioners, is that rural work will not support a desirable 'work/life balance'.
- The availability of supporting health care infrastructure, including diagnostic equipment and other advanced technologies, is often inferior. Additionally, access for GPs and allied health workers to supporting team members can be limited, as can the ability to make referrals to readily accessible specialists.
- Professional development opportunities and career pathways are more limited, increasing the risk that those practising in these areas will become 'locked in'.

Lifestyle concerns

Apart from these professional considerations, rural and remote areas usually have less well developed community infrastructure — including housing and transport infrastructure — than the major population centres. Also, in addition to professional and geographic isolation, social isolation can be a concern. And spouse and family considerations, especially relating to more limited employment and education opportunities, can further militate against practise in these areas.

These factors appear to be just as important for private, as well as public, provision of health services. As AHMAC noted:

> … even the private sector suffers from problems of maldistribution with many self-employed professionals choosing to locate in inner metropolitan areas where they deem both lifestyle and earning potential to be more attractive than outer metropolitan, rural or remote areas. (sub. 10, p. 3)

Rurally based education and training opportunities

In addition to these remuneration, professional and lifestyle considerations, rural and remote recruitment is made more difficult by the concentration of education and training facilities in the major centres. This can reduce the incentive for those from rural and remote areas — who are more likely to want to practise in the bush than those from metropolitan areas — to participate. The Faculty of Medicine, Health and Molecular Sciences, James Cook University observed:

> … evidence indicates that training rural/regional students in a metropolitan environment greatly increases the chance of those students STAYING in the metropolitan area. (sub. 5, p. 3)

Indeed, many participants saw initiatives focussed on regionally-based education and training as playing an important role in the recruitment and retention of health workers in rural and remote areas (see below).

It is against the backdrop of the above concerns that the Commission has considered what more could be done to promote better health workforce outcomes in rural and remote Australia.

10.3 What can be done to improve outcomes?

Health workforce concerns in a wider context

Despite the challenges present, it is important to recognise that the outlook for the health workforce in regional Australia is far from universally negative.

Notwithstanding access problems in many smaller communities, as noted earlier, access to health workforce services in some of the major regional centres, especially in the south east of the country, is not greatly different from that in the major cities. Similarly, the previously noted mining community example points to the dangers of over generalising.

Moreover, those rural and remote communities where access to health workers is a problem are often those experiencing declining populations and difficulties in accessing a range of other services. Such population movements have been occurring in response to a variety of economic and social factors — many of which are beyond the direct influence of government. In the face of these broader trends, and the implications for the working conditions and lifestyles of those remaining in smaller communities, there are clearly limits on the degree of improvement possible in the provision of health services. Indeed, even without constraints on the amount

of government funding available to enhance access and service quality in these areas, parity with metropolitan centres would be an unrealistic goal in most cases.

Further, while lesser access to health workers and services is one contributor to the poorer health outcomes observed in regional Australia compared to those in the major population centres — it is far from the only factor:

> … those who live outside Major Cities tend to have higher levels of health risk factors and somewhat higher mortality rates than those in the cities. … In addition, numerous rural occupations (for example farming, forestry, fishing and mining) are physically risky … (AIHW 2004a, p. 208)

But there is scope for improvement

Such observations do not, however, preclude the opportunity to substantially improve outcomes through health workforce policy. Indeed, there are many initiatives already in train aimed at exactly this. While the array of initiatives have originated from different jurisdictions, and even private organisations, they have not been without guidance.

Reform framework

Recently efforts to improve rural and remote health outcomes have been guided by not only the broader NHWSF, but also 'Healthy Horizons', a specific rural health framework (see box 10.1). An important perspective embedded in 'Healthy Horizons' is that there should be recognition of rural and remote health as an important component of the Australian health system.

In this respect, many of the changes that could ensue from the broad institutional, procedural and funding reforms being proposed by the Commission would be beneficial for rural and remote areas. For example:

- The proposed changes to accreditation and registration arrangements to facilitate job redesign and wider scopes of practice would help to reinforce and augment the changes that are already occurring in this area in rural and remote Australia.
- Reconfigurations to the MBS to encourage task delegation to other, appropriately qualified and more cost-effective, health professionals would reinforce developments of this sort in rural and remote areas.

In the Commission's view, it is important that the broader institutional frameworks in the health workforce system provide for explicit consideration of rural and remote issues. Apart from ensuring that the needs of rural and remote areas are appropriately considered within the broad policy-making process, embodiment

within broader frameworks will help to promote complementarities between specific policies for these areas and generally applicable health workforce arrangements.

Consistent with this approach, the Commission considers that the brief for the proposed new workforce improvement agency should include an explicit reference to the assessment of requirements in rural and remote areas.

DRAFT PROPOSAL 10.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

DRAFT PROPOSAL 10.2

The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- ***assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and***
- ***as appropriate, consider major job redesign opportunities specific to rural and remote areas.***

The quality and safety baseline

As noted above, there are limits on the degree of improvement in access to services possible in rural and remote areas. But, for those care services that are provided, maintaining appropriate levels of quality and safety remains paramount, as the following expressions from participants illustrate:

> No one will regard it as a particularly clever achievement to claim to have provided substantially more health services if those services are provided at a lower level of quality. (AMA, sub. 119, p. 4)

> The importance of providing appropriate, sustainable, high quality health care to all Australians, regardless of their socio-economic circumstances or geographical location, is paramount. The quest to get the right health professional to take up rural and remote practice should not be compromised … (Professor John Humphreys, sub. 96, p. 3)

An appropriate benchmark to ensure that rural and remote areas do not receive sub-standard care is to consider whether that care would be acceptable on a broader basis.

Box 10.1 **Addressing rural and remote issues within the NHWSF**

The NHWSF (see chapter 3) embodies previously developed frameworks for enhancing health workforce outcomes in rural and remote areas.

Healthy Horizons: A framework for improving the health of rural, regional and remote Australians

Developed in 2002, this framework aims to ensure that people in rural and remote Australia will be as healthy as other Australians. It embodies seven goals:

1. Improve the highest health priorities first;
2. Improve the health of Aboriginal and Torres Strait Islander peoples living in rural, regional and remote Australia;
3. Undertake research and provide better information to rural, regional and remote Australians;
4. Develop flexible and coordinated services;
5. Maintain a skilled and responsive health workforce;
6. Develop needs-based flexible funding arrangements for rural, regional and remote Australia; and
7. Achieve recognition of rural, regional and remote health as an important component of the Australian health system.

Source: AHMC (2004a).

Current initiatives

There have been a variety of recent initiatives focused specifically on improving health workforce outcomes in rural and remote areas, covering the spectrum of education and training, job design, service delivery and enhanced support for those health workers choosing to practise in these areas. Notably, these have not all been at the initiative of governments, but have also come from community-based organisations, professional bodies, education and training entities and service providers.

Amongst other things, the aims of the various measures have been to:

- encourage health workers (or in the case of overseas trained doctors, require them) to move to, or remain in, regional areas;
- encourage re-entry to the regional health workforce;
- boost the number of students from regional areas that train to become health workers;

- equip practitioners with the additional or different skills required to deliver services in rural and remote areas;
- reduce the risk of 'lock in' for those practising in rural and remote areas; and
- enhance access to services that can only realistically be provided in larger population centres — through transport assistance policies, facilitating the use of telemedicine etc.

Some specific examples are provided in box 10.2.

Also, as noted previously, health workforce shortages in rural and remote areas have encouraged a variety of innovation in job design and scopes of practice. Some examples of this include:

- The shortage of medical practitioners in rural and remote areas has been a key driver for the introduction of nurse practitioners in Australia (see chapter 4).
- Physician's Assistant and Perioperative Nurse Surgeon's Assistant roles are currently being trialled in a number of non-metropolitan areas.
- The Queensland Government has begun consideration of enhancing the role of paramedics in rural areas, seeing this as:

  > … a response to the shortage of specialist health care providers particularly in regional and rural areas of the State. Qualified, experienced paramedics would complete a two year post graduate degree as Paramedic Practitioners and would assist doctors in a variety of medical procedures such as minor surgery, investigative procedures such as endoscopies, anaesthetics and be able to request diagnostic tests such as x-rays and routine pathology. (Queensland Government, sub. 171, p. 8)

Such initiatives offer the prospect of more timely provision of services, or in some cases, access to services that would otherwise have been unavailable.

More flexible workplace roles have in turn been facilitated by the development of clinical protocols, providing guidance to practitioners performing tasks beyond their traditional responsibilities, as well as some protection against claims of negligence. Examples of these protocols include:

- the Central Australia Rural Practitioners Association Manual;
- New South Wales rural emergency clinical guidelines for adults; and
- Queensland's Primary Clinical Care Manual — aimed at practitioners in rural and remote areas, as well as Aboriginal Health Workers.

Indeed, several participants suggested that further development of such protocols will be very important in supporting future workplace redesign in rural and remote areas (see below).

Box 10.2 **Recent initiatives in rural and remote Australia**

In addition to job design and scopes of practice initiatives, examples of measures introduced to enhance workforce outcomes in the bush include:

By the Australian Government

- a range of financial incentives to encourage health workers, particularly GPs, to locate and practise in regional areas — for example, rural loadings in recognition of longer hours of work and rural retention payments for long serving GPs;
- requirements for overseas trained doctors to practise in areas of workforce shortage if they are to gain access to the MBS, and for non-vocationally registered GPs to practise in these areas in order to obtain the full MBS rebates;
- funding for rural primary health (including allied health) services;
- the provision of rural and regional training infrastructure and assistance to medical (and allied health) students from rural backgrounds; and
- bonded medical places which require students to work a minimum of 6 years in rural, regional and outer metropolitan areas.

By State and Territory and Local Governments

- financial assistance to patients who have to travel to see a specialist;
- support for practitioners, for example, housing assistance or scholarships; and
- grants for pre-school childcare payments, to help female GPs with young children in rural areas to remain in, or return to, the workforce.

By the education and training sector

- new undergraduate programs at James Cook University in occupational therapy, pharmacy and medical laboratory science. These programs are aimed at boosting the future health workforce in northern Queensland; and
- a Remote Emergency Care course, managed by The Council of Remote Area Nurses of Australia, covering trauma management in situations where there may not be a doctor present.

By private/community organisations

- the 'Easy Entry, Gracious Exit' model, implemented in north west New South Wales by the Rural and Remote Medical Services (RARMS), a non-profit entity established by the New South Wales Rural Doctors Network. In essence, RARMS is contracted by the doctors to: provide infrastructure and services, including the practice building, subsidised housing and practice staff; negotiate with Area Health Services; and handle all practice related financial transactions. Aided by special financial support from the Australian Government, this initiative has apparently increased the number of doctors in its area of operation, improved relations with the local Area Health Service, and expanded health promotion and outreach services to outlying communities.

10.4 Suggested further initiatives for rural and remote Australia

In their submissions to this study, participants suggested an array of health workforce initiatives to improve outcomes in rural and remote Australia. Most of what was put forward called for additional funding by governments. However, with growing fiscal pressure on government health budgets, it is also essential that the funds available to enhance health workforce outcomes in rural and remote areas are spent efficiently and effectively.

As such, the Commission has focused on those initiatives that would help to deliver better value from the funding support already available to improve the accessibility and quality of health workforce services in rural and remote Australia.

Making more efficient use of the available workforce

Scopes of practice

In an environment where access to health workers is often limited, it becomes even more important that the available workers have the right skills and that the best use is made of those skills.

Given the conditions prevailing in rural and remote areas, it is generally accepted that a somewhat different skills mix is required for practitioners working there. At the professional level, there is currently a debate about the most appropriate institutional model to support rural and remote specialist training (see box 10.3). More broadly, there are also different views on the required balance between generalist and specialist skills.

Some participants, for example, the NRHA and CMHS, ANU believed that those practising in rural and remote areas 'will continue to need higher levels of generalist skills' (sub. 126, p. 9). Additionally, the Royal Australasian College of Physicians commented that:

> If the aim is to enhance equity in the distribution of the work force across Australia, the likelihood of the outer urban, regional and rural health services each acquiring a 'critical mass' of consultant physicians and paediatricians will be enhanced if greater numbers can provide 'generalist' specialist services and if there is an increase in the monetary value of the MBS consultation items. (sub. 108, p. 6)

Others, such as the Sydney South West Area Health Service, contended that there is a need for a wider range of specialist skills:

> Allied health in these [rural] settings do not have more generalist skills than allied health in other settings, but rather have a need to have a wider range of specialist skills at their disposal. (sub. 30, p. 2)

Box 10.3 College arrangements for rural and remote medical practice

An application to create a new Australian College of Rural and Remote Medicine is now in its final stages with the Australian Medical Council. The basis for this application is that:

> … rural and remote medical practice is a distinct specialty of medicine, requiring appropriate specialist training, support and ongoing professional development. (ACRRM, sub. 72, p. 1)

However, the need to differentiate rural and remote medical practice in this way, as distinct from making explicit provision for it within the currently non-geographically based college structure, has been called into question. For example, the AMA has previously observed that:

> … existing vocational programs are more than capable of providing rural and remote doctors with the skills that they require in order to face the challenges of delivering medical services. General practice training has a long history of supplying rural and remote areas with a well-trained workforce and practitioners taking advantage of up skilling programs can tailor their choices according to the specific health needs of the community in which they are located. (AMA 2004a, p. 4)

And there are some who consider that the college structure per se is not appropriate for providing clinical training services in the bush. In this regard, the National Rural Health Alliance and College of Medicine and Health Sciences argued that:

> … few, if any, specialist medical colleges have structures adequate to support rural streams of training or even to incorporate significant rural components into their programs. It is therefore timely for the current specialist training arrangements to be opened up to bring in other potential providers, including the universities. This could be done either through a semi-competitive model (as in General Practice) or a co-operative model between the Colleges, universities and other potential providers. (sub. 126, p. 13)

The particular directions pursued in this area will in turn determine whether any specific new policy initiatives from government are required. For example, if clinical training in the bush were to be undertaken exclusively through some form of college-based system, the RDAA considered that:

> … the primary responsibility for action will lie with the specialist colleges and other professional organisations, and the rural specialists themselves. (sub. 46, p. 11)

However, a shift to the sort of competitive models canvassed by the National Rural Health Alliance and College of Medicine and Health Sciences, would require more active government involvement in the transition from the current regime.

And some called for the creation of rural-specific professions, such as a 'rural primary health care worker'. It was envisaged that such workers would assist in health promotion and screening of patients, operating under the supervision of other professionals:

> They could be employed in a variety of models including within general practices or Divisions, community health centres, and by the state health sector, but would be required to work as part of integrated teams to avoid the hazards of fragmentation of care. This would create the need for clear lines of authority and supervision. (Northern Rivers University Department of Rural Health, sub. 152, pp. 13–14)

Such proposals serve to further highlight the array of workforce innovation that is taking place across rural and remote Australia. Many of these need to be more formally evaluated with a view to determining whether they could be more widely applicable across the health workforce. The activities of the proposed health workforce improvement agency could be particularly helpful in this respect.

Clinical protocols that establish minimum levels of quality and provide clear guidelines and standardised processes for care will also be important in supporting the expansion of scopes of practice and the emergence of new professions. Indeed, as well as making better use of the competencies of the workforce, such protocols may actually enhance the quality of care provided. In this regard, Dr Patrick Cregan commented:

> These protocols will reflect a local environment and be based on guidelines developed at a high, usually national level. Such guidelines and protocols reflect the best available distilled evidence … There is outstanding evidence that this approach improves care. (sub. 4, pp. 5–6)

Some, such as the The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Committee, cautioned against over-reliance on protocols:

> Beware of the limitations of 'clinical best practice protocols' as a method of simplifying health service provision. The evidence bases for many so called best practices are seriously flawed, and what is deemed best practice today may not be shown to be best practice tomorrow. Reducing health care provision to a series of recipes is to oversimplify the complexities of human health and disease. (sub. 113, p. 7)

However, in the Commission's view, this is an argument for effective evidence-based protocols, not against the use of protocols per se.

Remote service provision

Taking greater advantage of new opportunities for 'remote service provision' will be important in the future delivery of health services to rural and remote Australia. While 'fly in-fly out' arrangements has long been used to deliver more specialised services in many remote areas, emerging telemedicine alternatives may often be more cost-effective. A range of care services, including mental heath care and oncology and radiology services, are already provided in this way in some rural and

remote areas. And, the joint Australian and State Territory Government initiative, 'HealthConnect', is trialling a network of electronic health records, aimed at improving information about, and access to, health services in regional areas, as well as reducing duplication of services.

The Human Genetics Society of Australasia recommended permanent or long term funding for telemedicine, noting that:

> Telemedicine is a cost-effective way to see patients whose diagnoses are already made, especially those who have a family history of cancer. State government telemedicine grants have enabled outreach genetic counsellors to run clinics without a geneticist having to drive or fly to the clinic or stay overnight. (sub. 97, p. 13)

However, the scope for widespread use of telemedicine was not accepted by all. For instance, James Cook University commented that telemedicine will have a 'limited role in [the] ability to greatly improve health services to rural/remote areas' (sub. 5, p. 3). Additionally, the Australian Psychological Society pointed out that:

> The potential for 'telemedicine' in the mental health area is limited. It carries the danger of over-reliance on use of prescription drugs as a ready electronic means of providing some help to a mentally disturbed client. … They should not be seen as a means of replacing the human service deliverer but may be a very useful supportive aid. However they do not save money … [and require] significant start-up and ongoing expense. (sub. 118, p. 62)

Moreover, whatever the precise scope for the use of telemedicine approaches, supporting changes in other areas may be needed for these initiatives to realise their full potential. For example, greater use of telemedicine (both in terms of video-conferencing and image transfer) will require appropriate communications infrastructure and, in some cases, changes to scopes of practice and associated professional regulation. As Professor John Humphreys said:

> While telemedicine has made significant differences in how health care can be delivered to rural and remote areas … it requires significant investment in developing adequate infrastructure, support and training. (sub. 96, p. 3)

Further uptake of telemedicine will also require consideration of the appropriate assignment (and management) of risk and liability between the 'on site' technician and the advising specialist.

But, such issues aside, in the Commission's view, future technological developments will provide greater capacity for 'on site' professionals in rural and remote areas to consult with more specialised health professionals in major population centres. Indeed, while remote service provision may not be as ideal as resident, face-to-face, consultation, it does provide a feasible and cost-effective means for improving patients' access to health services.

'Hub and spoke' models

In making more effective use of the available workforce in regional areas, further development of 'hub and spoke' models may also be helpful. This in turn highlights the role that effective transport infrastructure can play in improving health outcomes in the bush. Indeed, as noted earlier, some see the use of outreach service provision based in major regional centres as the only realistic way of providing many more specialised services to smaller communities.

Provision of practice support

There are many approaches being used or trialled to improve recruitment, retention and re-entry to professional life in rural and remote areas.

In this regard, the provision of infrastructure services on a contractual basis (see, for example, the 'Easy Entry, Gracious Exit' model in box 10.2) is seen as one way of reducing the risk of lock-in that arises from the purchase of a practice of uncertain future value. The NSW Rural Doctors Network also noted that:

> … the effort and investment often seen to be required to find or acquire suitable housing, surgery facilities, skilled practice staff and locally available services (IT, accounting, practice nurse etc.) [has been a barrier to recruitment] ... communities that can provide these elements, improve their prospects of recruitment and retention. … Many young doctors are reluctant (and untrained) to take on … [business management and] … A number of older doctors are now looking for ways to eliminate their business management workload ... (sub. 110, pp. 13–14)

Indeed, some smaller communities have adopted innovative approaches aimed at reducing the business management workload for doctors, as well as the risk of lock-in. For example, the Australian Local Government Association noted that:

> … in Queensland, the Kingaroy Shire Council has implemented its own Medical Workforce Strategy to help rebuild the town's medical workforce. … the council purchased and re-opened the town's private hospital, St Aubyn's, which had ceased operation in June 2001. The council now owns and operates the hospital and a medical practice, through a wholly owned council company. (sub. 172, p. 12)

More broadly, several participants commented that as a means of avoiding lock-in, salaried practice is likely to be intrinsically more attractive in rural and remote areas than in the major population centres. For example, the NRHA and CMHS, ANU suggested that:

> Consideration should be given to increasing the number of salaried staff working in rural and remote communities, with packages that might include guaranteed infrastructure, support and relief. … The evidence suggests that a greater number of young heath professionals would prefer to operate this way than used to be the case,

partly because they are uninterested in commercial business practice and because their indemnity risks can be borne or financed by the employer. (sub. 126, p. 11)

Training in rural and remote areas

As noted above, access to health workforce education and training opportunities outside the major population centres can both raise participation by students from regional and remote backgrounds and increase the proportion of students who subsequently practise in rural or remote areas. Accordingly, many participants saw initiatives to provide regional education and training opportunities as being a very important component of health workforce policy. Synthesising these views, James Cook University argued:

> … it is in the national interest to encourage training in regional/rural/remote locations for long-term workforce retention in these areas. (sub. 5, p. 2)

And, in lending weight to this argument, the Rural Health Research Collaboration (sub. 34, p. 4), amongst others, pointed to previous studies that indicate that rural background, and also rural undergraduate and postgraduate health workforce training, are predictors of practise in rural and remote areas. For example:

> … GPs who have spent any time living and studying in a rural location are more likely to be practising in a rural location. Those whose partners have also lived and studied for any period of time in a rural location are six times as likely to become rural GPs than those with no rural background. (Laven et al. 2003)

> … medical students who have undergraduate rural training, and … GPs who have rural postgraduate training, are more likely to become rural GPs. … of these factors, rural postgraduate training is the factor more strongly associated with rural practice than is undergraduate rural training. (Wilkinson et al. 2003)

There were also a number of more specific suggestions on how education and training courses and structures could be reconfigured to better meet care needs in rural and remote areas. For example, several participants pointed to scope for greater use of a 'hub and spoke' models in education and training to provide increased on-site training opportunities in more remote locations.

From the evidence presented to this study, there seems little doubt that education and training opportunities in rural and remote areas can lead to material improvements over the medium to longer term in access to health workers in these areas.

Clearly education and training costs are generally higher in rural and remote areas, as they do not have economies of scale — nor do they benefit from interaction across professional disciplines, or from opportunities for higher levels of clinical training. However, provision of education and training in rural and remote areas

may nonetheless be a more cost-effective way of improving workforce numbers than seeking to entice 'unwilling' practitioners away from the major population centres through the use of financial incentives. Notably, this view was also shared by several key participants. For example, the AMA concluded:

> The early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas. (sub. 119, p. 14)

Education and training located in regional areas can also provide broader social benefits, over and above the increased supply of health workers:

> …it builds community capacity and viability, enhances professional retention and supports quality and safety objectives. (Australian Council of Deans of Health Sciences, sub. 67, p. 2)

For these various reasons, the Commission supports a strong focus on the provision of regionally-based health workforce education and training. However, given recent initiatives that have significantly expanded such opportunities, the Commission considers that it would be timely to commence a rigorous evaluation process, before further programs are adopted.

More efficient funding mechanisms

Changes to the structure of MBS rebates?

A particular issue considered by the Commission is whether the configuration of MBS rebates should be used to encourage medical practitioners to locate in rural and remote areas by, for example, providing higher rebates for services delivered in these locations as against delivery in the major population centres.

There is of course already some such differentiation in remuneration through arrangements that sit outside MBS rebates for specific services. In particular, the Practice Incentive Program (PIP) provides a rural loading for general practitioners (as well as providing incentive payments for activities such as the provision of teaching, after hours care and the use of information technology).

While the MBS provides some differentiation in relation to the provision of particular services by overseas trained doctors — and non-vocationally registered GPs — in areas of workforce shortage, several participants advocated more extensive differentiation to encourage practise in rural and remote areas:

> The Commonwealth Medical Benefits Scheme does not recognise the environment in which rural doctors work nor the type and complexity of services that they provide in

> an after-hours setting. Remuneration … should reflect the training and expertise of those who provide this essential service, taking into account the higher indemnity risks of emergency care and the rates paid for after-hours services in other industries … (RDAA, sub. 46, p. 11)
>
> Differential MBS fees weighted for rurality/remoteness should definitely be considered in support of general practitioners and specialists working outside metropolitan centres. (Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Committee, sub. 113, p. 3)
>
> The RANZCP supports the use of incentives such as altered funding arrangements, for example higher MBS reimbursement for those working in rural areas, and perhaps also in selected regional and outer metropolitan areas. (Royal Australian and New Zealand College of Psychiatrists, sub. 79, p. 10)

But others questioned the effectiveness of such differentiation in rebates in encouraging practise in rural and remote areas:

> On the face of it, paying higher rebates in locations of workforce shortage would appear to be an administratively efficient way of supporting better recruitment and retention in such areas.
>
> However … alternative approaches seeking to pursue the same result through more targeted programs appear to be working effectively with considerable success in increasing the number of GPs practising in rural areas. ... [D]ifferential rebates … may be relatively blunt as a mechanism to achieve the same objectives. (Department of Health and Ageing, sub. 159, pp. 39–40)

Hence, there remains uncertainty about the extent to which such a change in the focus of funding support would materially affect incentives to practise in rural and remote locations, especially when compared to other financial incentives. The Commission was not made aware of any formalised attempts at evaluation of the relative effectiveness of such measures.

Greater reliance on block funding

A more fundamental reform would be to shift the focus of funding support for service delivery in rural and remote areas away from 'top-up' payments to individual providers, towards block funding to ensure delivery of desired levels of access and service quality in particular regions.

This would entail letting contracts for the provision of services in those communities and regions, with contracts awarded to the tenderer offering to meet service requirements with the lowest level of subsidy. Depending on the community and the breadth of the services covered, winning tenderers could variously be individual providers or consortia of providers, hospitals, charitable organisations, community organisations, or specialist health managers who would then sub-

contract, or otherwise engage, individual health professionals to deliver the services in question.

At least in principle, such an approach would have three benefits:

- It would make it incumbent on governments to be explicit about minimum levels of access and service quality that must be met in rural and remote areas, and to provide funding commensurate with achieving those care levels. At present, access and quality levels are effectively the outcome of a funding process with much less tightly defined objectives.
- By channelling funding into a single program employing a competitive tender process, the approach could be expected to reduce the costs of delivering any particular level of service access and care quality. Avoiding the almost inevitable overlaps and duplication in the current approach that targets particular aspects of access and quality through a range of different programs, would be one source of cost saving.
- And it could encourage innovation in the delivery of health workforce services in rural and remote areas, including through facilitating:
  - further development of multidisciplinary care models; and
  - exploration of ways to make it more attractive for health workers to practise outside the major population centres, including mechanisms to reduce the lock-in problem.

However, giving practical effect to such an approach would be very challenging:

- Decisions would be required on the geographical delineation of tenders, the range of services they covered, and the duration of tenders. Thus, the contracting process could become complex, with considerable scope for 'bureaucratic failure'.
- Pooling of funds for primary and acute care would raise questions about which level of government would control the process.
- Given the essential nature of health care services, governments would inevitably have to remain as the default provider in the event that a successful tenderer was subsequently unable to meet its contract obligations. This of itself could dilute the inherent efficiency advantages in such an approach.
- And, it could be extremely difficult to get governments to be explicit about floor levels of access and quality in rural and remote areas, let alone directly tie funding appropriations to those levels.

Box 10.4 **Coordinated care trials**

Nine coordinated care trials were run in six States and Territories, from June 1997 to December 1999. Trials were run on either a randomised or geographically controlled basis, and were measured against control groups.

The trials were found to have several flaws, including their short time frame preventing any real impacts on complex illnesses, poor choice of individuals to participate in the trials and the application of the same intervention to all patients, regardless of the severity of their condition.

Overall, the results from the trials were seen as disappointing:

> Intervention groups did not perform better than control groups for either [general measures of health status] … or reductions in hospitalisation, readmission, or length of stay for those hospitalised. Trials were unable to fund coordinated care out of savings from reduced hospitalisation. (Esterman and Ben-Tovim 2002, p. 469)

Indeed, while these trials may have improved the range and coordination of services, as well as improving infrastructure (particularly IT), they did reveal that coordinated care may not be the answer if cost containment is a primary objective:

> The possibility remains, however, that the essential premise that better coordination reduces hospitalisation is misguided. It may be that lack of coordination in a complex care system operates as a functioning rationing system, so that better care coordination reveals unmet needs rather than resolving them. … the government has given priority to increased service coordination, vertical integration and cost containment. … [it] might well be that the objectives are mutually exclusive and that improved coordination comes at a cost. (Esterman and Ben-Tovim 2002, p. 470)

Indigenous coordinated care trials

In addition to the general trials above, four trials were run in Indigenous communities between 1997 and 1999. These trials were viewed as more successful than the general trials:

> … [the Indigenous] trials showed enhanced service access, progress in infrastructure development, and improved individual and community empowerment. Funds pooling was successful in providing greater flexibility in resource allocation. (Esterman and Ben-Tovim 2002, p. 469)

A second round

The second round of trials, which began in late 2002, have been altered to reflect some of the lessons learnt from the first trials — notably the trial duration is longer, at three years, and the targeting of interventions and measurement of outcomes have been improved.

Source: Esterman and Ben-Tovim (2002).

The Commission notes that previous coordinated care trials have raised significant design and administration issues, and were not generally viewed as successful, at least in terms of reducing the cost of care provision. One observation arising from

the evaluation of the trials was that the lack of coordination in current arrangements could act as a de facto rationing mechanism. To that extent, it is possible that the benefits of more coordinated care under these trials have been manifest in the provision of additional and higher quality services, rather than through cost savings. Trials in Indigenous communities were assessed as giving better results (see box 10.4).

Such observations do not of themselves rule out the use of this approach in the future. Indeed, introduction on a trial basis in a small number of rural or remote areas might well be helpful in a number of ways. First, it may provide a basis for assessing the wider applicability, in both rural and mainstream settings, of block funding. Second, the models of service provision adopted by successful tenderers may highlight cost effective models for rural and remote care. Finally, a trial may also provide hitherto lacking quantification of the costs of meeting access and quality objectives in these areas through subsidisation of service provision. This could in turn assist evaluation of the effectiveness of subsidising service provision relative to other broad vehicles for improving health workforce outcomes (see below).

Regional development

Beyond the health workforce policy environment, the general economic wellbeing of rural and remote communities is likely to play a pivotal role in their capacity to attract and retain sufficient numbers of health workers. Accordingly, some participants pointed to the important complementary role of regional development policy:

> Family factors … and community resource factors are significant contributors to poor retention indicating that in addition to revised service delivery models community development action is also required. (QRMSA 2004, p. 2)

> The best medium-term program for the recruitment and retention of workers to country areas would be successful rural development. (National Rural Health Alliance and College of Medicine and Health Services, ANU, sub. 126, p. 11)

Amongst other things, regional development can help to make communities more attractive places for health professionals to live and work in. Moreover, regional development and better transport and communications links with major centres — that would facilitate easier access to services in those centres and greater use of telemedicine — often go hand in hand.

However, regional development policy, and government support for such policies, is well beyond the remit of this study.

Better program evaluation is essential

The Commission, in its visits to a number of rural and remote centres, saw for itself the many health workforce innovations in these areas, but little broadly based evaluation or dissemination of these initiatives. The lack of rigorous cross program evaluation (or even proper evaluation of some individual programs), means that there is still considerable uncertainty about what approaches are the most efficient and effective. Commenting on this lack of comprehensive program evaluation, the Australian Health Ministers' Advisory Council said that:

> There are a range of strategies in place to influence workforce distribution. However, there is little coordination of initiatives between jurisdictions and little sharing of evaluation and identification of best practice strategies. (sub. 166, p. 18)

In light of this, the Victorian Government recommended that:

> … the Commonwealth, States and Territories agree to a common approach to program evaluation and sharing of learnings to inform future national and jurisdictional policy and program development in rural recruitment and retention. (sub. 155, p. 32)

However, evaluation needs to address not only recruitment and retention initiatives, but also:

- the longer term effectiveness of providing regionally-based education and training opportunities relative to other initiatives;
- the provision of financial incentives through the MBS rebate structure as compared to practice grants that are unrelated to servicing volumes; and
- financial incentives versus coercive mechanisms (see box 10.5).

Effective program evaluation is also important in identifying duplication and overlaps, and in helping to tailor programs within rural and remote areas. As many participants pointed out, regional Australia is far from homogeneous and programs that work well in one area will not necessarily do so elsewhere.

Some of this more detailed evaluation will be most appropriately undertaken at the jurisdictional, regional, or even community level. However, responsibility for many of the major policy settings that influence health outcomes in rural and remote areas resides at the Australian Government level. Hence, evaluation of the cost-effectiveness of different *broad* approaches for improving service access and quality outcomes in rural and remote Australia, must logically be undertaken at the national level, collectively by the Australian, State and Territory governments.

Box 10.5 **Incentives versus coercive approaches**

As well as the provision of financial incentives, governments also employ some more coercive approaches to boost workforce supply in these areas. Examples include:

- making some subsidised medical places at universities conditional on students agreeing to work in regional areas for up to 6 years; and
- requiring overseas trained doctors to practise in 'districts of workforce shortage' in order to be eligible for Medicare Provider numbers.

And some have suggested that the latter approach be extended more generally, through administratively allocated geographic provider numbers.

However, several participants pointed to downsides of using coercion in an effort to boost workforce supply in the bush. Thus, the Doctors in Rural and Remote Training Association observed:

> To insist that doctors remain in an area of need may translate to a reduction in the quality of service that they provide. While this satisfies the basic requirement of having a medical practitioner in town, … [h]aving unmotivated and frustrated doctors will do nothing to improve their retention. (DIRRTA 2001, p. 1)

And, in relation to the use of geographic provider numbers, the AMA said that it:

> … opposes geographic provider numbers as a means of regulation. Locking in younger doctors to a career in certain areas tends to discourage rather than promote participation. (sub. 119, p. 15)

Some also expressed concern about the implications for continuity of care, if most of those 'conscripted' to work in rural and remote areas leave as soon as their period of bonding is over.

Accordingly, the Commission proposes that, through the Australian Health Ministers' Advisory Council, the Australian Health Ministers' Conference initiates a cross program evaluation exercise. This would provide for a national, coordinated approach towards rural and remote health workforce policy, while affording individual States and Territories the opportunity to feed in considerations specific to their particular jurisdictions. Such evaluations could draw on experiences with different approaches in other countries — though it is important to recognise that in an area like health care, experience does not always readily translate across countries.

DRAFT PROPOSAL 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- ***the provision of financial incentives through the MBS rebate structure versus practice grants; and***
- ***'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.***

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

11 Addressing special needs

Key points

- As well as catering for 'mainstream' needs in both the cities and regional areas, an effective health workforce system must address the particular requirements of a range of groups with special needs.
  - Broader institutional frameworks should provide for explicit consideration of these needs to help ensure complementarity between system-wide and specific policy responses.
- Improving Indigenous health outcomes will require action on a variety of fronts extending well beyond the health arena, including to: further enhance educational attainment; increase capacity for self-driven economic and social development; and continue to improve community and health workforce governance structures.
- Workforce-specific reform directions that warrant close attention include:
  - encouraging a further widening of scopes of practice for workers providing health services to Indigenous people;
  - giving greater recognition to prior learning and on-the-job training in Indigenous workforce areas;
  - providing increased health workforce education and training opportunities for Indigenous students in, or adjacent to, their communities; and
  - ensuring that training wages provide appropriate incentives for Indigenous participation in health workforce education and training.
- The provision of aged care, disability and mental health services accounts for a growing share of overall health care expenditure.
  - This reflects the increased incidence of (reported) mental illness and recognised disabilities, and Australia's ageing population profile.
- The shift in the provision of services from institutional to community-based settings has had implications for the types of health workers required in these areas.
- A common set of workforce issues confront policy makers in each of these areas, including the need to:
  - overcome current and looming workforce shortages and maldistribution;
  - ensure that particular workforce needs in these areas are reflected in education and training arrangements, job design, and career pathways; and
  - address particular workplace environment and remuneration factors that currently make recruitment, retention and re-entry more difficult.

11.1 General approach

As well as catering for 'mainstream' needs in both the cities and regional areas, an effective health workforce system must address the requirements of a range of groups with special needs.

Most obviously, Indigenous Australians suffer particular disadvantage, and require access to, amongst other things, culturally sensitive health workforce services. Those in the community who require mental health care, disability services and aged care (in both institutional and community settings) also face particular problems and have some specific workforce needs.

As is the case in the provision of workforce services in rural and remote areas, the system-wide institutional, procedural and funding changes proposed by the Commission would help to underpin better outcomes in these special need areas. But more specific initiatives will also be required.

Moreover, it is very important that the broader institutional frameworks in the health workforce system provide for explicit consideration of special needs issues, as embodiment within those broader frameworks will help to promote complementarity between policies for these groups and generally applicable health workforce arrangements.

In this context, the proposed health workforce improvement agency (chapter 4) and the secretariat responsible for numerical workforce projections (chapter 9) should be required to have regard to any particular workforce requirements of Indigenous Australians, people with mental health illnesses, people with disabilities, and those requiring aged care. Similarly, the terms of reference for the advisory Health Workforce Education and Training Council (chapter 5) should include an explicit requirement to address any particular education and training issues applicable to these groups. That said, the Commission emphasises that this principle must be applied across the board to existing as well as new health workforce institutions.

DRAFT PROPOSAL 11.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

The remainder of this chapter explores some specific workforce issues in the various special need areas. However, time constraints have limited the depth of this assessment, especially in the mental health, disability and aged care areas.

Moreover, in keeping with the approach elsewhere in this paper, the discussion focuses on higher level issues and approaches, rather than on the host of more detailed matters that arise in each of these areas.

11.2 Indigenous health workforce issues

The current state of play

The parlous state of Indigenous health has been extensively documented (see box 11.1). Put simply, Indigenous Australians are likely to die at a considerably younger age and suffer more extensive health-related disability than their non-Indigenous counterparts.

In response to this large and longstanding gap in outcomes, per capita spending on Indigenous health care is considerably higher than for the rest of the population, and there are many targeted health and health workforce programs in place. Apart from funding for primary health care provision by Aboriginal Community Controlled Health Services, the Australian and State and Territory Governments provide support for programs to:

- make better use of the workforce available to provide care to Indigenous Australians;
- facilitate job redesign; and
- encourage more Indigenous people to train as health workers (see box 11.2).

What more can be done to address the problems?

While some improvement has been evident, the gap in health status with other Australians remains unacceptable. Consequently, governments, communities and professional organisations are devoting considerable attention to what more can be done.

Multifaceted responses are required

It is widely recognised that improving Indigenous health outcomes will require action on a variety of fronts extending well beyond the health arena. As the AMA has observed:

> No single intervention can solve the crisis in Aboriginal and Torres Strait Islander health. (AMA 2004b, p. 1)

Box 11.1 **Indigenous health**

The health status of Indigenous Australians is significantly below that of the Australian population as a whole. This discrepancy has been long-standing and sits alongside a number of other social disadvantages in the Indigenous community.

- Compared to the total Australian population, infant mortality is almost double and Indigenous life expectancy is around 17 years lower.
- Indigenous people have a higher rate of environment and trauma-related disabilities. Factors that heighten the risk of non-genetic disabilities for Indigenous people include diabetes, some infectious diseases, accidents and violence, mental health problems, and substance abuse.
- Hospitalisations from kidney-related complications of diabetes are some thirteen times higher for Indigenous than non-Indigenous people.
- The rate of hospitalisation of Indigenous children aged four years and under for infectious diseases is more than double that for non-Indigenous children.

A host of factors underlie these outcomes. At a broad level, economic and social disadvantage and lower rates of educational attainment play a key role. More specifically, poor dietary practices, unsanitary living conditions and difficulty in accessing health services are major contributors. In regard to the latter, for example, a 2001 survey of people living in discrete Indigenous communities revealed:

- over 50 per cent lived at least 100 kilometres from the nearest hospital (with 12 per cent of this group having no access to a medical emergency air service); and
- around 45 per cent lived in communities that had no community health centre, with 3 per cent located 100 kilometres or more from the nearest centre.

As part of the push to address Indigenous health issues, the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework aims to build:

> … a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples …

It contains a number of strategies to achieve this, including increasing the number of Indigenous students in health courses, identifying unmet needs for specific allied health professionals in Aboriginal primary health services, and developing policies to enhance the focus of training on preparing for work in multidisciplinary teams in integrated and coordinated services. The framework is now embodied within the broader National Health Workforce Strategic Framework (see chapter 3).

Sources: SCRGSP (2005a); Access Economics (2004); AHMC (2004).

Of particular importance at a broader level is the need to achieve further improvements in the educational attainment of Indigenous Australians. This would have a direct impact on health outcomes through improving health awareness and dietary practices, and through increasing the willingness and capacity to seek

appropriate medical treatment. It would also help facilitate higher standards of living in Indigenous communities, with consequent health benefits.

Box 11.2 **Indigenous health programs**

Beyond general funding for primary health care and the delivery of public hospital services, governments also support the provision of primary health care by Aboriginal Community Controlled Health Services.

In addition, governments provide support for specific programs to: make better use of the workforce available to treat Indigenous people; improve access to particular types of health workers; facilitate job redesign; and encourage more Indigenous people to train as health workers (at present, Indigenous people make up 2.4 per cent of the population, but only 0.9 per cent of the health workforce). Some examples include:

- Australian Government funding for the 'Pathways into Health — Workplace Learning' initiatives for Aboriginal and Torres Strait Islander school students;
- support for the development of clinical protocols relating to Indigenous health;
- the development of nurse practitioner roles for remote area clinics;
- scholarship schemes to encourage Indigenous students to study in health related fields, such as the Office of Aboriginal Health Scholarship in Western Australia;
- the provision of financial and peer support for Indigenous people training to become mental health workers;
- the provision of allied health and specialist medical outreach services; and
- initiatives to 'encourage' OTDs to work in or adjacent to Indigenous communities.

Overall, government support for health care for Indigenous Australians is considerably higher than the average for the community as a whole — more than $3600 per person compared to a little over $2200 per person in 2001-02 (the latest data available). However, such higher expenditure levels are unsurprising, given the poor status of Indigenous health, and the fact that a significant proportion of the Indigenous population live in remote areas. Indeed, as the Rural Health Education Foundation noted, remoteness and poorer health outcomes for Indigenous people are strongly correlated:

> [T]he health outcomes of Aboriginal Australians declines as their 'remote-ness' increases, so that health outcomes consistently decline from 'metropolitan' to 'inner regional/rural' to 'outer regional/rural' to 'remote' to 'very remote'. (sub. 84, p. 5)

Additionally, some of this expenditure is through specific programs. This effectively substitutes for spending on mainstream health services, which on a per capita basis, is much lower for Indigenous than for non-Indigenous Australians.

Sources: AIHW (2004a); SCRGSP (2005b); State health departments.

Improved educational attainment is also likely to encourage increased Indigenous participation in the health workforce — itself a contributor to better health

outcomes. As well as being readily accessible and able to provide culturally sensitive care, Indigenous health workers typically play an important leadership role on health care matters within their communities. The AMA, amongst others, drew attention to the beneficial linkages between Indigenous participation levels and improved health outcomes observed in other countries:

> The USA, Canada and New Zealand all have more [Indigenous] health professionals and, despite continuing disparities, have made greater improvements in health for their Indigenous populations. (AMA 2004b, p. 3)

Programs aimed at building capacity for self-driven economic and social development (see box 11.3) will be similarly important — not only in terms of the health benefits that come from higher standards of living, but also through reinforcing incentives for participation in education. Thus, the South Australian Government observed that:

> In SA, experience has shown that in order to bring more Indigenous people into employment, education and training, a significant investment has to be made in community capacity building and in healing the community before more people are ready and able to take up new opportunities. (sub. 82, p. 15)

Less commonly raised in the context of improving health and health workforce outcomes, but still important, is the need to continue to improve community and health service governance structures. Poor governance structures and practices can lead to a variety of problems, including:

- inefficient use of funds available to improve access to health workforce services;
- discouragement for practitioners to work in Indigenous communities and for Indigenous people to train as health workers; and
- reduced incentives for economic development and participation in education, thereby constraining improvements in standards of living and the health benefits that follow from them.

As the circumstances of individual communities vary considerably, governance structures will similarly need to vary. In a health workforce context, community-driven care — to provide 'ownership' of services and to facilitate tailoring of governance structures to particular circumstances — will continue to be a key foundation in most cases. However, 'community-driven' care need not always translate to 'community-managed' care. As for other economic and human services, contracting out of service delivery may sometimes be efficient. Indeed, in common with other aspects of health workforce reform, a willingness to look beyond current models is likely to be helpful in achieving better outcomes.

Box 11.3 **Indigenous Enterprise Partnerships**

The Indigenous Enterprise Partnerships (IEP) program is designed to build capacity for self-driven development in Indigenous communities. IEP is a not-for-profit organisation, which aims to foster long-term economic and social development by facilitating partnerships between Indigenous and corporate and philanthropic groups.

This program has been operating, on a pilot basis, in Cape York since 2001, though its principles are intended to have broader application. The pilot program has delivered a number of direct benefits including the installation of new building and telecommunications infrastructure, the provision of training and personnel development support, and assistance for the establishment of businesses to provide commercial employment opportunities in Indigenous communities. But it has also provided less tangible, though equally important, broader economic and social benefits:

> … such as improved commercial literacy and Indigenous motivation to participate in business or employment … [and] personal development and empowerment gains. Other benefits include building the capacity of Indigenous organisations through factors such as organisational development plans or direct training.

Source: SCRGSP (2005a, p. 11.19).

What health workforce-specific directions look most promising?

Submissions to this study have put forward a wide range of possible initiatives to improve the access of Indigenous Australians to health workers, and the effectiveness of the services provided. Many of these were directed at immediately increasing the numbers of health workers available to treat Indigenous Australians not only in communities, but also in the cities. However, others were variously directed at:

- making better use of available resources — for example, through changes to scopes of practice or greater use of telemedicine;
- facilitating greater Indigenous participation in the health workforce through changes to training delivery, career pathways and remuneration structures;
- enhancing service quality through a greater emphasis on culturally appropriate models and methods of delivery in training programs (see box 11.4);
- improving the coordination of service provision through, for example, reducing barriers to cross-jurisdictional practice; and
- increasing the emphasis on preventive health.

In the Commission's view, a greater emphasis on preventive health strategies will be especially important — though the specific requirements to give effect to this go

well beyond a study into the health workforce. Beyond that, it considers that the following reform areas warrant particular policy attention in an Indigenous context.

Box 11.4 **Cultural training**

Indigenous people are more likely to understand, respect and use services that are provided in a culturally appropriate fashion. Accordingly, the principle of culturally appropriate service provision is enshrined in the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (see box 11.1).

To promote the delivery of culturally appropriate services, several participants emphasised the need for training programs for non-Indigenous health professionals providing services to Indigenous people, to include a significant cultural component. Apart from enabling them to provide effective services to Indigenous people, a good grounding in Indigenous culture can assist non-Indigenous health professionals to:

- convey broader health awareness and disease prevention messages to patients and communities; and
- understand the role of Aboriginal Health Workers and to make best use of their skills.

In commenting on some of these roles, the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan Steering Group suggested that:

> … non-Indigenous staff be required to undertake a cultural awareness program that highlights the role of Indigenous Health Workers. We also strongly recommend an appropriate mentorship program for the mentoring of non-Indigenous staff by Indigenous staff on areas such as cultural issues and localised cultural conduct. This could also be seen as two way 'skills exchange'. (sub. 74, p. 1)

Others also suggested that a greater emphasis on cultural training might increase Indigenous usage of health services in metropolitan areas where, despite better access to health workers, the health status of Indigenous people still lags that of other Australians.

Wider scopes of practice and greater recognition of prior learning

As is the case for rural and remote service provision more generally, the often acute shortages of health workers available to treat Indigenous people have resulted in more flexible scopes of practice than in the major population centres. Two examples are the development of nurse practitioner roles in remote area clinics and expanded roles for Aboriginal Health Workers (AHWs) who, apart from their clinical role:

> … play a key role in cultural brokerage between Western medical systems and Indigenous communities. (General Practice and Primary Health Care Northern Territory, sub. 132, p. 6)

However, this process could clearly go further. For example, the Commission was advised that, with fairly modest additional training, AHWs could take responsibility for a wider range of tasks, such as performing injections, conducting renal dialysis and midwifery functions. In regard to the latter, the Centre for Midwifery and Family Health said that:

> The Bachelor of Midwifery has also been developed to attract Indigenous women to undertake midwifery. In NSW, four places [are provided] for Aboriginal women. These women have all been working as Aboriginal Health Workers as part of the NSW Aboriginal Maternal and Infant Health Strategy and have completed a 12 month Maternal and Infant Preparatory Course … (sub. 41, p. 4)

The development of wider scopes of practice would be facilitated by further development of clinical protocols to support appropriate task delegation in Aboriginal Community Controlled Health Services. It would also be assisted by greater recognition of prior and on-the-job learning in registration and credentialing arrangements.

Moreover, wider scopes of practice and greater recognition of prior learning in accreditation arrangements for training courses would enhance career pathways for Indigenous health workers, allowing AHWs, for example, to more easily progress to nursing and other professions. This in turn would encourage Indigenous participation in the health workforce, not only by providing a more accessible career pathway, but also by improving the standing of Indigenous health workers in their communities.

Though necessity will continue to drive further broadening in scopes of practice, and possibly greater recognition of prior learning and on-the-job training, that impetus must be reinforced by broader institutional arrangements impacting on job design and education and training regimes. It is precisely for this reason that the Commission is proposing that those broader frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including Indigenous Australians (see proposal 11.1).

An emphasis on increasing participation in education and training

The Commission supports a strong focus on education and training initiatives. In particular, the provision of locally-based training options can increase incentives for Indigenous participation in the health workforce. Those who contemplate joining the health workforce are often important members of the community, and may be heavily involved in day-to-day community life. As such, they may be reluctant to travel long distances, or spend a long time away from their communities, for training purposes. Moreover, training provided in larger centres — especially for

AHWs — may not pay sufficient regard to cultural and other issues pertaining to specific Indigenous communities.

Appropriate remuneration arrangements

Indigenous participation in the health workforce will obviously be influenced by remuneration levels, not only in relation to other occupations but also compared with community development program payments and forms of income support. While it appears that remuneration for those who have completed training provides reasonable incentives to pursue a career in the health workforce, the level of payments for those in training seems more problematic. Such training wages must of course be considered in the context of other support available to students. However, in this regard, the South Australian Government noted:

> … most Indigenous people seeking employment in the health sector are of mature age, not school leavers, so they are ineligible for Commonwealth Cadetship monies for 17 – 28 yr olds. … Many have financial commitments that require a full-time salary to cover their cost of living, often coupled with family responsibilities that may extend to a number of family members. For example, an individual may wish to become a qualified Health professional, but cannot afford to live on Abstudy because of financial responsibilities and the future impact of a HECS debt. Individuals are also often required to forfeit their Abstudy allowance if they are recipients of scholarships. (sub. 82, p. 15)

Given the inter-relationships between training wages (generally the responsibility of the States and Territories) and income support and training support payments (mainly an Australian Government responsibility), such remuneration issues would need to be addressed at an intergovernmental level. However, in the Commission's view, they are issues that appear to warrant greater policy attention.

More evaluation is required

In sum, in seeking to improve Indigenous health outcomes through health workforce specific initiatives, the Commission supports the following directions:

- encouraging the further widening of scopes of practice for those providing services to Indigenous people;
- facilitating Indigenous workforce participation through giving greater recognition to prior learning and on-the-job training;
- providing increased health workforce education and training opportunities for Indigenous students in, or adjacent to, their communities; and

- ensuring that training wages, in conjunction with other support mechanisms, provide appropriate incentives for Indigenous participation in health workforce education and training.

That said, as in other areas of health workforce policy, there has not been a great deal of evaluation of the effectiveness of the various workforce-related approaches for achieving better Indigenous health outcomes. Hence, better evaluation of existing and proposed programs in this area should also be a high policy priority for the future. Indeed, there would be value in encompassing the evaluation of Indigenous programs within the broader evaluation initiative that the Commission has proposed for rural and remote health workforce policies (draft proposal 10.2). And that evaluation could draw on the extensive overseas experience with providing health care services to Indigenous groups — subject to the caveat on the extent to which it is possible to translate such experiences across countries.

11.3 Mental health

Mental health disorders are the leading cause of disability burden in Australia, accounting for about 27 per cent of the total years lost to disability. Mental health problems and mental illness will affect more than 20 per cent of the adult population in their lifetime and between 10 and 15 per cent of young people in any one year. This is associated with significant social, individual and economic costs (DOHA 2005b).

Prevalent mental health disorders include:

- affective disorders (such as depression, mania and bipolar affective disorder);
- anxiety disorders (such as panic disorder, agoraphobia, social phobia, obsessive compulsive disorder and post-traumatic stress disorder); and
- substance abuse disorders.

The Royal Australian and New Zealand College of Psychiatrists said that, while most mental illness is treatable, people with mental illness often face stigma and discrimination. For a proportion of patients, it is chronic, disabling, and affects all aspects of life. Moreover, sufferers may require significant assistance in relation to work, family and accommodation, and for related matters such as drug and alcohol problems (sub. 79, pp. 1–3).

Mental health services are delivered in a variety of settings, including general practice, private psychiatrists, private and public psychiatric and general hospitals and community mental health services. Total spending on these services in 2001-02 was around $3.1 billion, an increase of about 65 per cent since 1992-93. Funding

responsibility is essentially shared between the Australian (37 per cent of the total in 2001-02) and State and Territory Governments (58 per cent), though there is a small contribution from private heath insurance funds (around 5 per cent) (sub. 79, p. 3).

Over the last decade, there have been significant changes to the delivery of mental health care that have led to the deinstitutionalisation and mainstreaming of mental health services into general health services. These changes have been guided by the National Mental Health Strategy (NMHS) — a reform framework endorsed by all jurisdictions in 1992, and updated since (box 11.5). A central element of the Strategy has been an expansion of treatment and support services in community-based settings. As a result, the share of funds allocated to community-based mental health services increased from 29 per cent of the total in 1992-93 to 51 per cent in 2001-02.

Box 11.5 **The National Mental Health Strategy**

In 1992, Health Ministers agreed to a National Mental Health Policy, to be implemented under a five-year National Mental Health Plan, to coordinate mental health care reform nationally. It focused on State and Territory public sector services and specialist mental health services. It decreased reliance on stand-alone psychiatric hospitals, 'mainstreamed' acute beds into general hospitals and increased the emphasis on community-based services, including residential accommodation.

Whereas the first plan focused on severe and disabling low-prevalence illnesses, particularly psychoses, the second (1998) was broadened to encompass high-prevalence illnesses, such as depression and anxiety disorders. It also added a focus on mental health promotion and mental illness prevention, and on how the public mental health sector could best dovetail with other areas such as private psychiatrists, general practitioners, the general health sector, emergency services and non-government organisations.

The third plan — the National Mental Health Plan 2003–2008 — builds on the work of the two previous plans, and provides an ongoing agenda for mental health services. Its broad aims are to:

- promote the mental health of the Australian community;
- prevent, where possible, the development of mental disorder;
- reduce the impact of mental disorder on individuals, families and the community; and
- assure the rights of people with mental disorder.

Source: DOHA (2005b).

A range of specific policy initiatives has also been introduced in this area, including initiatives to support GPs in primary mental health care (in recognition that most

people seeking help for a mental disorder generally approach their GP, rather than a specialist mental health professional). For example, the *Better Outcomes in Mental Health Care* initiative provided for education and training for GPs to treat patients in primary care settings, financial incentives, allowing MBS rebates for the services of some allied health professionals (such as psychologists and social workers) where referred by a GP, and more support for psychiatrists (Australian Government 2001).

However, the Royal Australian and New Zealand College of Psychiatrists argued that the main barrier to the provision of effective treatment to those requiring specialist interventions is their inability to access service responses appropriate to their needs or in a timely manner.

> We currently have services that are significantly under-funded for the needs of the community, with service components that are significantly disintegrated, and … workforce shortages with inadequate strategies to meet workforce needs in terms of both numbers and skills. (sub. 79, p. 2)

The Mental Health Council of Australia went further, saying that 'countless reviews and reports' have identified a 'crisis' in mental health care in Australia (sub. 162, p. 2).

Mental health workforce

The wide-ranging changes in the financing and structure of mental health services are also reflected in the composition, size and distribution of the workforce. The main professional disciplines (other than general practice) that make up the bulk of the mental health workforce are psychiatry, nursing (including a mental health specialty), psychology, social work, occupational therapy, other allied health occupations and Aboriginal and Torres Strait Islander Mental Health Workers. In 2002, there were just under 3000 practising psychiatrists (80 per cent of the total) and psychiatrists-in-training (20 per cent) in Australia. This represented an increase of about 16 per cent since 1998 (AIHW 2005b, pp. 193–195). There were also around 12 000 specialist mental health nurses in 2001 and approximately 7600 clinical psychologists, an increase of 44 per cent since 1996 (AIHW 2005b, pp. 199–200).

Since the commencement of the NMHS, the size of the public sector clinical workforce (medical, nursing and allied health) has risen by 25 per cent, with expansion of ambulatory and residential services accounting for the entire increase. There has also been a shift in staffing mix, with medical and allied occupations increasing their workforce share from 26 to 34 per cent in the decade to 2001-02. Reflecting the shift from hospital to community-based practice, the nursing share of

the workforce (the bulk of which comprises registered nurses) has declined to around 63 per cent.

Mental health workforce issues

The main workforce issues in the mental health area involve shortages, geographic distribution and ageing. For example, an AMWAC study into the psychiatry profession noted that the overall supply of psychiatrists was inadequate and that shortages existed in all geographic areas other than capital cities. (In 2002, 85 per cent of psychiatrists worked in a major city.) Access to both private and public sector psychiatrists was seen as inadequate in both urban and rural locations, with AMWAC also observing that future supply would be affected by the cohort of psychiatrists aged 55 years and over proceeding through to retirement and the comparatively large and increasing representation of female psychiatrists working on a part-time basis (AMWAC 1999, p. 7).

Shortages of mental health nurses and some allied health professions have also been identified (see, for example, SCAC 2002, p. xiii and AHWAC 2003, p. 8). AHWAC attributed difficulties in recruiting and retaining qualified and experienced mental health nurses to a range of issues including:

- lack of awareness and negative views of the mental health sector;
- shortcomings in education programs (for example, removal of direct entry psychiatric nursing programs leading to a decline in new entrants to mental health nursing);
- workplace issues (including pay and working conditions);
- regulation/accreditation difficulties; and
- the lack of ease and affordability of re-entry (including access to relevant training programs).

Participants' views on problems and solutions to mental health workforce issues

While acknowledging some of the recent initiatives in the mental health area, a few submissions questioned their effectiveness. Commenting on the increased support for GPs to treat mental illnesses, the Australian Psychological Society (APS) said:

> Although the involvement of GPs in managing mental health disorders has been significantly enhanced by the recent Better Outcomes in Mental Health Care (BOMHC) initiative, funding for this initiative is capped and access to the program is limited to

> GPs who have undergone training for the program. Of the 32,000 GPs in Australia, only 12 percent are currently involved in BOMHC. (sub. 118, p. 18)

The Mental Health Council of Australia said that 'deinstitutionalisation' in mental health and the closure of long-term mental health institutions have not been matched by increased funding for community service and support. In its view:

> … chronic under-funding has undermined the success of [the National Mental Health Strategy] process over the last 13 years. … Compounding this problem have been rising prevalence rates, increasing case complexity and rising drug and alcohol use. (sub. 162, p. 2)

It further stated that, as a result, the process had been undermined and this is increasing pressure on the mental health workforce.

> There is an increasing number of clients and a decreasing number of beds and staff (in terms of FTE hours worked). There is a paucity of community-based services and these are often not properly resourced. This leaves them ill-equipped to share the burden with acute care service providers. (sub. 162, p. 2)

As well as increased funding, the Council called for job redesign to allow for the more efficient use of the existing workforce:

> Consideration should be given to where improved role definition (and redefinition) can make better use of the current workforce across both the mental health and community sectors. (sub. 162, p. 6)

The APS noted that the existing psychology workforce was underutilised in both the public and private sectors and that there was significant scope for substitution between the relevant professional groups. It suggested that extending the BOMHC program to accredited psychologists (through access to the MBS) would ameliorate both the extent of workforce shortages and maldistribution problems, as the psychology workforce was more geographically dispersed (sub. 118, p. 18).

Others focused on the contribution to nursing workforce shortages of changes in education and training arrangements and the shift to community-based care. The New South Wales Mental Health Co-ordinating Council said:

> In NSW the demands for a skilled workforce for the sector have been further complicated by the simultaneous move from institutional to community care, occurring since the mid '80s, with the move from hospital based to university based training for nurses, who were previously the main workforce in mental health. Currently nurses trained at university receive a generic qualification and, with a few exceptions, those wanting to specialise in mental health need to undertake post graduate 'user pays' training. Similar processes have occurred in psychology, social work and occupational therapy. This has led to a shortage of trained mental health workers available for care of people with a mental illness living in the community. (sub. 125, pp. 4–5)

The School of Nursing at the University of Melbourne highlighted the lack of clinical exposure to specialist nursing environments as a contributor to problems of mental health nurse recruitment:

> Undergraduate curricula are typically compressed with little flexibility and little choice of clinical places. As a consequence there is a lack of exposure of undergrad nurses to specialised areas such as mental health, operating room and paediatric settings due to rigidity of mandated clinical component in curriculum from regulatory authorities and low availability of clinical places. (sub. 150. p. 2)

The New South Wales Government said that, following the success of its 'Nursing Re-Connect' program that commenced in 2002, for nurses who have been out of the workforce for some time:

> A Mental Health Nursing Re-Connect was launched in April 2005. The mental health nurse recruitment strategy includes orientation programs; scholarships for further study; flexible rostering, mentoring, clinical skills updates and professional development. (sub. 178, p. 56)

The Royal Australian and New Zealand College of Psychiatrists highlighted the negative view of the mental health sector as a major contributor to workforce shortages and called for improvements in the mental health sector generally and changes to funding arrangements specifically (such as increasing the MBS rebate) to provide incentives to enter the specialty:

> Recruitment levels are influenced by the marginalisation of the specialty within medicine and by the stigma associated with the profession and mental illness — these are specific issues facing psychiatry as a discipline, which impact on the status and desirability of the profession. Much of this is a direct result of under funding, system dysfunction and chronic workforce shortages, and improvements in the mental health system are necessary to combat psychiatry's unattractiveness as a career. (sub. 79, p. 2)

The College also drew attention to the key role of Aboriginal and Torres Strait Islander Mental Health Workers, noting that their current status and career structure is 'poorly defined', and that there needs to be a more effective career structure for this group (sub. 79, attachment no. 2, p. 2).

11.4 Aged care

Aged care services play a central role in the delivery of health care services in Australia. Aged care covers a number of services ranging from those provided in residential aged care facilities and acute hospitals, through to community health services such as home and community aged care programs (eg home-help, home nursing services, and home and centre-based respite care). In recent years, deliberate policy initiatives have resulted in a marked shift in the balance between

these alternative care streams toward the delivery of services in community-based settings. In 2002-03, around 218 000 people received either permanent or respite residential care, while 731 000 received care through home and community care programs.

Arrangements for the provision of aged care are complex and varied with all tiers of government involved either as regulators, providers or both. Providers comprise private sector entities, local and state governments and a range of not-for-profit groups such as charitable and religious organisations. The total cost of supplying formal aged care services (residential care services, community care packages and Home and Community Care) was $7.8 billion in 2002-03 (two thirds of which was accounted for by labour costs). This represented a little over 1 per cent of GDP. Reflecting Australia's ageing population profile, this share is expected to double over the next four decades (Hogan 2004, p. 131).

Aged care workforce

The aged care sector is a major employer in the Australian economy with approximately 131 000 people (or 1.3 per cent of the workforce) employed in the aged care industry in June 2000 (the latest available ABS data), as well as 33 000 volunteers (Hogan 2004, p. 219). The bulk of the paid workforce is made up of personal care workers. In addition, in 2003, there were estimated to be some 2.6 million carers (some of whom have access to a carers allowance), who provided help for those needing assistance due to age or disability (ABS 2004).

The employed aged care workforce has undergone considerable adjustment over the last decade in response to government policy initiatives, industry growth, a changing consumer profile and the dynamics of the nursing workforce. For example, the number of employees in the residential aged care sector (which accounts for 20 per cent of total industry employment) fell by around 5 per cent in the five years to June 2000. Over the same period, the share of employment accounted for by registered and enrolled nurses has declined, while the use of personal care assistants has increased significantly. These changes reflect both the growing shortage of nursing staff and the development of more efficient workforce structures (Hogan 2004).

Current workforce issues

There have been longstanding concerns about the size, skill mix and availability of aged care workers — particularly in regard to nursing staff. A number of recent reports have reinforced these concerns. For example, the Senate Community Affairs

Committee Inquiry into Nursing identified aged care as the area of nursing in greatest crisis, experiencing an acute shortage of nurses and increased use of unregulated workers that has impacted on the quality of care (SCAC 2002, ch. 4). Also, submissions to the House of Representatives Standing Committee inquiry on *Future Ageing* from aged care providers referred to difficulties in obtaining regular and reliable GP and allied health services in residential care homes (HRSCOHA 2005, p. 167).

The Hogan Report noted that:

> … [the] residential care sector faces significant workforce issues that need to be addressed in the near future if the quality of care in residential care services is to be maintained. (Hogan 2004, p. 221)

According to that report, these include:

- the general shortage of trained nursing staff, which is greater in the residential care sector than in other areas of the health system;
- specific barriers to recruitment, retention and re-entry to the aged care workforce (including pay structures, working conditions, lack of career opportunities and poor sector image);
- the ageing of the aged care sector's nursing workforce;
- differences between the States and Territories in the regulatory frameworks governing training, medication management and employment conditions; and
- the changing profile of consumers of residential aged care services, with implications for the nature and extent of the demand for future services and the composition and skills mix of the workforce.

In its response to that report, the Australian Government recently announced a package of measures under the *Investing in Australia's Aged Care: More Places, Better Care* (Bishop 2004). This provides additional funding over four years to support a range of workforce measures, including increased education places for registered and enrolled nurses and community/personal care workers, skill upgrading for existing aged care workers and higher payments to aged care providers to reduce pay discrepancies between aged care and other health services.

A National Aged Care Workforce Strategy (DOHA 2005a) has also been developed (focusing on the residential aged care sector) to address many of these issues through a range of specific strategies covering workforce supply, workforce education, training and recruitment, and workforce retention — while also aiming to enhance the safety and desirability of the aged care sector as a place to work.

Participants' views on problems and solutions to aged care workforce issues

While acknowledging the recent policy initiatives in the aged care workforce area, a number of participants questioned their ability to fully overcome current problems. Accordingly, many proposed additional measures build on these recent changes. The COTA National Seniors Partnership, for example, said:

> Through the package *Investing in Australia's Aged Care: More Places, Better Care*, the Government has allocated funding to increase nursing places in universities and other education and training facilities. There will be 1,203 aged care nursing places to universities by 2008, commencing with 440 from next year. The question is — will this be sufficient to meet the demand for nurses in aged care? (sub. 123, p. 12)

It saw an increased reliance on unpaid carers as inevitable and called for additional government financial assistance to provide encouragement for those carers:

> With increased pressure and need for unpaid carers due to the rapid growth in the number of people needing care and the fact that the health and aged care system is not meeting existing demand, it is obvious that appropriate and encouraging government policy needs to be in place to provide assistance and incentives to unpaid carers so as to maximise the resource that this group are currently injecting into the economy and community. (sub. 123, p. 10)

The Aged Care Association of Australia contended that workforce shortages across medical, nursing and allied health professionals are the result of both the poor image of aged care work and inappropriate remuneration arrangements. While acknowledging recent initiatives to support GPs and allied health professionals in aged care, it suggested workforce problems could be further ameliorated by, for example: funding salary-based (as opposed to Medicare-based) GP services to the aged care industry; expanded roles for enrolled nurses and personal care assistants; and designating aged care as an 'area of need' to promote the development of nurse practitioners in the industry.

Aged and Community Services Australia focused on nursing shortages and the need to reduce wage differentials with nurses operating in hospital-based settings. It argued that current funding for aged care 'does not enable this wages gap to be closed' (sub. 64, p. 2). It also called for attention to be given to skills mix issues in the specific context of aged care to address the inadequacy of nurse availability under current models of care.

11.5 People with disabilities

Around 20 per cent of the Australian population suffered some form of recognised disability in 2003 — up from 15 per cent two decades earlier (ABS 1999, 2004). The main disabilities are attributable to intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury, or some combination of these. People with a disability receive specialist support services ranging across accommodation services (in hostels, group homes and institutions), community support and access programs (including case management and counselling), disability-specific employment services and advocacy support, together with informal care and assistance from family and friends in home-based environments.

The third Commonwealth State/Territory Disability Agreement (CSTDA) — which operates over five years to 2006-07 and currently involves a total financial commitment of $16.7 billion — provides the national framework for the delivery, funding and development of specialist disability services for people with disabilities (FaCS 2005a). Under the three agreements signed so far (the first in 1991):

- the Australian Government has responsibility for the planning, policy setting and management of specialised employment assistance;
- State and Territory Governments have similar responsibilities for accommodation support, community support, community access and respite; and
- there is shared responsibility for support for advocacy and print disability.

Disability support services provided under the CSTDA accounted for some $3.3 billion in government expenditure in 2003-04 and provided assistance to around 188 000 people. More than half of this amount was spent funding accommodation services (Australian Healthcare Associates 2005, pp. 9, 53, 58).

Over the last two decades, there has been a significant increase in the share of accommodation services provided in community-based as opposed to institution-based settings. Accordingly, the States and Territories now provide the bulk of direct funding for specialist disability support services (just over 70 per cent of the total in 2003-04). Based on data for the period January to June 2003, around 53 per cent of users of CSTDA services had an intellectual disability and 47 per cent had an intellectual disability as a primary disability (SCRGSP 2005b, p. 13.9).

A statement of principles that guide government policy is contained in the Commonwealth Disability Strategy, a strategic framework intended to ensure that people with disabilities can participate in Government policies, programs and services (box 11.6).

However, this Strategy is not intended to deal with broader matters such as disability workforce issues. The National Health Workforce Strategic Framework fulfils that role for the health workforce generally (chapter 3). Nevertheless, the Commission considers there may be merit in the development of a specific disability workforce strategy, which could subsequently be incorporated into the National Health Workforce Strategic Framework.

Box 11.6 **The Commonwealth Disability Strategy**

This strategy was launched in 1994 to provide a ten-year planning framework to help Australian Government agencies ensure that their services, programs and employment opportunities are accessible to people with disabilities. This is intended to:

- promote acceptance that people with disabilities have the same rights as others in the community;
- identify and remove barriers in program development and delivery;
- eliminate discriminatory practices in employment and program administration; and
- develop plans, strategies and actions to ensure planning and service delivery takes account of the needs of people with disabilities.

The Strategy is based on the following principles:

Equity — people with disabilities have the right to participate in all aspects of the community, including the opportunity to contribute to its social, political, economic and cultural life.

Inclusion — all mainstream Australian Government programs, services and facilities should be available to people with disabilities. The requirements of people with disabilities should be taken into account at all stages in the development and delivery of these programs and services.

Participation — people with disabilities have the right to participate on an equal basis in all decision-making processes that affect their lives.

Access — people with disabilities should have access to information in appropriate formats about the programs and services they use.

Accountability — all areas of Australian Government organisations should be clearly accountable for the provision of access to their programs, facilities and services for people with disabilities. This includes specifying the outcomes to be achieved, establishing performance indicators and linking reporting on outcomes of the Strategy to mainstream reporting mechanisms.

The Strategy was revised in 1999, and is currently being further evaluated to assess its effectiveness and the progress that has been made in removing barriers for people with disabilities.

Source: FACS (2005b).

Disability workforce

The provision of disability services requires a mix of practitioners from the health and community services sectors, and also relies heavily on volunteer carers.

A number of medical practitioners and allied health professionals may be involved in the treatment of people with disabilities, including specialists in rehabilitation medicine, general practitioners, nurses, dieticians, speech pathologists, neurologists, psychiatrists and home-care workers.

As noted earlier, there were, in 2003, estimated to be some 2.6 million carers (some of whom have access to a carers allowance) who provided help for those needing assistance due to age or disability (ABS 2004).

Disability workforce issues

To the extent that many people with disabilities are treated in the general health system, shortages in the numbers of general practitioners, nurses and allied health professionals will impact on their treatment. Shortages have specifically been reported in the number of rehabilitation specialists (although this is based on 1997 data).

Approximately 40 per cent of people with intellectual disabilities also have mental health conditions. Accordingly, the shortage of psychiatrists and other mental health professionals (mentioned earlier) has an impact on a significant cohort of people with disabilities.

Participants' views on problems and solutions to disability workforce issues

Participants commenting on disability workforce issues concentrated on workforce shortages, problems with education and training arrangements and inappropriate payment mechanisms for service providers. While the comments related to the specific area of intellectual disability, it was noted that the arguments had equal relevance to other disabled groups.

The Australian Association of Developmental Disability Medicine said that current education and training programs do not provide the necessary skills required to effectively treat people with developmental disabilities and that a medical speciality in intellectual disability is required (as has occurred in some other countries) as well as specialist skills for allied health workers and nursing staff. It said:

> While inroads have been made in the education of medical students in some medical schools with the establishment of centres (Centre for Developmental Disability Health Victoria, Queensland Centre for Intellectual and Developmental Disability, the Centre for Developmental Disability Studies in NSW and more recently the Centre for Intellectual Disability Health in South Australia) there is a need to have more input into the undergraduate programs in the other states and territories and there remain real gaps in post graduate training. Two important groups in the delivery of health services to adults with intellectual disability; General Practitioners … and Psychiatrists … while indicating that they would like to better service the needs of this group have acknowledged gaps in their own training. (sub. 114, p. 2)

It went on to comment on the adverse impact of fee-for-service funding arrangements for GPs on their constituents, saying:

> Even with appropriate training, medical practitioners are concerned if they demonstrate an interest they will be overwhelmed by a group with complex health needs and support structures that demand more time and would therefore be severely financially disadvantaged in a system that rewards more frequent and shorter consultations. (sub. 114, p. 3)

The NSW Council for Intellectual Disability referred to shortages in the availability of specialist services for the intellectually disabled, citing research showing there were only 5 to 6 full time equivalent psychiatrists specialising in this area in 2002. It said there needs to be:

> … an enhanced availability of psychiatrists and other mental health professionals with particular expertise in intellectual disability. (sub. 73, p. 5)

It also commented that:

> … there is currently very limited education at a tertiary level on the health needs of people with intellectual disabilities. (sub. 73, p. 3)

The Council also noted that specialist psychiatric and mental retardation nursing courses previously offered in New South Wales had been merged into general nursing courses.

11.6 Concluding comments

While several submissions provided useful information on the special needs areas covered in this chapter, the Commission has not had time to examine in detail many of the specific health workforce issues that arise in mental health, disability and aged care, in both institutional and community settings.

However, it is conscious that people requiring these services face particular health problems and that there are health workforce issues that need examining. Moreover,

there are some common themes in each of the above areas of special need. Among these are the typically poor health status of many in these groups, the need for more flexible job design and perhaps wider scopes of practice, and a corresponding case for enhanced education and training arrangements and better career paths for some health workers.

The higher level institutional, procedural and funding changes proposed in this report should move workforce arrangements at least partly in the direction that some participants have been suggesting, and should thereby help to underpin better outcomes in these areas. But some other concerns of participants, particularly those that relate to funding levels, would have significant implications for the broader health system and are outside of the scope of this workforce-oriented study.

In the Commission's view, the broader institutional frameworks in the health workforce system should explicitly provide for consideration of special needs issues. This should help to promote complementarity between the specific policies for these groups and more general health workforce arrangements. The Commission has made a specific proposal (draft proposal 11.1) to help ensure that special needs issues are in fact addressed in this way.

12 After hours GP services and other matters

Key points

- There has been a range of initiatives to improve access to after hours primary health care services — including the establishment of GP clinics in or adjacent to hospitals.
- Their efficiency and effectiveness is still largely to be determined. Accordingly, there should be continued experimentation with, and evaluation of, alternative delivery models.
- For a variety of reasons, including the absence of a user charge, some patients will continue to use emergency departments for some of their primary care needs.
- However, the relationship of after hours services provided by GPs in or near hospitals and acute care can only be properly resolved within a broader review of intergovernmental financial responsibilities for primary and acute care.
- Policy settings in a range of other areas will influence the efficiency and effectiveness of future health workforce arrangements. Key areas include medical indemnity and general labour market arrangements; and migration, taxation and superannuation policies. And reforms to enhance the efficiency of Australia's transport and communications infrastructure will help improve access to health services in rural and regional Australia.

12.1 After hours GP services

In the past, after hours primary care was typically provided by GPs through home visits, rostered after hours services and locum services.

But that care model is changing, with many GPs becoming increasingly reluctant to provide 'own-practice' after hours care. For example, a greater emphasis has been placed on deputising services, with nearly 60 per cent of after hours primary care in inner metropolitan areas now provided this way (DOHA 2002).[1]

[1] Deputising services are generally defined as after hours and related services that are provided by doctors as their sole function. In contrast, locum work involves filling a temporary vacancy in the absence of a doctor, and performing their normal duties, both during and out of normal working hours.

This shift has been attributed largely to the general trend towards reduced working hours, reinforced by the ageing and feminisation of the GP workforce (chapter 2). In metropolitan areas in particular, concerns about safety and limited access to locums are also dissuading GPs from providing these services (Victorian Government, sub. 155, p. 55).

The request in the Commission's Terms of Reference for advice regarding after hours care is narrow — to provide advice on the issue of GPs in or near hospitals after hours, including the relationship of services provided by GPs and acute care. There appears to be two considerations underpinning the request for advice on this matter:

- The reduced availability of after hours GP services in some parts of Australia, including outer metropolitan areas, may be contributing to increased low acuity presentations at emergency hospital departments. There are concerns that such added pressure on emergency departments has been to the detriment of patients in genuine need of acute care.
- And there are intergovernmental financial implications associated with the provision of primary care services and acute care, given that the Australian Government provides MBS rebates for services provided by GPs, while the States and Territories operate public hospitals.

Evidence to support the contention that high acuity patients presenting at emergency departments are being disadvantaged is far from conclusive. Triaging protocols have been well developed, such that those with serious complaints almost always receive priority over those requiring less urgent primary care. Indeed, several participants argued that the major treatment 'blocker' for more seriously ill admitted patients in emergency departments is a shortage of public hospital beds to which they can have access (box 12.1).

That said, although the magnitude of the issue varies across regions, it is clear that increased presentations at emergency departments for often relatively minor primary care needs add to the already considerable pressures on these departments and those waiting in them. And whatever the precise impact on emergency departments and their patients, there is the underlying need to ensure the availability of adequate and cost-effective after hours primary care services and their provision in appropriate settings.

Box 12.1 **Impacts on emergency hospital departments**

Several State Governments commented on the increased presentations at emergency departments for after hours primary care. For example, the Victorian Government said:

> In many areas, particularly in the outer metropolitan suburbs, there are large numbers of patients attending hospital emergency departments who could be managed by a GP. These hospitals lie within recognised areas of GP shortage. Presentations are most noticeable in the out of hours periods and on week ends. (sub. 155, p. 55)

The New South Wales Government stated also:

> … public hospitals are increasingly wearing the brunt of decreased bulk billing rates and lack of access to general practitioners in the community. This reduces the ability to achieve efficient coordination of primary care for patients with chronic and complex conditions. (sub. 20, p. 6)

However, Family Care Medical Services, the largest provider of after hours services in Australia, said that in its experience in southern Queensland, there is no evidence that public hospital departments are overburdened by patients seeking GP-like services. While over 90 per cent of its after hours services are bulk billed, it experiences low patient demand during the week and only moderate demand on weekends (sub. 28, pp. 1-2).

Moreover, the impact of such presentations on waiting times and the treatment of those with more serious complaints was the subject of debate. For example, the Australasian College for Emergency Medicine said that most emergency department overcrowding is due to:

> … 'access block', which relates to the inability of admitted patients to access inpatient beds in a timely manner. (sub. 76, p. 8)

Similarly, Family Care Medical Services, said:

> … seriously ill patients (category 1, 2 and 3) are trapped in Emergency Departments awaiting the availability of a bed within the main public hospital and … these beds are taken up by chronically ill patients. … significant under funding and poor productivity in State hospitals blocks patients leaving the ED and accessing a State hospital bed. (sub. 28, p. 2)

What has been done to improve access to after hours services?

A range of initiatives has been introduced by governments and health service providers to improve after hours care in the community. Examples include new after hours clinics and the development of other cooperative arrangements amongst GPs. There are also specialist management companies providing fee-for-service administrative support to groups of practitioners delivering deputising GP and related services. And triaging arrangements by hospitals have been supplemented by use of telephone help lines, staffed by nurses, to help ensure that people do not unnecessarily access after hours services.

However, despite these policy initiatives, after hours primary care arrangements and the availability of such services are far from uniform across Australia.

For its part, the Australian Government has sought to facilitate better access to after hours care through increased financial support. For example, the Practice Incentive Program provides additional remuneration to GPs, or groups of GPs, providing own-practice after hours services (with remuneration tiered to reflect the level of own-practice involvement). The MBS schedule has also been amended to provide a loading to rebates for after hours GP attendances.

As well, the Australian Government has provided funding for experimental services, including through the After Hours Primary Medical Care Program (AHPMCP) (box 12.2). This program is designed to test the effectiveness of alternative approaches for providing after hours care and has financed trials of different care models, in a variety of locations — including GP services in or adjacent to hospitals (see below).

After hours GP services in or near hospitals

The provision of after hours primary health services through GP clinics located in or adjacent to hospitals is expanding. For example, the Australian Government, through its 2004-05 budget initiative *GP Services — Improving After Hours Access*, has provided exemptions from the *Health Insurance Act 1973* on a case-by-case basis to facilitate the establishment of up to 10 after hours co-located GP with assistance from the States. Through the exemptions, the clinics will be able to access Medicare rebates (sub. 159, p. 80). And, as noted above, this model of after hours care has also been subject to a national trialled assessment (box 12.2).

Participants expressed a variety of views about such clinics (box 12.3). Some said they provided tangible benefits for patients, for instance, by reducing waiting times for treatment and possibly allowing hospitals to better manage their acute care patients. Others, however, said that diversion of patients from emergency departments has often been low and there have been difficulties in attracting doctors to work in the clinics.

Box 12.2 **The After Hours Primary Medical Care Program (AHPMCP)**

The AHPMCP was introduced in 2001-02 with initial funding for $43 million over four years. However, it was recently announced that the program is to be extended for one year to 30 June 2006.

A range of after hours care models have been funded under the program, including:

- triaging services;
- GP after hours clinics;
- home visits; and
- patient transport arrangements.

These trials have generated some information on the efficiency and cost effectiveness of different approaches. For instance, an evaluation during the program's initial year of operation suggested that the most appropriate model depends very much on local circumstances, including the characteristics and attitudes of particular GPs and other relevant local service providers. However, that early stage evaluation was unable to shed light on the merits, from an access perspective, of government support for new models of care relative to increases in MBS rebates for after hours services.

Sources: DOHA (2002).

Further examination is required

The efficiency and effectiveness of these new health care models, including co-located GP clinics, essentially remains an open question. Some evaluation is already occurring — for example, the Department of Health and Ageing is presently undertaking an external evaluation of after hours care initiatives (sub. 159, p. 50). However, it is important that such evaluation gives appropriate emphasis to the comparative analysis of options, especially the merits of support for co-located GP clinics relative to changes to MBS arrangements for after hours services provided in community settings.

Box 12.3 **Participants' views about co-located GP services**

A range of comments were provided regarding the effectiveness of after hours GP services near hospitals. Family Care Medical Services said that such services can reduce the call on emergency departments (sub. 28, p. 1). This view was also shared by the Australian Healthcare Association, which said that co-located GP clinics in particular:

> … will reduce waiting times for emergency treatment and may take some of the pressure off staff in hospital emergency departments. GPs co-located in hospital emergency departments could also be used to better co-ordinate care between the hospital and the community care setting. (sub. 151, p. 12)

It added that, if implemented with the involvement of all stakeholders, and restricted to providing care after hours:

> … co-located clinics have the potential to provide benefits to both patients and doctors. For example, clinics could support multi-disciplinary care by enabling GPs, emergency staff and nursing staff working together to provide the most appropriate form of care to patients presenting to emergency departments. (sub. 151, p. 12)

The South Australian Government also said that there are benefits to emergency departments from the arrangement, including better management of acute care patients (sub. 82, p. 16). Specifically, its trial of co-located GP clinics (as part of the AHPMCP), revealed that:

- between 29 and 35 per cent of low triage patients presenting at hospital emergency departments after hours could also be treated by a GP if the services were available;
- outcomes for patients seeing the GP were equivalent to those seen in the emergency departments; and
- waiting times for low priority patients were reduced, and the arrangement allowed for improved management of more acute patients.

While the service was not continued beyond its trial period, the South Australian Government recommended further national development of a sustainable model of after hours GP care in hospitals.

The Victorian Government said of a new GP clinic, established under the Australian Government's recent expansion initiative, at the Northern Hospital:

> Initial evidence is that there is some diversion of emergency activity although no formal analysis has yet been carried out. Prior to the clinic opening recruitment of GPs had been identified as a major risk; in practice GP workforce has not been an issue. (sub. 155, p. 56)

While the Victorian Government supported the expansion of co-located clinics to other hospitals with high patient demand for primary care, it noted that another of its clinics established under the program, at the Sunshine Hospital, had not yet commenced operation due to an inability to attract GPs (sub. 155, p. 56).

(Continued next page)

Box 12.3 (continued)

The Australasian College for Emergency Medicine also raised the recruitment issue, alongside some other problems with the service model:

> a. The numbers of patients diverted from EDs are low (often only 1-2 patients per hour maximum), often at a high marginal cost.
>
> b. Difficulties finding experienced staff, who are often paid at a premium (often 2-3x the cost of ED staff, with a lot less responsibility and skills).
>
> c. A proportion of patients will still need to be referred to the ED, reducing the efficiency. (sub. 76, p. 9)

And the Department of Health and Ageing questioned the value of co-located GP clinics, especially in taking pressure off emergency departments:

> Early evidence suggests that while these clinics can provide a practical model for after hours services, they are not having a significant impact on easing ED pressure. Depending on how they are established, there is also the potential for negative impacts on the existing GP after-hours workforce and it is therefore important they are set up in cooperation rather than competition with existing providers. Given that this model represents only one of a number of models currently being examined, the Department does not consider there to be a strong case for specific initiatives to encourage more co-located clinics at this time. (sub. 159, p. 50)

How would changes in general funding arrangements help?

As noted above, the requirement for the Commission to provide advice regarding after hours care is seemingly in part to do with the intergovernmental financial arrangements for the provision of primary care services and acute care.

Under the current delineation of funding responsibilities, the Australian Government subsidises the costs of care provided by GPs, whereas the States and Territories provide a primary care service through the emergency departments of their public hospitals (subject to the operation of the Health Care Agreements).

The Australian Government's initiatives in relation to co-located GP clinics give effect to the principle, endorsed by CoAG in its recent communiqué (see chapter 1), that funds follow function — specifically, through the allowance for these clinics to access Medicare rebates, even when they are established with support from the States.

However, in terms of primary care services provided in emergency departments, there remains a broader issue as to whether the Health Care Agreements could be a vehicle for making explicit recognition of the Australian Government's financial responsibility for primary care in the community. Under such an arrangement, the

Australian Government would be effectively purchasing GP-like services from State and Territory public hospitals as part of its overall primary care strategy.

But, the various funding models being trialled are unlikely to alter the fact that some primary care will continue to be delivered in less efficient settings. People seek to access primary health care through emergency departments for a variety of reasons, including: a lack of timely access to alternative services (especially after hours); the availability of a broader range of services, such as X-rays and other diagnostic tests; and the provision of services without a user charge.

Therefore, the relationship of after hours services provided by GPs in or near hospitals and acute care can only be properly resolved within a broader review of intergovernmental financial responsibilities for primary and acute care.

12.2 The influence of policies in other areas

While this study is focussing on health workforce reform, policy settings in a range of other areas will have an influence on the efficiency and effectiveness of future workforce arrangements. Such areas include arrangements for medical indemnity, migration, taxation and superannuation.

Medical indemnity arrangements

Medical indemnity arrangements will continue to influence the health workforce — for example, affecting career choices, the distribution of health workers across the public and private systems and workplace practices.

There have been a number of policy measures to address the medical indemnity issue in recent times. Some of these measures, primarily introduced by the Australian Government, have been designed to improve the availability and affordability of insurance, and security of coverage (box 12.4). Others, such as State and Territory tort law reforms, have sought to reduce the number and cost of claims through, for example, changes to caps and thresholds on damages, limitations periods and practitioner standards of care.

Box 12.4 **Medical indemnity policy initiatives**

Recent medical indemnity policy measures introduced by the Australian Government include:

- *Premium Support Scheme* — funds 80 per cent of eligible doctors' medical indemnity costs if these exceed 7.5 per cent of their gross income. Doctors eligible under the scheme are those in 'high-risk' specialties such as neurosurgeons, obstetricians and procedural GPs.

  For procedural GPs working in rural areas, the scheme funds 75 per cent of the difference between their premiums and the premiums for non-procedural GPs working in similar circumstances. (Some States also provide additional subsidies for premiums for higher risk specialties, particularly in rural areas.)
- *High Cost Claims Scheme* — funds medical indemnity insurers for 50 per cent of all insurance payouts that exceed $300 000, up to the limit of the practitioner's cover.
- *Exceptional Claims Scheme* — covers doctors for claims that exceed their level of insurance. From July 2003, doctors must have cover of at least $20 million for the scheme to apply.
- *Run-off Cover Scheme* — a reinsurance scheme backed by the Australian Government that provides cover for eligible doctors who have ceased practice, either permanently or on maternity leave. The scheme is funded by a charge on medical indemnity insurers, which is then passed on to doctors through insurance premiums.

Sources: MIIAA (sub. 62); DOHA (sub. 159); Victorian Government (sub. 155).

Most consider that such reforms have largely addressed previous problems in the area. For example, the Medical Indemnity Industry Association of Australia (MIIAA) said:

> … the industry is sustainable, collecting enough capital to satisfy all future claims on a vigorous actuarial model.

It also noted, in relation to the costs of insurance, that:

> Premiums for medical indemnity cover have risen on average 245 per cent over the nine years to June 2004. In the last two years, since the majority of reforms, premiums have decreased. (sub. 62, p. 11)

The Victorian Government further commented:

> In Victoria, concern over medical indemnity has been greatly diminished through a number of initiatives introduced by both the Commonwealth and State governments. Indemnity is now less likely be a major factor in preventing practice, particularly for those practitioners working in rural locations. (sub. 155, p. 35)

However, indemnity issues may still have some adverse impacts on workforce productivity. For instance, the extent to which the indemnity environment leads to the practise of 'defensive medicine' can generate inefficiencies. Similarly, the costs and time taken to defend actions can often be considerable. Concerns about actions may also be counterproductive to an open evaluative culture within the health care sector.

Other relevant policy settings

Other policy arrangements likely to have a significant impact on the health workforce include:

- General labour market arrangements, such as those relating to industrial relations, that may variously help or hinder some specific health workforce reforms.
- Rules governing migration that will affect the scope for, and cost effectiveness of, supplementing locally trained health workers with those trained overseas.

Further to these, taxation policies will have an influence on the recruitment, participation and retention of health workers, as they do on the broader workforce. A particular example of a taxation benefit afforded to health professionals in the public system is access to Fringe Benefits Tax exemptions up to $17 000. The Victorian Government noted that this benefit is an 'important financial attraction' that assists to retain those workers in the public system (sub. 155, p. 34).

In conjunction with taxation arrangements, policies for superannuation will also affect participation incentives — influencing the timing of exits from the health workforce, as well as the opportunities for older health workers to continue to contribute in a part-time capacity.

And finally, in a broader sense, reforms to enhance the efficiency of Australia's transport and communications infrastructure will help to improve access to health services in rural and regional Australia.

APPENDIXES

A Inquiry processes and consultation

The Commission has sought to facilitate public participation in this study process, to the maximum extent possible.

- An initial circular, in March 2005, invited submissions from interested parties. To help in the preparation of submissions, the circular included a brief overview of relevant issues and some specific questions for interested parties to consider.
- A more detailed Issues Paper was published in early June 2005. Its purpose was to serve as a progress report to CoAG, while providing further guidance to participants in the preparation of their submissions by building on the topics and questions outlined in the initial circular.
- The Commission has consulted extensively with a wide cross section of interested parties in all States and Territories and visited a number of rural and remote centres and Indigenous communities. A listing of these visits and informal discussions is provided below.
- The Commission received almost 180 submissions prior to the release of this Position Paper. These submissions are also listed below. All public submissions may be read on the Commission's website.

The Commission thanks all those who have contributed to date to the study and looks forward to receiving further comment on its analysis and draft proposals.

Visits and informal discussions with interested parties

New South Wales

National Health Workforce Secretariat

Centre for Health Economics Research and Evaluation, University of Technology, Sydney

College of Health Sciences, University of Sydney

Clinical Research Unit for Anxiety and Depression

Community Services and Health Industry Skills Council

New South Wales Government — various departments

Victoria

Affinity Health
Australian Dental Council
Australian Physiotherapy Association
Borland, Professor Jeff
Duckett, Professor Stephen
Health Services Advisory Committee
Melbourne Institute of Applied Economic and Social Research
Monash University Department of Epidemiology and Preventive Medicine
Optometrists Association Australia
Victorian Government — various departments

Queensland

Australian College of Rural and Remote Medicine
Australian Rural Health Research Centre
Family Care Medical Services
Queensland Government — various departments
Rockhampton Health Service District
University of Queensland Medical School
Woorabinda Indigenous Community
Wronski, Professor Ian

Western Australia

Australasian Association of Clinical Biochemists
Kimberley Aboriginal Medical Services Council
Port Hedland Hospital (with video links to Tom Price, Mt Newman, Karratha, Paraburdoo and Carnarvon hospitals)
South Western Health Services
Tjalku Wara Aboriginal Community
WA Country Health Service
Western Australian Government — various departments

South Australia

Australian Research Centre for Population Oral Health

Kearney, Professor Brendon

National Centre for Vocational Education Research

Nurses Board of South Australia

South Australian Government — various departments

Tasmania

Alexander, Dr Graeme

Calvary Private Hospital

Ramsey, Mr John — Australian Health Workforce Officials' Committee

Tasmanian Government — various departments

University of Tasmania School of Medicine

Australian Capital Territory

Access Economics

ACT Government — various departments

Australian Competition and Consumer Commission

Australian Council of Physiotherapy Regulating Authorities

Australian Government — Education, Science and Training; Health and Ageing; Prime Minister and Cabinet

Australian Institute of Health and Welfare

Australian Medical Association

Australian Medical Council

Australian Nursing Federation

Catholic Health Australia

Consumers' Health Forum of Australia

Council of the Ageing / National Seniors

General Practice Education and Training

National Rural Health Alliance

Pharmaceutical Society of Australia

Pharmacy Guild of Australia

Royal College of Nursing Australia

Rural Doctors Association of Australia

Northern Territory

Menzies Health Research Institute

Northern Territory Government (by video conference) — various departments

Tiwi Islands Indigenous Community

Roundtables

Allied health professionals roundtable, Melbourne (18 May 2005)

This roundtable was held with the Health Professions Council of Australia and its member organisations, namely:

Audiological Society of Australia

Australian Association of Social Workers

Australian Institute of Radiography

Australian Physiotherapy Association

Australian Psychological Society

Australasian Podiatry Council

Dieticians Association of Australia

Orthoptic Association of Australia

OT Australia

Society of Hospital Pharmacists of Australia

Speech Pathology Australia

Professional colleges roundtable, Sydney (18 May 2005)

This roundtable was held with the Committee of Presidents of Medical Colleges and its member Colleges, which are:

Australian and New Zealand College of Anaesthetists

The Australasian College of Dermatologists

The Australasian College for Emergency Medicine

The Royal Australian College of General Practitioners

The Royal Australasian College of Medical Administrators

The Royal Australian and New Zealand College of Obstetricians & Gynaecologists

The Royal Australian and New Zealand College of Ophthalmologists

The Royal College of Pathologists of Australasia

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Radiologists

Royal Australasian College of Surgeons

List of submissions

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ACT Health	18
ACT Government	177
Aged and Community Services of Australia	64
Aged Care Association of Australia Ltd	115
Alexander, Dr Graeme	23
Anderson, Moya	100
Australasian Association of Clinical Biochemists Inc	35
Australasian College for Emergency Medicine	76
Australasian College of Dermatologists	104
Australasian College of Physical Scientists and Engineers in Medicine	157
Australasian College of Podiatric Surgeons	131
Australasian Podiatry Council	88
Australasian Society of Cardiovascular Perfusionists	37
Australian and New Zealand Association of Physicians in Nuclear Medicine	168
Australian and New Zealand College of Anaesthetists	38
Australian Association of Developmental Disability Medicine	114
Australian Association of Pathology Practices Inc	111
Australian Association of Social Workers	116
Australian Association of the Deaf Inc	75
Australian College of Ambulance Professionals	145
Australian College of Midwives	99
Australian College of Non VR General Practitioner's Inc	128
Australian College of Rural and Remote Medicine	72

Submissions (continued)

Participant	*Submission number*
Australian Council of Deans of Health Sciences	67
Australian Dental Association Inc	103
Australian Dental Council	32
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Chamber of Commerce and Industry Western Australia	69
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Committee of Presidents of Medical Colleges	47
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Council of Deans of Nursing and Midwifery (Australia and New Zealand)	63
Council of Remote Area Nurses of Australia Inc	134
Council of Social Service of New South Wales	40
Cregan, Dr Patrick, F.R.A.C.S.	4
Department of Epidemiology & Preventive Medicine, Monash University	138
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Eggert, Marlene, RN	26
Faculty of Health Sciences, University of Sydney	39
Faculty of Medicine, Health & Molecular Sciences, James Cook University	5, 106
Family Care Medical Services (Australia) Pty Ltd	28
General Practice and Primary Health Care NT	132
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Gibbon, Professor Wayne	48
Harris, John	94
Health Professions Council of Australia	70
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Heinzle, Dr Erich	174
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Participant	*Submission number*
Joint Faculty of Intensive Care Medicine (ANZCA/RACP)	43
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Medical Training and Education Council of NSW	154
Melbourne Institute of Applied Economic and Social Research and Department of Economics	50
Menadue, John, AO	149
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National Rural Health Alliance and College of Medicine and Health Sciences, ANU	126
Neurosurgical Society of Australasia	117
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Participant	*Submission number*
Queensland Community Services and Health Industries Training Council Inc	102
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Queensland Nurses' Union	2, 80
Royal Australasian College of Medical Administrators	140
Royal Australasian College of Physicians	108
Royal Australasian College of Surgeons	148
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	112, 175
Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Committee	113
Royal Australian and New Zealand College of Ophthalmologists	33
Royal Australian and New Zealand College of Psychiatrists	79
Royal Australian and New Zealand College of Radiologists	78
Royal Australian College of General Practitioners	143
Royal College of Nursing, Australia	52
Royal College of Pathologists of Australasia	44
Royal College of Pathologists of Australia	122
Rural Doctors Association of Australia	46, 161
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School of Pharmacy, University of Queensland	169
Segal, Associate Professor Leonie	144
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Short, Ms Leonie M	124
Society of Hospital Pharmacists of Australia	60
South Australian Government	82
Speech Pathology Australia	53
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Strategic Planning Group for Private Psychiatric Services	147
Sturmberg, Associate Professor Joachim P	95
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Sydney South West Area Health Service	30

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Participant	*Submission number*
Tasmanian School of Medicine and Faculty of Health Science, University of Tasmania	101
Thompson, Dr Barrie G	167
Urological Society of Australasia	130
University of Adelaide Medical School Curriculum Committee	14
Victorian Government	155
Vision Group Pty Ltd	170
Wentworth-Walsh, D	68
Western Australian Government	179
Western Australian Local Government Association	86

B An overview of the current health workforce

Australia ranks relatively highly for several measurable health indicators, such as life expectancy and infant mortality (see table B.1) with total spending on health care as a percentage of GDP in line with many other (non-USA) OECD countries (see table B.2).

B.1 The health workforce

A snapshot

There were over 450 000 Australians employed in health occupations at the time of the 2001 Census accounting for around 5 per cent of the total workforce (AIHW 2004a). Of these, some 356 000 or just under 80 per cent were employed in health service industries (including aged and community care) with the remainder employed in other activities such as safety inspection, OH&S and retail pharmacy. In addition, some 200 000 non-health workers, such as clerks and service workers, were employed in the health service industries.

More than half of the health workforce (54 per cent) was employed in nursing occupations, with medical professionals (12 per cent) and the allied health professionals (eg physiotherapists, occupational therapists, podiatrists etc) (9 per cent) being the next most important groupings (see table B.1).

Health care is also provided by unpaid (informal) carers in community and family settings. Many of those with chronic illnesses or disability are cared for by family members or friends and relatives. There is also a sizeable volunteer workforce providing various community-based care services, such as first aid and support to hospital patients and aged care residents. Such care is often coordinated through St John Ambulance, Red Cross and other charitable organisations.

Table B.1 **Life expectancy and infant mortality, selected countries**

Male life expectancy at birth 2002		*Female life expectancy at birth 2002*		*Infant mortality rates per 1000 live births (latest available year)*	
Japan	78.4	Japan	85.2	Japan (1999)	3.7
Iceland	78.4	France	83.5	Finland (2000)	4.1
Sweden	78.1	Switzerland	83.4	Sweden (1999)	4.1
Australia	**77.9**	Spain	83.0	Korea, Republic (2000)	4.5
Switzerland	77.7	**Australia**	**83.0**	Czech Republic (2000)	4.6
Israel	77.4	Sweden	82.7	Norway (1999)	4.6
Singapore	77.4	Italy	82.5	France (1999)	4.8
Canada	77.2	Canada	82.3	Germany (1999)	5.0
Italy	76.7	Austria	82.1	Spain (1998)	5.2
New Zealand	76.7	Iceland	81.8	**Australia (2002)**	**5.4**
France	75.9	New Zealand	81.2	Canada (1998)	5.7
UK	75.8	UK	80.5	New Zealand (2000)	6.5
USA	74.6	USA	79.8	USA (1999)	7.7

Source: AIHW (2004a).

Table B.2 **Health care spending in selected OECD countries**

Country	*Health spending per capita, 2002*	*Health spending as a share of GDP, 2002*	*Real growth in health spending, 1992–2002*
	$A 000	%	%
Australia	**3.6**	**9.5**	**4.5**
Canada	3.9	9.6	3.2
France	3.7	9.7	2.7
Germany	3.8	10.9	2.3
Japan	2.8	7.8	3.8
Netherlands	3.6	9.1	3.5
New Zealand	2.5	8.5	4.9
Sweden	3.4	9.2	3.6
United Kingdom	2.9	7.7	4.1
United States	7.1	14.6	4.5
OECD-10 mean	3.7	9.7	3.7

Source: AIHW (2004b).

Australia's (paid) health workforce has been growing considerably faster than the population. Between the 1996 and 2001 Censuses, the health workforce increased by over 11 per cent, nearly double the population growth of around 6 per cent.

However, this growth was not uniform across the workforce. By occupation, the number of enrolled nurses grew more slowly than the population, the numbers of registered nurses and dentists grew at a slightly higher rate, while growth in the

allied and complementary health professions was four and five times the growth in population in this period, respectively (see table B.3).

Table B.3 **Health occupations, employed persons and rate of growth**

	2001	*Proportion of health workforce*	*Percentage change between 1996 and 2001*
	'000	per cent	
Registered nurses/midwives	174	38.7	7.3[a]
Enrolled nurses	19	4.3	2.7[a]
Nursing assistants/ personal carers	51	11.2	18.8
Medical professionals	52	11.5	12.6
Dentists	8	1.9	7.9
Dental technicians/assistants	18	3.9	12.5
Pharmacists	14	3.0	13.0
Allied health workers	39	8.6	26.5
Complementary health workers	9	1.9	29.6
Medical imaging workers	8	1.8	25.0
Medical scientists	11	2.6	16.8
Ambulance officers/paramedics	7	1.5	12.5
Other	41	9.1	30.2
Total	450	100	11.4

a Percentage changes between 1997 and 2003.

Sources: AIHW (2004a; 2005c).

By location, the health workforce is concentrated in the major cities, with the numbers declining the more rural and remote the location. This concentration is more pronounced amongst the more highly trained health workers. For example, the nurse to population ratio is broadly comparable across regions, whereas the distribution of medical specialists to population is heavily skewed towards major cities (see table B.4).

Key developments and trends

Workforce shortages in a number of areas

Though identifying workforce 'shortages' in the health care sector is not straightforward (see chapter 2), studies undertaken by a range of government agencies, government appointed committees and professional bodies have pointed to significant and growing shortages in many areas of the health workforce. For example, recent quantitative work undertaken by the Australian Medical Workforce

Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) pointed to:

- sizeable shortfalls in some medical specialties such as thoracic medicine, and medical oncology and haematology. By way of example, for thoracic medicine, the restoration of a 'balance' between demand and supply was projected to require an 85 per cent increase in training places, equivalent to 3.5 per cent of the existing thoracic medicine workforce;
- smaller shortfalls in other specialties, including anaesthesia and radiology — for anaesthesia the 'required' increase in training places was projected to be 7 per cent, equivalent to 1.5 per cent of the existing workforce; and
- a shortfall of nurses of around 2.2 per cent by 2006, requiring an additional 4000 graduates (an increase of 40 per cent over projected graduate completions).

Table B.4 **Geographical location of the health workforce, 2001[a]**
(percentage of the total occupational workforce)

Occupation	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*
General practice	73.0	18.2	7.4	1.0	0.3
Specialist medical	77.4	17.3	4.9	0.4	0.1
Nurses	65.8	21.5	10.3	1.6	0.8
Dental services	74.3	17.5	7.2	0.8	0.2
Optometry & optical dispensing	73.7	19.2	6.6	0.5	0.03
Physiotherapy	74.5	17.9	6.5	0.8	0.2
Distribution of Australian population	***66.3***	***20.7***	***10.4***	***1.7***	***0.9***

a More recent survey data (AIHW 2004a) indicates that in 2002, nearly 80 per cent of medical practitioners worked in major cities, with commensurately lower percentages working in inner regional and outer regional areas than are shown in the table.

Sources: AIHW (2003a; 2003b).

And in other health occupations, the Department of Employment and Workplace Relations (DEWR) has identified shortages of dentists, hospital and retail pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists and sonographers (DEWR 2005).

As well as overall shortages, there are even more pronounced shortages in rural and remote areas and in Indigenous communities, reflecting the concentration of many highly trained professionals in major cities (see table B.4). Thus, AMWAC and AHWAC have noted particular concerns in relation to access to GPs in rural and remote areas and the distribution of the available pool of gynaecologists and pathologists. Submissions from allied health groups to this study also said that shortages of many of these workers are particularly acute in rural and remote areas. For example, OT Australia said, 'OTs [occupational therapists] are underrepresented in rural and remote areas of Australia' (sub. 21, p. 6).

Some of these shortages are being ameliorated through increased use of overseas trained professionals (see below). More recently, there has also been an increase in the number of education and training places for health workers. For example:

- Medical school commencements of Australian citizens and permanent residents increased by 78 per cent (or more than 700 places) between 1996 and 2004 (AMWAC 2004).
- This has flowed through to specialist training where the number of specialists in training similarly increased by around 700 between 2000 and 2003 (a rise of 14 per cent) (AIHW 2005a).
- Nursing school commencements in 2004 were around 8800, some 10 per cent higher than in 2003 (but still below the levels of the mid to late 1990s). Moreover, the Australian Government has identified nursing as a national priority and is to provide an additional 1200 nursing places between 2005 and 2008 (AIHW 2005c, Bishop 2004b).

Also, there have been various initiatives to attract more health professionals to locate in regional areas (see chapter 10).

An older workforce

Like the wider workforce, the health workforce is ageing. Between 1996 and 2001, the proportion of the health workforce aged over 45 years increased from around 31 per cent to nearly 39 per cent.

The most rapidly ageing occupation was nursing where the proportion of the workforce older than 45 years increased from 29 per cent to 41 per cent over this period. In the medical workforce, the proportion of over 45 year olds increased from 41 per cent to 46 per cent, dentists from 39 per cent to 43 per cent, allied health workers from 27 per cent to 31 per cent and medical imaging workers from 21 per cent to 27 per cent (AIHW 2004a).

Such ageing is likely to have significant implications for the available pool of health workers in coming years. For example, according to work undertaken by the Australian Rural Health Research Collaboration (sub. 34), if the current large cohort of older or 'baby boomer' nurses retires at the same rate as previous generations, there is likely to be a very rapid attrition of the nursing workforce in the next 15 years. It also found that a similar scenario was facing the medical workforce, though not on the same scale — many doctors will still continue to work beyond the traditional retirement age (Australian Rural Health Research Collaboration, sub. 43).

Female dominated

The health workforce has traditionally been predominately female. In all health occupations, apart from medicine and dentistry, females account for the bulk of the workforce. For example, in 2001 females accounted for over two-thirds of the podiatry workforce, around three-quarters of the physiotherapy workforce and over 90 per cent of the occupational therapy and nursing workforces, the latter traditionally having been a female occupation (AIHW 2004a, sub. 21).

However, the traditionally male dominated health occupations of medicine and dentistry are becoming increasingly feminised. Females accounted for nearly 32 per cent of the medical workforce in 2003 up from 27 per cent in 1996. This trend will continue as females have made up around half of the medical school graduates between 1996 and 2001 (AIHW 2004c).

In dentistry, females accounted for just over a quarter of practising dentists in 2001, up from 21 per cent in the mid-1990s. As in medicine, this trend will continue, with females accounting for more than half of dentistry graduates since the late 1990s (AHWAC 2004a).

Some working fewer hours

The health workforce, on average, is more reliant on part-time workers than the wider workforce. For example, in 2001, nearly 40 per cent of the health workforce worked fewer than 35 hours, compared with 33 per cent in the wider workforce and more than half of the nursing workforce was working part time (AIHW 2003b).

More important has been the recent decline in average hours worked by medical practitioners. In 1996, 53 per cent of medical practitioners worked more than 50 hours a week, whereas by 2003 this had fallen to around 44 per cent. For female medical practitioners, who on average work fewer hours than their male

counterparts, the average working week declined from around 40 hours to 38 hours over the same period (AIHW 2005a).

Table B.5 **Medical and nursing workforce, key trends 1996–2003 and 1997–2003**

Medical workforce	*1996*	*2003*
Number of medical practitioners	43 756	56 207
Percentage female	27.6	31.9
Average hours worked	48.1	44.4
Average male hours worked	51.1	47.5
Average female hours worked	40.2	37.8
Percentage working 50 hours or more per week	53.0	43.7
Average age in years	44.9	45.6
Nursing workforce	*1997*	*2003*
Number of nurses (enrolled and registered)	264 086	282 546
Percentage female	92.7	91.4
Average hours worked	30.7	32.5
Percentage working 35 hours or fewer per week	52.0	50.0
Average age in years	40.3	43.1

Sources: AIHW (2003b, 2004a; 2005a).

This decrease in hours worked was reflected in a marginal decline between 1996 and 2002 in the full-time equivalent medical workforce from 278 to 271 practitioners per 100 000 population (Department of Health and Ageing, sub. 9). However, more recent data indicates that this situation may since have been reversed by the continuing increase in the number of practising medical practitioners as in 2003 the full-time equivalent medical workforce had increased to 279 practitioners per 100 000 population (AIHW 2005a).

A number of factors are contributing to the reduction in average working hours by medical practitioners. Some of these are common across the workforce as a whole, including a generational shift in attitudes to balancing work and other aspects of life, and an older workforce. Others are more specific to the medical workforce, including changes in the role of medical workers and their standing in the community, the introduction of safe working hours legislation, particularly for practitioners working in hospitals, and the increasing feminisation of the medical profession. Women, in particular, are more likely to want to work fewer hours to allow them to undertake family duties and are less likely to want to own their own practice and the longer hours this involves (DOHA, sub. 9).

That said, in overall terms, the greater feminisation of the medical workforce has not so far been the major driver of the decline in average hours worked. The

decrease in average hours worked by male medical practitioners has been much more important. However, the more even gender balance in new entrants to the medical workforce will continue to place pressure on the supply of medical services in the future.

In the second half of the 1990s, average hours in nursing were also declining. However, the latest data produced by the AIHW (2005c) indicates there was a sharp rise in the average hours worked by nurses in the 2001-2003 period. It is too early to say whether or not this is a reversal of the previous trend or merely a short term perturbation.

For the other health occupations, the trends in hours worked have been variable. For example, the proportion of pharmacists working more than 50 hours per week declined between 1996 and 2001. However, there was a modest increase for allied health professionals and medical imaging workers, and a substantial increase for dentists (see table B.6).

Increasing specialisation

There has also been a shift towards greater specialisation within the health workforce. For example, orthopaedic surgeons have become 'super specialised,' often focussing on specific joints such as knees or hips rather than the full range of orthopaedic surgery. Similarly, there has been a trend for nurses to become specialised in fields such as accident and emergency and intensive care, rather than in general nursing. This increased specialisation, particularly in the medical workforce, is one of the factors reinforcing the geographic concentration of health professionals in the major cities. That is, the more specialised the health profession, the more likely the practitioner will work in a major city where there is a large enough population to support such a practice.

Greater reliance on overseas medical practitioners

Australia's health system has become increasingly reliant on overseas trained doctors (OTDs). At present, OTDs make up around 25 per cent of the overall medical workforce compared to 19 per cent a decade ago (DOHA, sub. 159, AMWAC 1996b). The most important source of OTDs are those arriving on temporary resident visas who are increasingly being used in designated 'areas of need', or are in Australia undertaking vocational training (AMWAC 2004). In the decade to 2002-03, there was a fivefold increase in temporary resident doctor arrivals from around 670 to about 3000.

Table B.6 **Dentist, pharmacy, allied health and medical imaging workforce, key trends 1996–2001**

	1996	*2001*
Dentists		
Number of dentists	7604	8206
Percentage female	21.3	26.0
Percentage working fewer than 35 hours per week	23.8	23.1
Percentage working more than 50 hours per week	13.4	18.5
Percentage aged over 45 years	39.0	43.6
Pharmacists		
Number of pharmacists	12 311	13 911
Percentage female	47.6	51.9
Percentage working fewer than 35 hours per week	28.8	28.7
Percentage working more than 50 hours per week	25.1	23.8
Percentage aged over 45 years	43.5	41.6
Allied health		
Number of allied health workers	34 038	39 457
Percentage female	72.5	77.7
Percentage working fewer than 35 hours per week	41.1	39.8
Percentage working more than 50 hours per week	9.8	11.0
Percentage aged over 45 years	27.4	31.1
Medical imaging workers		
Number of medical imaging workers	6513	8141
Percentage female	67.9	69.2
Percentage working fewer than 35 hours per week	30.7	28.6
Percentage working more than 50 hours per week	5.8	7.9
Percentage aged over 45 years	21.6	27.6

Sources: AIHW (1996, 2003a), AHWAC (2004a).

By jurisdiction, Queensland, Western Australia and Victoria appear to be the most reliant on OTDs to fill vacancies in areas of need, primarily in regional general practice positions, locum services and some junior hospital positions. Collectively, around 80 per cent of the OTDs working on this type of visa in 2002-03 were located in these three states (Birrell 2004).

While there are overseas trained health workers practising in Australia in areas other than medicine, other health occupations are not generally as reliant on these workers to meet their workforce requirements (see box B.1).

Box B.1 **More on overseas trained health workers**

For several years, Australia has been relying on overseas trained health workers to meet shortages in the medical workforce. The attraction of using these workers is that it avoids the considerable time lag involved in educating and training new workers, thereby providing a more immediate response to these shortages.

There are a range of visas categories, both temporary and permanent, that can be used to bring overseas health workers to Australia. Permanent migration mainly occurs under the General Skilled Migration program, where certain health occupations have been allocated extra points in the migration points test to facilitate their entry (DIMIA, sub. 11).

However, temporary entrants account for the greatest proportion of health workforce professionals entering Australia. The most widely used form of entry is the separate visa for temporary resident doctors (TRDs), who enter Australia to work in medical positions designated as being an 'area of need' by the relevant State or Territory Health Authority. These doctors are granted conditional registration and can only gain access to Medicare rebates following a commitment to work in an area of workforce shortage. This allows State and Territory Governments to direct them to rural and regional areas through the conditions placed on their registration.

This visa category also enables overseas medical students who have completed a medical degree in Australia to remain in Australia to complete their internship.

In comparison with medical practitioners, the number of non-medical overseas trained health professionals entering Australia each year as a share of the health profession is very small (usually less than 2 per cent). For example, in 1999-2000 around 2000 nurses, 230 pharmacists and 70 dentists entered Australia, both on a permanent and temporary basis (SCAC 2000, AIHW 2003a). The respective workforces in these professions were around 193 000, 14 000 and 8000.

Australia's use of overseas health workers is also governed by an Australian Government Code of Practice for International Recruitment of Health Workers. This is intended to provide a framework within which international recruitment should take place to allay concerns that excessive recruitment of overseas health workers from developing countries will be detrimental to the development and the health of the population in these countries.

Changing models of care and scopes of practice

A variety of models of care have long been employed in Australia's health care system to meet the diverse care needs of patients. While some forms of care can be supplied by a single professional, others have always required a multidisciplinary approach. Similarly, there has been a blend of care provided in community, private and institutional settings.

However, the balance of the care mix has been changing and will need to evolve further in the future. The Commission was frequently told that a multidisciplinary approach to patient care involving close cooperation between medical practitioners, nurses, pharmacists and allied health professionals will become increasingly more important in the treatment of chronic disease, which is becoming a larger share of Australia's burden of disease (DOHA, sub. 9). In addition, the tightening general labour market, in conjunction with greater technological possibilities for arms-length care, is likely to see a greater emphasis on care provided in community settings.

In some cases, there has been a widening of scopes of practice, especially in rural and remote areas where lesser access to more highly qualified practitioners has put a premium on workforce flexibility and adaptiveness. But in other areas increasing specialisation has occurred.

The average per capita number of services provided has been increasing — for example, the average number of Medicare services provided per person per year increased from around 9 in 1990-01 to just over 11 in 2001-02 (AIHW 2004a). Such increased servicing trends have reflected amongst other things:

- technological changes that provide more treatment and diagnostic testing options; and
- concerns about medical liabilities which has encouraged practitioners to provide 'protective services'.

Problems with job satisfaction

Job satisfaction is reported to be low in a number of health professions and especially in rural and remote areas.

A number of causes for this have been put forward:

- A 2002 study of GPs pointed to relatively poor remuneration, often long working hours and increasing complexities of training, accreditation and administration (Access Economics 2002).
- Factors identified in a parallel study on the nursing workforce included rates of pay, safety, increased workload leading to stress and burnout, inappropriate nursing skills mix, insufficient recognition of skills and knowledge, occupational health hazards and a lack of accommodation and childcare (SCAC 2002).
- And in regard to practice in regional and rural areas, these studies gave particular prominence to the limited locum services; restricted access to peer support; fewer professional development opportunities than in the major

population centres; limited opportunities for spouses and children; inadequate accommodation; lack of remuneration commensurate to qualifications and the degree of isolation (Access Economics 2002).

- There have also been suggestions that some of the current problems with job satisfaction may relate to training and expectations that do not meet the reality of the workplace.

Such problems are likely to reduce productivity and impede quality. Also, to the extent that they lead to higher turnover rates and add to difficulties of recruitment, they may exacerbate any shortages in the number of health workers.

That said, job satisfaction problems are not uniformly evident across the health workforce. For example, satisfaction amongst the allied health professions is believed to be generally high, although there are some concerns in relation to being 'overworked and undervalued' by the system (Sydney South West Area Allied Health Service, sub. 30).

Moreover, it is not clear that job satisfaction is any worse than it was in the past, is worse in the health area than in other parts of the workforce, or that it increases the rate of exits from the health workforce.

- Based on responses to a Household, Income and Labour Dynamics in Australia (HILDA) survey, while nursing professionals had the lowest level of overall job satisfaction among the professional groups encompassed in the survey, those classified as other health professionals had the highest overall level of job satisfaction (Webster, Wooden and Marks 2004).
- The available evidence suggests that while medical and allied health professionals are changing employment within the profession, few are exiting the profession for reasons other than age. In the case of nursing, while a large percentage of nurses leave the profession within the first year of graduating, the exit rates decline rapidly with increasing lengths of employment.

B.2 Influences on the health workforce

Australia's health system is complex with a wide range of service providers and an array of funding and regulatory mechanisms in place. There are also various pathways for gaining qualifications to practise as a health professional.

- Private and public providers of health services operate in both primary and acute settings, as well as in aged care.
- Funding is provided by the Australian Government, State and Territory Governments, health insurers and private individuals.

- Most health professions are regulated by governments primarily through bodies with delegated powers including registration boards and some accreditation bodies.
- In some cases, employers develop rules that allow for credentialing; a formal process used to verify the qualifications, experience, professional standing and other professional attributes of health practitioners.
- Education and training of the workforce involves both tiers of government, universities, vocational education and training providers, specialist colleges and professional associations, accreditation agencies and health service delivery bodies. Box B.2 provides further elaboration on the range of institutions, agencies and organisations involved in the health workforce and section B.3 provides further detail on education and training requirements.

Although there is a diverse array of entities involved, it is government that has the major impact on health workforce outcomes. Through its involvement in the funding of health, education and training, its use of numerical workforce planning, direct public provision of some services and an array of regulation, it has a pervasive influence on the overall size of the workforce, the activities it undertakes, its location and its responsiveness to changing health needs. Figure B.4 synthesises these influences, the entities involved and their roles, with a more detailed discussion in the subsequent text.

Government funding and the health workforce

Funding of health care

Government dominates expenditure on health care in Australia. Collectively, Australian Governments funded over two-thirds of the $72 billion spent on health care services in 2002-03. The Australian Government funded nearly 46 per cent and the States and Territories around 22 per cent.

Box B.2 Health workforce institutions, agencies and organisations

The sheer number of institutions, agencies and organisations involved in the health workforce area makes a comprehensive listing impractical in a paper such as this. However, the following provides an indication of the range and diversity of the institutions, agencies and organisations involved and their often overlapping roles.

Employers — A significant number of health workers are self-employed. However, many are also employed by State and Territory Government Departments (ie public hospitals and other facilities), Australian Government agencies (eg defence forces), community controlled entities (eg Aboriginal Medical Services), private hospitals and aged care facilities and private firms.

Regulators — Most health professions are regulated via statutory registration boards in each State and Territory. Professional bodies influence workforce deployment through their formal and informal input into accreditation, registration, credentialing and education issues. Accreditation agencies, such as the Australian Medical Council and the Australian Dental Council accredit university courses for their respective professions, which entitles graduates of those accredited courses to registration, and specialist training courses. They also assess the qualifications of overseas trained practitioners. In some cases, such as in dentistry and physiotherapy, the professional body and registration board are represented on the accreditation agency.

Trainers and educators — Universities offer a wide range of courses in the health area, with the cost of those courses being subsidised by the Australian Government. The TAFE system, which is funded by the States and Territories and the Australian Government, provides vocational training for enrolled nurses, personal assistants and Indigenous health workers (amongst others). The specialist colleges supervise training and set examinations for specialists in training positions in public hospitals funded by State and Territory Governments. Private consortia are also involved in the training of GPs through the GPET program which contracts out GP training on a regional basis. In VET, industry skills councils comprising representatives from government, employer groups and employees, design and develop training packages, which provide the basis for competencies in particular occupations. For example, the Community Services and Health Industry Skills Council develops packages for enrolled nurses.

Funders — As discussed in the text, Australian governments provide the majority of funding for health care services, with the remainder provided by private insurers, workers' compensation agencies and private individuals.

Planning agencies — Through a system of advisory councils and committees, the Australian, States and Territory Governments are jointly involved in advising on the future number of health workers required and the implications on education and training places. State and Territory Governments also collect and report on workforce requirements at a jurisdictional level.

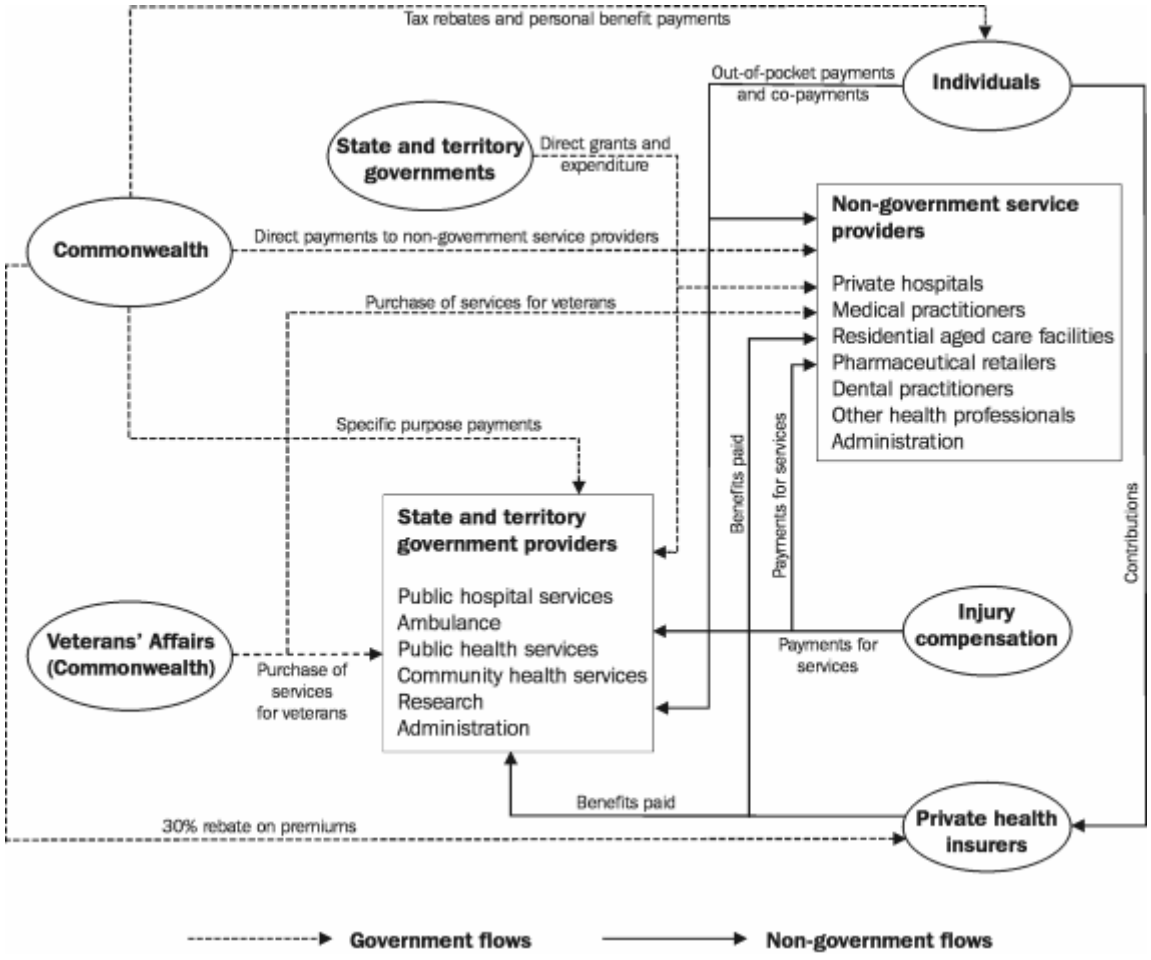
Workforce — Most professions are represented by an umbrella association and often have further specialised representation such as that provided by the various medical and dental colleges and nursing associations. In addition, there are other groups and associations representing specific sectors of the health workforce such as rural doctors and Indigenous doctors. And unions are predominant in nursing, where different unions represent enrolled and registered nurses in most jurisdictions.

- The Australian Government funds the major primary care health programs including Medicare, the Pharmaceutical Benefits Scheme (PBS) and programs to provide access to health services in particular areas, including rural and remote areas, and for specific groups such as Indigenous Australians. It also provides the health-related SPP payments to the States and Territories for public hospital care, funds hospital care for veterans and funds the rebates and subsidies provided to holders of private health insurance and to those individuals or families incurring high out of pocket health expenditures in any one year (see figure B.1). This funding accounts for around 18 per cent of the Australian Government's total expenditures (Australian Government Budget Papers 2005-06).
- State and Territory Governments, drawing on health related SPPs and other revenue sources, fund the public hospital system, as well as a range of community based health care services. Provision of these services typically accounts for about 25 per cent of State and Territory budgets. The State and Territory Governments also provide a range of health services for rural and remote areas.

Apart from affecting demand for health services and hence for health workers, as discussed in chapter 8, the nature of those funding mechanisms influences the mix of health workers available, where they locate and their work practices. And through their influences on relative incomes across the health professions, funding mechanisms are one of several factors affecting the career choices made by those training to become health workers.

The PBS and Medicare Benefits Schedule (MBS) are important elements of the health system in Australia. The Pharmaceutical Benefits Advisory Committee (PBAC) assessment is a prerequisite for listing on the PBS. Similarly, the Medical Services Advisory Committee (MSAC) undertakes health technology assessment of most new procedures prior to listing on the MBS. Some of the agencies and committees in Australia involved in this process are shown in figure B.2.

Figure B.1 **Health funding arrangements**



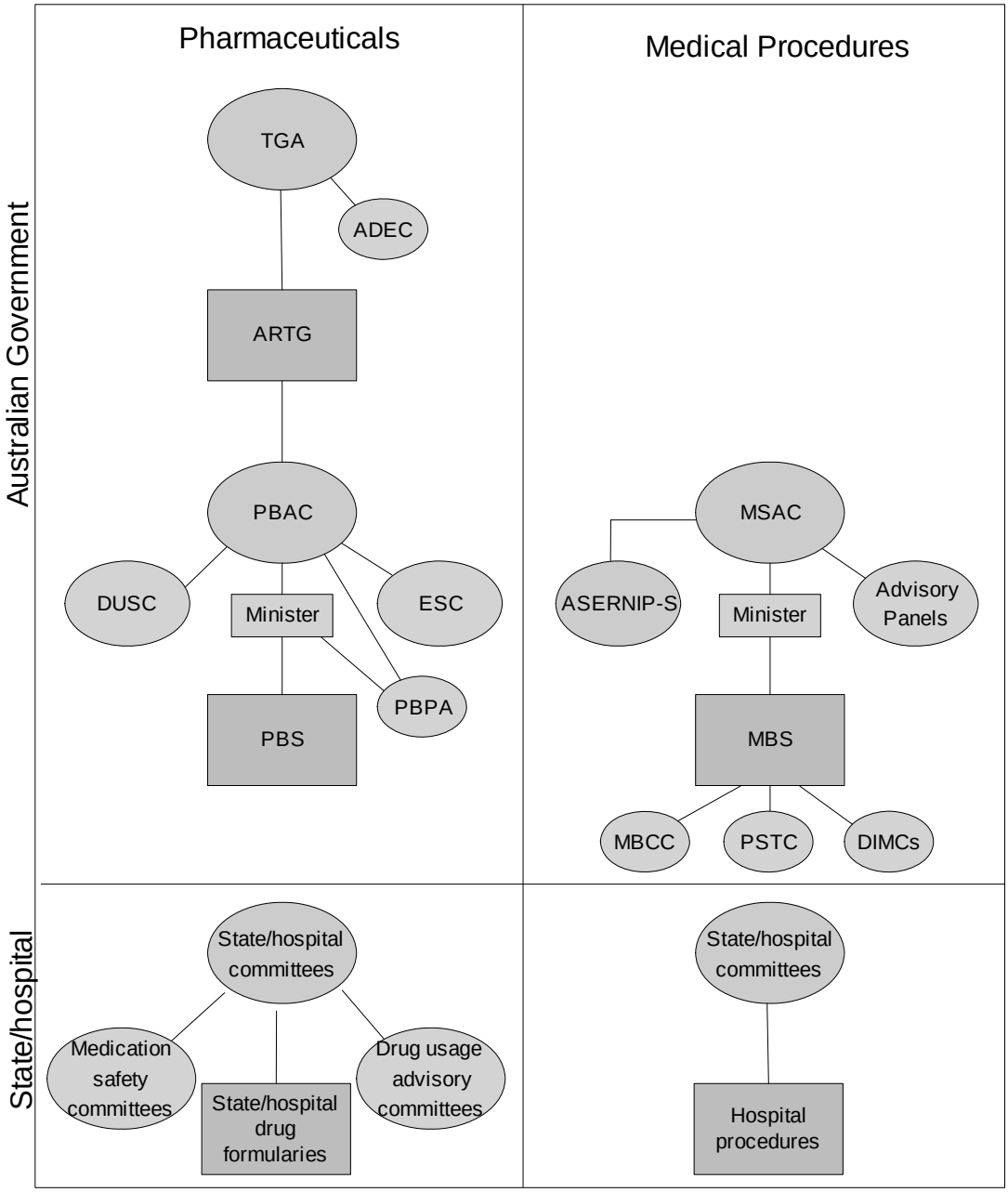
Source: AIHW (2004b).

Funding of education and training

Total government funding of higher education and training was around $9 billion in 2001-02. While not as significant as expenditures on health care, such funding enables governments to influence the overall number of entrants to the health workforce and their distribution across the different professional categories.

The most important influence in this regard is the Australian Government's funding of university education, which enables it to determine the number of subsidised health workforce places within each discipline and by university (see box B.3). This funding role has also been used to influence the geographical distribution of the medical workforce, for example, through locating new medical schools in regional areas with set rural place allocations, as well as through the use of bonded medical scholarships requiring the recipient to work in rural, regional or outer metropolitan areas of workforce shortage for a minimum period after completion of training.

Figure B.2 **Some of the agencies and committees involved with the PBS and MBS in Australia**



The following abbreviations are used: TGA Therapeutic Goods Administration; ADEC Australian Drug Evaluation Committee; ARTG Australian Register of Therapeutic Goods; DUSC Drug Utilisation Sub-Committee; ESC Economics Sub-Committee; PBPA Pharmaceutical Benefits Pricing Authority; MSAC Medical Services Advisory Committee; ASERNIP-S Australian Safety and Efficacy Register of New Interventional Procedures – Surgical; MBCC Medical Benefits Consultative Committee; PSTC Pathology Services Table Committee; and DIMCs Diagnostic Imaging Management Committees.

Source: Based on PC (2005c).

Box B.3 **Government funding of university places**

The Australian Government has primary responsibility for the public funding of the higher education sector. To receive funds, each higher education institution enters into a funding agreement with the Australian Government via annual negotiations with the Minister for Education, Science and Training as to the number of places and the discipline cluster mix the Government will support. The Australian Government then provides a contribution, depending on the discipline cluster, towards the cost of an agreed number of student places. The exception is medicine, where the total number of places to be funded is jointly determined by the Minister for Education, Science and Training and the Minister for Health and Ageing.

Medicine and dentistry are in the second highest funding group of the 12 discipline clusters and receive a subsidy of around $15 000 per year per student place. This is in contrast with the allied health disciplines which receive a subsidy of just over $7000 per year per student place and accounting, economics and commerce which, being in one of the lower clusters, receive a contribution of around $2500 per year per student place. Nursing, which is funded as a national priority, receives a contribution of around $9700 per year per student place.

Universities can request a shift in clusters as part of annual negotiations to provide more places in certain courses. It is also possible for universities to shift their load within their existing cluster profile to commence new courses. For example, Griffith University commenced a new dentistry course in 2004. However, the number of funded places in medicine is fixed as part of the funding allocation to individual universities and cannot be subsequently altered by the universities.

To date, universities have been able to close courses without consultation with the Government. However, the Minister for Education, Science and Training has decided to include a clause in funding agreements that consultation is required before courses of national importance are closed, such as certain courses for health workers where there is a national shortage.

As of this year, the student contribution for each course is to be set by individual universities within a range determined by the Australian Government. For example, medicine and dentistry are in the top HECS band which provides for a student contribution of up to $8000 per year, while nursing as a national priority is in the lowest band requiring a student contribution of no more than $4000 per year.

Source: DEST (information supplied to the Commission).

Workforce planning

While governments, and in particular the Australian Government, have long 'shaped' the size and composition of the health workforce through their role in funding training and service delivery, arrangements to undertake more formalised

projections of future workforce requirements were only introduced in 1996 (see box B.4).

Box B.4 **Background to health workforce planning**

While Australian Governments have long subsidised health care services and subsidised the education and training of health workers, workforce planning mechanisms to explicitly project workforce needs and the attendant education and training requirements are more recent.

Increasing attention began to be paid to the size and distribution of the health workforce in the 1980s. This was because of cost pressures resulting from advances in medical science and technology and a considerable expansion of medical education which resulted in a large increase in the number of medical practitioners. The introduction of universal subsidies for medical services in 1984 further heightened cost pressures.

Responses included slowing the overall growth of the workforce, capping medical training intakes and restricting practitioner access to Medicare benefits while increasing the supply of practitioners in certain geographic areas and particular specialties.

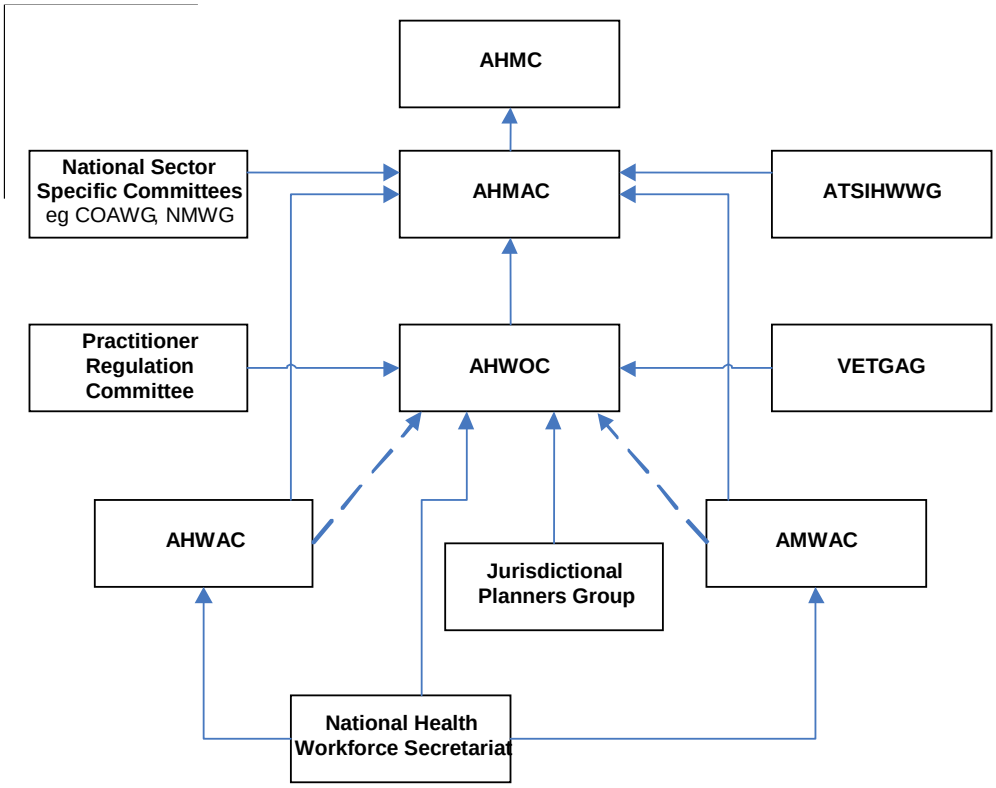
However, such initiatives served to highlight the constraints imposed by the lack of detailed and robust data on the health workforce. As a response to this, and flowing from a 1988 review of the medical workforce (the Doherty Report), a national Medical Workforce Data Review Committee was established to improve data administration. In the early 1990s, further work on data collection and management was also undertaken by the (then) Australian Institute of Health, primarily involving annual medical workforce surveys.

In 1996, the Australian Health Ministers' Advisory Council established a sub-committee, AMWAC, as part of a more 'strategic' approach to workforce planning and data analysis. This was followed by the establishment of AHWAC in 2000.

Source: DHAC (2001).

Under these arrangements, the Australian Medical Workforce Advisory Committee (AMWAC) advises the Australian Health Ministers' Advisory Council (AHMAC) on the number of medical professionals required to meet community health care 'needs' and the attendant education and training implications. In 2000, similar planning arrangements were extended to non-medical health professionals, such as nurses and allied health professionals, through the establishment of the Australian Health Workforce Advisory Committee (AHWAC).

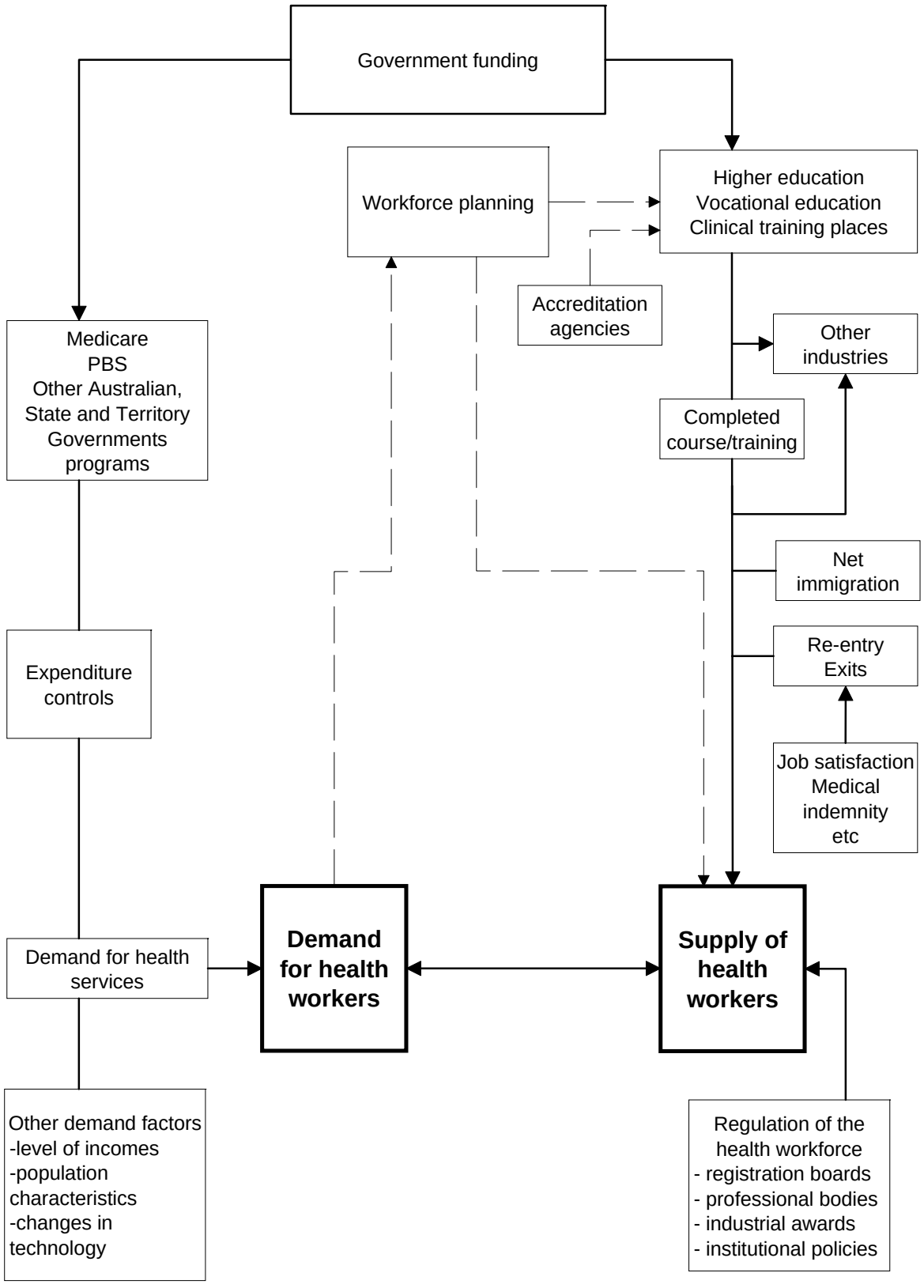
Figure B.3 **National health workforce planning reporting structure**



Source: Victorian Government (sub. 166).

As well providing advice on the future demand and supply of health workers and education and training requirements, AMWAC and AHWAC are charged with developing models to describe and predict those requirements, devising strategies to meet them and establishing and developing health workforce data sets. In addition to AMWAC and AHWAC, there are a range of other bodies and committees involved in workforce planning at the national level (see figure B.3). Most States and Territory Governments also undertake projection exercises, especially in relation to the number and type of workers required for their public health systems.

Figure B.4 Government (and other) influences on the health workforce



Regulation

The regulatory framework in which the health workforce operates is extensive and often complex. This regulation is largely profession-based and is primarily aimed at protecting the public by determining who can work in specific health occupations, and by defining and oversighting the roles and responsibilities of those within these occupations. However, some of this regulation is also aimed at containing government expenditure on health care services.

Registration boards

The majority of the health workforce is subject to some form of professional regulation. This regulation is administered by State and Territory Governments through statutory registration boards. Professions subject to registration include medical practitioners, dentists, pharmacists, physiotherapists, optometrists, osteopaths, chiropractors and nurses. Accordingly, there is a multitude of registration bodies (see box B.5). Moreover, those professions not subject to statutory registration are generally subject to self-regulatory arrangements administered by peak professional bodies. These self-regulatory arrangements may also apply to registered professions through their peak professional bodies, such as in the case of specialist colleges.

Those professions where service provision can carry a high degree of risk, and where the protection of the public interest is greatest, are more likely to be subject to statutory registration requirements.

However, for some professions requirements vary across jurisdictions. For example, occupational therapists are only required to be registered in Queensland, Western Australia, South Australia and the Northern Territory. Those wishing to work in the other States, particularly in the public health system, would simply be expected to have qualifications acceptable to OT Australia, the professional association. In the case of Chinese medicine, only Victoria requires practitioners to be registered.

In addition to the applicable regulatory requirements, there are protections provided by other features of the service delivery environment including the discipline exerted over professions through rules imposed by employers and health funds, current self-regulation activities and the demands of other health practitioners.

Box B.5 **Health workforce registration bodies**

Medicine: NSW Medical Board, Medical Practitioners Board of Victoria, Medical Board of Queensland, Medical Board of South Australia, Medical Board of Western Australia, Medical Council of Tasmania, Medical Board of Northern Territory and Medical Board of ACT.

Nursing: Nurses and Midwives Board NSW, Nurses Board of Victoria, Queensland Nursing Council, Nurses Board of South Australia, Nurses Board of Western Australia, Nursing Board of Tasmania, Nursing Board of Northern Territory, and Nurses Board of the ACT.

Physiotherapy: Physiotherapists Registration Board of NSW, Physiotherapists Registration Board of Victoria, Physiotherapists Board of Queensland, Physiotherapists Board of South Australia, Physiotherapists Registration Board of Western Australia, Physiotherapists Registration Board of Tasmania, Physiotherapists Registration Board of the Northern Territory and Physiotherapists Registration Board of the ACT.

Dentistry: Dental Board of NSW, Dental Practice Board of Victoria, Dental Board of Queensland, Dental Board of South Australia, Dental Board of Western Australia, Dental Board of Tasmania, Dental Board of Northern Territory and Dental Board of ACT.

Pharmacy: Pharmacy Board of NSW, Pharmacy Board of Victoria, Pharmacists Board of Queensland, Pharmacy Board of South Australia, Pharmaceutical Council of Western Australia, Pharmacy Board of Tasmania, Pharmacy Board of Northern Territory and Pharmacy Board of the ACT.

Optometry: NSW Board of Optometrical Registration, Optometrists Registration Board of Victoria, Optometrists Board of Queensland, Optometrists Board of South Australia, Optometrists Registration Board of Western Australia, Optometrists Registration Board of Tasmania, Optometrists Board of the Northern Territory and ACT Optometrist Registration Board.

Chiropractic: Chiropractors Registration Board of New South Wales, Chiropractors Registration Board of Victoria, Chiropractors Board of Queensland, Chiropractors Board of South Australia, Chiropractors Registration Board of Western Australia, Chiropractors & Osteopaths Registration Board of Tasmania, Chiropractors & Osteopaths Board of the Northern Territory and Chiropractors & Osteopaths Board of the ACT.

Osteopathic: Osteopaths Registration Board NSW, Osteopaths Registration Board of Victoria, Osteopaths Board of Queensland and Osteopaths Registration Board of Western Australia (South Australian, Tasmanian, Northern Territory and ACT osteopaths registered with chiropractors).

(Continued next page)

Box B.5 **(continued)**

Podiatry: Podiatrists Registration Board NSW, Podiatrists Registration Board of Victoria, Podiatrists Board of Queensland, Podiatry Board of South Australia, Podiatrists Registration Board of Western Australia, Podiatrists Registration Board of Tasmania and Podiatrists Board of the ACT (no registration in the NT).

Occupational therapy: Occupational Therapists Board of Queensland, Occupational Therapists Registration Board of South Australia, Occupational Therapists Board of Western Australia and Occupational Therapists Board of the Northern Territory (no registration in NSW, Vic, ACT and Tasmania).

Psychologists: Psychologists Registration Board NSW, Psychologists Registration Board of Victoria, Psychologists Board of Queensland, South Australian Psychological Board, Psychologists Board of Western Australia, Psychologists Registration Board of Tasmania, Psychology Registration Board of the Northern Territory and Psychologists Board of the ACT.

Radiography (including imaging, radiation and nuclear medicine): Medical Radiation Technologists Board of Victoria, Medical Radiation Technologists Board of Queensland and Medical Radiation Service Professionals Registration Board Tasmania (other jurisdictions only require licences to operate certain radiation equipment).

Speech pathology: Speech Pathologists Board of Queensland (registration not required in other jurisdictions).

Aboriginal Health Work: Aboriginal Health Worker Registration Board, Northern Territory (registration not required in other jurisdictions).

Optical dispensing: NSW Optical Dispensers Licensing Board, South Australian Optical Dispensers Registration Committee, Optical Dispensers Licensing Western Australia (registration not required in other jurisdictions).

Chinese medicine: Chinese Medicine Registration Board of Victoria (registration not required in other jurisdictions).

Dental technicians (DT) and dental prosthetists (DP): Dental Technicians Registration Board of NSW (DT/DP), Dental Technicians and Dental Prosthetists Board of Queensland (DT/DP), Dental Prosthetists Advisory Committee, Western Australia (DP), Dental Prosthetists Registration Board, Tasmania (DP), Dental Technicians and Prosthetists Registration Board of the ACT (DT/DP) (Victorian DT/DPs and South Australian DPs registered by dental boards. No registration in Northern Territory).

Source: Various.

The role of registration boards

The legislation establishing State and Territory registration boards provides for them to undertake a number of regulatory roles including:

- *Establishing criteria for admission and reservation of title.* These typically require the applicant to have the necessary education and training and in some cases to meet certain character requirements. They also make it an offence for an unregistered person to practise and the complementary reservation of title provisions make it an offence for an unregistered person to describe themselves as a member of that profession.
- *Regulating the practice of members.* Depending on the profession, the legislation may provide for the registration board to regulate particular techniques or core practices and stipulate that certain interventions can only be undertaken by registered practitioners (Duckett 2004). (Exemptions apply for emergencies and where students are performing such a practice under the supervision of an authorised person.) However, the scope of practice for each profession is generally determined by the relevant board as part of the development of standards of practice and codes of conduct. For the most part, these codes and standards do not place prescriptive limitations on the scope of practice. Rather, they require the health professional to operate in a professional manner within their area of competency as defined by their training.
- *Enforcing compliance.* An important role of the registration boards is to enforce compliance with codes of conduct and professional standards. To this end, they receive and investigate complaints of poor performance or unprofessional conduct, including breaches of board developed standards of practice and codes of conduct, and where appropriate, impose sanctions, including deregistration.
- *Continuing professional education.* A number of the registration boards also take a role in providing further education requirements to ensure that registered professionals are up-to-date with current practices and procedures.

The make up of the boards

The members of the regulatory boards are appointed by the relevant Minister in each jurisdiction and are generally made up of registered members of the profession representing the professional association; any sub-groups within that profession; the relevant Health Department; an educational institution involved in training; and representatives of consumer and/or community interests.

Box B.6 Other regulation impacting on the health workforce

Workforce regulation

The health workforce is also subject to institutional policies relating to supervision, delegation and support and assistant roles. For example, a hospital may have policies in place covering the delegation roles of registered nurses in relation to enrolled nurses. Other workplace policies, while reflecting the scope of practice contained in the codes of conduct developed by the registration boards, may actually prescribe and limit the role of certain health workers, for example, as to the administration of medicine and insertion of intravenous equipment.

Industrial awards and enterprise bargaining agreements may also act to reinforce professional regulation and institutional policies by further prescribing the roles and responsibilities of particular health workers.

Drugs and poisons legislation

The scope for health professionals to prescribe and administer medication is set out in the relevant State and Territory drugs and poisons legislation. For the most part, this legislation restricts prescribing of medicines to registered medical practitioners and dentists. However, there is some variation in this legislation across jurisdictions to reflect recent developments, such as the introduction of nurse practitioners in some jurisdictions.

Competition regulation

Associations of health professionals are regulated by the *Trade Practices Act 1974* (TPA) and individual health professionals by the equivalent State and Territory legislation which prohibits anti-competitive practices including price fixing, collusion and misleading advertising.

This regulation has been used in relation to arrangements operating within the health workforce, the most high profile case being the arrangements governing the Royal College of Surgeons training program. Though this training program was authorised by the ACCC, the agency responsible for compliance and enforcement of the TPA, authorisation was conditional on the College meeting a number of requirements to lessen potentially anti-competitive elements of its training program.

Since then, the ACCC and the Australian Health Workforce Officials Committee (AHWOC) have reviewed the medical specialist colleges' training and accreditation arrangements. The recommendations in the review have been accepted by the Australian Health Ministers Conference and reflect the key principles of transparency, accountability, stakeholder participation and procedural fairness contained in the conditional authorisation provided to the College of Surgeons (ACCC 2005a). The role of professional bodies in training is discussed further in chapter 5.

Professional bodies and regulation

As noted above, peak professional bodies play an important regulatory role in the health area, in complementing statutory regulation, or in providing for self-regulation where formal registration requirements do not apply. While membership of a professional body is voluntary, access to rebates from private health insurance funds is usually restricted to those who are registered with the statutory boards where applicable, and/or who are members of a designated professional association. Specialists are required to be members of the relevant College to receive payments through the MBS.

In addition, the activities of health workers are also influenced by workplace regulation, drugs and poisons legislation and generally applicable competition regulation (see box B.6).

B.3 Education and training requirements

University education

The majority of health professionals (ie doctors, registered nurses, dentists, pharmacists and allied health professionals) are educated at university. Completion of this training, except for medical practitioners, enables registration with the relevant board and, depending on the profession, is offered on both an undergraduate and postgraduate basis. For example, the 17 medical schools in Australia offer both undergraduate and postgraduate courses. Similarly, physiotherapy qualifications can be acquired through a four year undergraduate degree or via a two year masters degree.

Accreditation

As completion of the required university degree is a prerequisite for professional registration, courses are subject to accreditation. In the case of medicine, the Australian Medical Council (AMC) undertakes the accreditation function on behalf of the state/territory medical boards. The AMC assesses medical courses for compliance with agreed national guidelines for basic medical education (including curriculum design) so as to ensure consistency in standards for entry into the medical profession and the achievement of a range of learning outcomes. The AMC also accredits specialist medical training, conducts examinations for overseas trained doctors and advises on the recognition of new specialities.

Similar accreditation of the university courses for other health professions is undertaken by bodies such as the Australian Dental Council and the Australian Council of Physiotherapy Regulating Authorities (see table B.7).

VET

Educational requirements for enrolled nurses involve the attainment of a certificate level IV or diploma course qualifications (which teach supervisory and advanced technical skills), either through an institution-based or apprenticeship arrangement. Institution-based education for enrolled nurses is delivered by either private training providers or through government institutes of technical and further education (TAFE).

Requirements for personal care workers and nurses aides are certificate level III. Indigenous health workers are trained to certificate level III or certificate level IV depending on the jurisdiction.

The training and qualifications provided by the VET sector are formally competency-based. Under current VET arrangements, industry skills councils are responsible for developing national training packages that describe the skills and knowledge required to work in particular occupations. Training packages provide the framework for competencies for a particular industry or occupation through a range of training pathways.

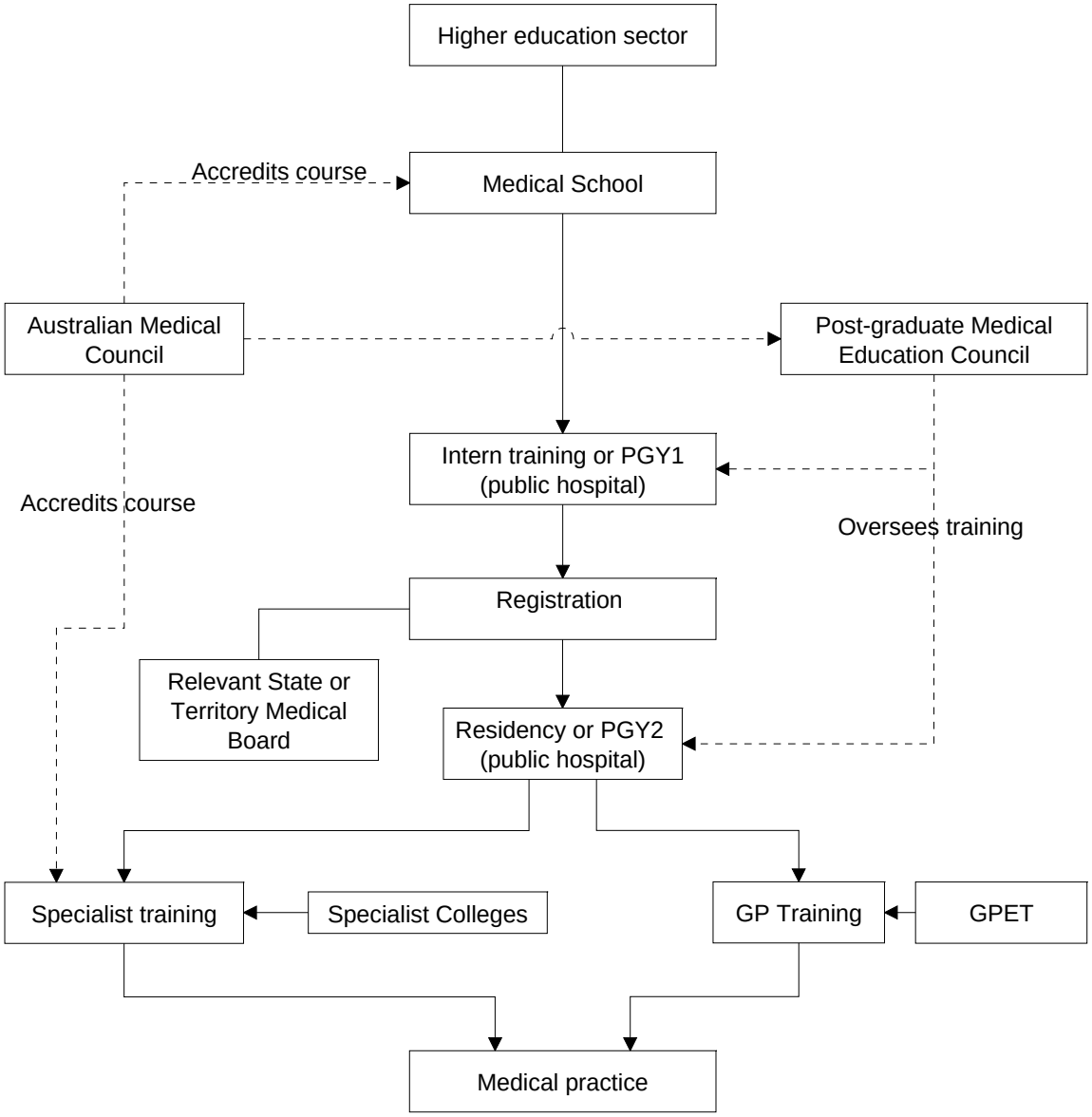
Postgraduate training

Postgraduate training is required in certain health professions prior to registration, or before graduates can obtain employment in that profession. Further post-graduate training is also required for those wishing to specialise, including for admission to specialist medical colleges (see table B.7).

Medicine

Medical graduates enter the medical workforce as interns (postgraduate year 1) — primarily in the major public hospitals. This intern training involves a series of work rotations to specific clinical departments in a hospital environment — broadly in line with AMC guidelines on intern training and/or guidelines set by the state or territory Postgraduate Medical Education Council (PMEC), or equivalent body. Full medical registration with the relevant State or Territory Medical Board is dependent on the successful completion of the intern year, although such registration is not sufficient to enable independent practise.

Figure B.5 **Outline of medical training in Australia**



Source: Various.

Following completion of the internship, further training is undertaken as a resident medical officer to prepare for vocational training (postgraduate year 2) under guidelines set by the relevant PMEC.

Specialist training

Successful completion of the intern year, subsequent registration by a State or Territory Medical Board and a further training period as a resident medical officer, enables junior doctors (resident medical officers) to seek admission to a vocational

training program run by one of the specialist colleges and accredited by the AMC. Many colleges require candidates to sit a primary examination and then to secure employment in a college-accredited hospital registrar position. The range of criteria for such accreditation can be extensive. However, not all colleges accredit training positions, but may instead require evidence (certified by a college supervisor) of the completion of specific clinical activities.

Advanced vocational training usually takes between three and six years depending on the specialty. As such, the total length of education and training requirements for medical practitioners (undergraduate/graduate degree programs, internship, basic and advanced training) can be in excess of ten years.

General practice training

In contrast to training programs for other specialties, general practice training is funded and controlled by the Australian Government through General Practice Education and Training Ltd (GPET) — established in 2001. The Australian Government sets the number of training positions available. Training is currently delivered by 22 regional training providers.

Prior to the introduction of this arrangement, general practice training was overseen by the Royal Australian College of General Practitioners and before 1996, there was no prerequisite training to enter general practice, other than to complete the hospital based post-graduate training (internship and residency).

GP training is a three year full-time program, conducted primarily in designated private GP training practices in a community-based setting (the program includes one year of hospital-based training). Two training pathways are provided — a rural and general pathway. Doctors electing to take the rural pathway are required to undertake the majority of their training, at least 18 months, in rural and remote areas, while those doctors in the general training pathway are required to undertake at least six months training in a rural or remote area and also a placement of at least six months in a designated outer metropolitan area.

Other professions

Pharmacists are required to undertake a year of work experience under the supervision of a registered pharmacist before they too can be registered. And while not required for registration, nurses are generally required to undertake a year of postgraduate training in a hospital setting before being offered employment as a registered nurse. Further training is required to practise in and/or be registered in speciality nursing areas such as midwifery and mental health or as nurse

practitioners. Similarly, although not required for registration, allied health professions will undertake further training to specialise in a particular field.

Dentists wanting to practise in one of the dental specialities (eg orthodontics, oral surgery, periodontics) undertake training in the university sector under the supervision of fellows of the relevant college.

Further details on the education, training and registration of the health workforce by profession/occupation is provided in table B.7.

Table B.7 **Selected health workforce training & registration requirements**

Profession/ Occupation	*Entry training and qualification*	*Accreditation*	*Postgraduate training to practise*	*Registration*
Medicine	MBBS both as u/grad 5-6 years and p/grad 4 years	Australian Medical Council, Postgraduate Medical Education Councils, specialist medical colleges	Yes. Internship and residency followed by GP or specialist training	Medical Board in relevant State and Territory
Nursing	Bachelor of Nursing (3 years)	Australian Nursing Council in conjunction with nurse registration boards	No, but postgraduate training required for certain specialist fields (eg midwifery)	Nursing board in relevant State and Territory
Enrolled nursing	TAFE qualification or apprenticeship or trainee program (Cert IV TAFE)	Community Services and Health Industry Skills Council[a]		na
Dentistry	Bachelor of Dental Science (5 years)	Australian Dental Council	No, but specialist training for orthodontists, dental surgeons etc	Dental board in relevant State and Territory
Pharmacy	Bachelor of Pharmacy (4 years)	Council of Pharmacy Registering Authorities	Yes. Postgraduate training year	Pharmacy board in relevant State and Territory
Physiotherapy	Bachelor of Physiotherapy (4 years) Masters Degree (2 years)	Australian Council of Physiotherapy Regulating Authorities	No	Physio board in relevant State and Territory
Occupational Therapy	Bachelor of Occupational Therapy or Health Science (Occupational Therapy) (4 years)	Council of Occupational Therapists Registration Boards	No	Registration only required in Qld, SA, WA and NT with relevant OT Board.
Aboriginal Health Work	Certificate III or IV in Aboriginal Health Work (Clinical) or equivalent	Community Services and Health Industry Skills Council[a]	No	Registration only required in the NT
Chiropractic	Bachelor of Chiropractic Science (4 years) or 2 year Masters	Australasian Council on Chiropractic Education	No	Chiropractors board in relevant State and Territory
Optometry	Bachelor of Optometry (4 years)	Optometry Council of Australia and New Zealand	No	Optometry board in relevant State and Territory
Podiatry	Bachelor of Podiatry (4 years)	Australasian Podiatry Council	No	Podiatry board in relevant State and Territory

a Develops competencies and training packages for enrolled nursing.

Source: Various.

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