NSW GOVERNMENT HEALTH WORKFORCE ISSUES PAPER FOR SUBMISSION TO THE PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY

1. INTRODUCTION

This issues paper outlines the key impediments to the capacity of New South Wales (NSW) to recruit and retain the health workforce needed by the community. Such issues are reflected nationwide. The health workforce described in this paper covers the areas of medicine, dentistry, nursing and allied health in addition to support and other health staff.

The current health workforce challenges in NSW fit broadly into the categories of structural disconnection, productivity and lack of workforce flexibility and difficulties with distribution.

This paper highlights the facts with regard to these broad categories and the significant impact of the complexity of service delivery for rural, remote and Aboriginal and Torres Strait Islander communities. Some possible areas for improvement and reform are suggested to promote discussion. These ideas are not exhaustive.

2. STRUCTURAL DISCONNECTION

There are a number of disconnects across the health system and the most critical relate to the health and education and training interface, and regulatory arrangements for the health workforce.

Disconnects, divided responsibilities and differing agendas between levels of government, the health and education and training sectors and other stakeholders present impediments to current service delivery and greater obstacles to system evolution or reform.

2.1. Education and training

The structural arrangements for the education, training and regulation of the health workforce create significant problems in providing flexibility and responsiveness to deliver adequate numbers of health workers with the appropriate skills to meet the changing health care needs of the community.

FACT **NSW has a significant nursing shortage**
ISSUE: *In 2004/05 NSW universities (Universities of Technology Sydney and Charles Sturt) turned away over three thousand potential nurses due to the lack of HECS funded places.*

FACT **NSW has a significant medical and allied health shortage**
ISSUE *In medicine and some allied health professions there has been a shift to postgraduate entry-level training. While this may provide a wider choice for students it also increases the length of time to registration, eg medicine increased 6 to 7 years, pharmacy from 4 to 5 years.*

Current education and training arrangements for the health care workforce are becoming less effective. Since the Australian Government assumed responsibility for the funding of higher education, structures were put in place in an attempt to coordinate the differing needs of the states and the Australian Government. While the *Agreement between Commonwealth and States in relation to Higher Education 1991* established protocols for bilateral consultation for the coordination of Australian / State objectives through the Joint Planning Committee, this consultation and coordination process is no longer working. It is vital that this is remedied.

FACT - **Diabetes is a National Health Priority.**

- **There is a recognised national shortage of podiatrists to deliver high-risk foot care for diabetics.**

ISSUE *In 2004/05 the University of Western Sydney suspended the undergraduate intake for two years. This action exacerbates the national shortage of podiatrists as it closely follows the closure of the undergraduate podiatry course at Curtin University in Western Australia.*

In order to bring about significant reform there needs to be enhanced collaboration between the health sector and the education and training sectors. This collaboration needs to ensure that educational imperatives are driven by community needs for services delivered by both the public and private health workforce. As a minimum there is a need for greater collaboration regarding:

- alignment of the number and type of university and other training places required with the clinical and service needs of the community
- consultation with jurisdictions prior to increasing the length of time for education and training programs which have a direct impact on the supply of the health workforce
- the increased specialisation of education and training programs
- the significant differential between the Australian Government's course contribution for different professions and the lack of transparency in the determination of this contribution
- the need for more consistent practices for managing undergraduate places and other work based learning
- standards of training
- the development of appropriate curricula
- the fees imposed on students, such as HECS, for courses in areas of community health need

2.2. Clinical Placements

Universities design curricula and clinical placement requirements with minimal input from those that are responsible for pre entry experience and preparation for practice, namely the employer. As a result, demand for clinical places does not always align with clinical service requirements. Often the demand for supervision of those on clinical placement is in direct conflict with clinical needs. There is a lack of flexibility by education providers in relation to the time of the year that students can undertake student placements with demand reflecting the academic year and term arrangements.

While the health system welcomes any increase in undergraduate places, there is minimal consultation with jurisdictions about the capacity for supervision or management of those additional students. For example, some time ago a decision was taken by individual universities to double the number of courses offered for occupational therapy and speech pathology. This doubled the number of students and doubled the number of clinical placements needed. In occupational therapy this was compounded by a lengthening of the course from 3.5 years to 4 years thereby increasing the number of weeks that students needed to be accommodated. For these changes there appeared to be little or no consultation regarding the impact on health service provision.

The location of clinical placements has traditionally been through discrete arrangements between individual universities, and hospitals/clinics. These arrangements have often been between professionals that have developed personal relationships. In many allied health disciplines, a phone call to an individual professional by an academic requesting help in finding a supervised placement is the current method of allocation.

This approach is clearly ad hoc and, with the increasing pressure placed on a workforce in shortage, this system is not sustainable.

FACT **Clinical placement supervision varies across health professions and services**

ISSUE *The Australian Government course contributions vary between professions. Medicine and dentistry receive $15,422 per student per year, nursing $9,733, and allied health $7,392.*

Higher Education Support Act 2003

The limited support and the assumption that clinicians have the skills required to train and supervise undergraduate students places additional pressure on clinicians and may be a deterrent to accepting students. Some professions offer free student clinical supervision courses, although this is not universal across all disciplines. In some professions clinical supervision is paid by the University.

Developments that could be considered include a number of broad areas of reform identified from the NSW Clinical Placements Forum held in September 2004. These are not exhaustive but could include:

- Building clinicians teaching and supervision capacity
- Developing agreed modes of clinical placement, including possibility of interdisciplinary models
- More efficient management of clinical placements.

2.3. Training Sites and Course Content

There is increasing evidence to suggest that better primary and community care results in greater health gain. However, the majority of training experience and funding approaches continue to be focussed on the acute care component of service delivery.

Postgraduate training and where and how people will need to practise in the future are not matched sufficiently. With respect to paediatrics and child health, nearly all training for paediatricians is hospital-based and runs on the back of junior doctors' service jobs, yet the growth area is in conditions that can usually be managed outside of hospital in locations close to where people live.

NSW has placed significant resources into development of a network approach to post graduate medical training. The creation of the Medical Training and Education Council has already resulted in increased numbers of doctors seeking to become physicians and work is currently occurring on review of network arrangements for postgraduate medical training in surgical, psychiatry and emergency specialties.

The Australian Government is also currently exploring better use of the private sector as a site for training and ensuring no disadvantage to public service delivery will be a focus of this work.

In addition to ensuring that sites for training prepare people for the type of service needed, the content of courses must also reflect changing practice. As an example there is a view that there is insufficient focus on the creation of researchers in health while at the same time there is a recognised need for greater emphasis on improving skills in communication and engagement with individuals and communities. Better linkages between health and education should ensure these and other service imperatives are met.

The way in which health workers are educated is also at odds with the creation of cohesive teams in the workplace.

FACT **Quality patient care requires all professionals to work as a team**

ISSUE *Education for health students occurs in distinct professional, educational and clinical streams. On graduation, however, they are expected to work as teams.*

2.4. Industry as Client

The Vocational, Education and Training (VET) sector provides an alternate model for the delivery of education and training. This industry led approach to training has demonstrated advantages of timely response to the needs of the community and the health industry. The VET programs are transparent in terms of assessment and outcomes and responsive to industry needs.

The professional associations have shown some resistance to VET sector qualifications in new and emerging workforce roles. This reduces the opportunity for workplace re-design and enhanced productivity.

Collaboration between jurisdictions and the VET sector enables flexibility for states and local industry to utilise the qualifications available to meet their workforce needs. This is working well in NSW, particularly in relation to nursing.

Drawing on the successes to date in the interaction between health and the VET sector, a more functional interface between the health and education and training sectors needs to be established, particularly at the higher education level. This would involve clear, embedded mechanisms to address issues of mutual concern including health courses intake, confirmation of clinical placement capacity and course closures.

3. REGULATION

A large range of regulatory issues impact on the health workforce at both a state and national level. The health sector is characterised by traditional role delineations, which are reinforced by the professional regulatory framework that focuses on individual occupations, (for example, through professional boards), and tends not to reflect the team nature of most health care work. Workplace culture underpins this delineation of roles that impedes the development of interdisciplinary education, training and practice and the development of new models of care.

3.1. Professional Regulation

Regulation, including professional registration, plays an important role in ensuring health care professionals meet minimum standards to maximise patient safety. The registration process is costly, with limited consistency across the nation. In addition, processes for reform are usually driven by professional organisations. Registration boards influence education and training through course and individual accreditation as well as regulation of clinical supervision requirements. Some registration processes restrict health care workers ease of movement between different states and territories. Regulatory mechanisms can either enhance or reduce the capacity to engage in innovative job redesign.

The role of the clinical colleges in determining training numbers, length and content of training and location of training places has led to restrictions in available numbers of medical specialists in certain fields. The recent determination by the Australian Competition and Consumer Commission that required the Royal Australasian College of Surgeons to work with jurisdictions on trainee numbers provides a useful example of both the current processes and the continued need for reform in this area.

Existing regulatory practices have created a health workforce that is overly rigid and has limited capacity to adapt to what is a complex, changing environment with ever evolving service delivery needs. A key question is: what changes would enable the systems that produce and regulate the health workforce to become self-adjusting, flexible and responsive to external influences, while providing a workforce that operates as a team in delivering the quality care expected by the community?

3.2. Funding Models

The funding of education and training is described earlier as one of the structural barriers to health workforce.

3.2.1. Funding of education and training

The complexity of the funding arrangements to educate and train the health workforce make it difficult to identify clearly the different contributions to health education and training and the associated costs and benefits. The public sector contributes most clinical education and training settings, while the private sector derives its workforce from the same courses, but only makes a limited contribution to clinical education.

In addition, many health professionals are now entering the workforce with outstanding HECS debts. Major banks are now advertising education saving schemes that commence in primary school. In future, many students may pay full fees for their academic training. These factors may deter students from pursuing careers in medicine and other health related professions.

3.2.2. Medical Benefits Scheme (MBS) reimbursements

Funding arrangements also impact on individuals' career choices within the health sector. 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.

3.2.3. Funding models for health care

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. While this Productivity Commission study is not about health funding, it does offer the opportunity to review how funding impacts on the health workforce.

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. For example, 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.

4. PRODUCTIVITY AND WORKFORCE FLEXIBILITY

4.1. Reduction in Workforce Participation Measured by Hours Worked

Participation in the health workforce, as measured by hours worked, has been declining in recent years. The average hours worked by professional groups continues to decline. The greatest reductions are in nursing[1]. Between 1995 and 2001 the average hours per week worked by nurses fell by 1.9 hours from 32.4 to 30.5 hours. The average hours worked by medical practitioners has declined since 1996 from 48.1 hours to an average of 44.4 hours per week in 2002[2].

There are a number of reasons for the trend in the medical workforce to work less hours.

- There are more women in the medical workforce, who tend to work part time and less hours than their male counterparts, highlighting family commitment as a high priority.
- There is an acknowledgment of the need to work in a safe working environment, part of which relates to the number of hours worked over a given period.
- New and younger employees in the medical workforce have indicated that they are not willing to work long extended hours, worked by their older counterparts, highlighting the need to travel and spend time with their families as high priorities.

As a result of this change in hours worked, strategies adopted to replace the reduced hours rely on the use of locums, overseas trained staff, increased use of overtime and increased numbers of recruitment and retention incentive packages. These strategies have added significantly to the replacement cost of the health workforce. For example, the increased reliance on overseas trained health professionals as a means of meeting workforce shortages has led to a reduced capacity of the workforce in general due to the need to provide further supervision, training and support to these staff.

FACT **Nationally, 11% of the medical workforce in public hospitals is reported to be trained overseas.[3]**

ISSUE *Many services employ medical locums, overtime or extra staff at an added cost.[4]*

[1] *Australian Health Workforce Advisory Committee (2003) Annual Report 2002-03 AHWAC Report 2003.1, Sydney*
[2] *Australian Medical Workforce Advisory Committee (2004) Annual Report 2004-05 AMWAC Report 2004.5, Sydney.*
[3] *Australian Medical Workforce Advisory Committee (2004) Public Hospital Medical Workforce in Australia*; p2/17
[4] ibid. p53

4.2. Attracting and Retaining the Workforce

Incentives and other approaches to attracting and retaining the health workforce are being pursued in NSW through the NSW Workforce Action Plan. This Plan is consistent with the National Health Workforce Framework.

As an example, along with many other health services in NSW, mental health services are currently addressing issues around recruiting and retaining adequately qualified and experienced mental health professionals. Areas being progressed include:

- Focusing on awareness of work opportunities in mental health through the media and broader community consultation, including benefits of working in mental health.
- Education, including increasing the number of university placements, curricula content, support for students, post graduate opportunities and career advice.
- Working conditions, including support for career development, scholarships and promoting a safe environment.
- Professional registration, including registration for overseas trained doctors and nurses, and accreditation for nurse practitioners, and the importance of streamlined processes.
- Re-entry into the workforce, especially for nurses, and proactively encouraging those outside the workforce to participate (i.e. as implemented through the Nursing Reconnect Program).
- Incentives to delay retirement, including an examination of the disincentives to staying in the workforce.
- Flexible working arrangements, including the introduction of team models of care and the generic mental health worker in the community setting

The changing generational perspectives on work and the attrition rates of the general health workforce inhibit advances in productivity. The significant impact of superannuation and other tax limitations also reduce the capacity of employers to offer incentives to retain the workforce.

Changes to superannuation arrangements and provision of tax incentives based on geography could increase the retention rates of staff thereby increasing productivity and participation. Changing superannuation disincentives would also mean that the increasingly older workforce would not be forced to leave the workplace and could continue to provide critical services.

FACT	**NSW has a chronic shortage of medical staff in rural areas**
ISSUE	*The FBT free cap of $17,000 per annum per employee for public hospital employees, inserted into the FBT legislation from the 1 April 2000 has never been increased or indexed. The value of that benefit has been steadily eroded over the past five years and does not provide the same incentive as it once did, particularly for medical staff.* (Fringe Benefits Act, 1986) It is anticipated that either indexation, or review and increase, of this sum would increase productivity and participation.

In addition, increases in the Remote Area Housing and Remote Area Energy benefits for employees working in rural and isolated NSW could increase the willingness of health professionals to work in areas of shortage.

Professional issues are not the only factors cited as reasons for health care workers not relocating to or remaining in rural and remote areas. The lack of appropriate employment opportunities for spouses and availability of child care and schooling for children are also issues which create a problem for recruiting and retaining staff in rural and remote areas.

4.2.1. Models of Service Delivery

The health system works primarily within a traditional workforce framework that is based on an apprenticeship hierarchy with clearly defined roles and responsibilities. The health workforce is structured similarly in inner and outer metropolitan, rural and remote areas.

New models of care need to be developed to assist health care providers to meet the challenges of the ageing population, burden of disease, advances in technology and the like. However, the specialisation of the workforce and the education and regulatory framework within which it operates limits the ability of employers to develop innovative approaches to the delivery of health care services.

The current method of approval of course content, type and length, predominately by professional associations through boards and faculties, seems to prevent the evolution of new staff categories required to meet changing community needs.

Instead, more flexible approaches to work linked to patient outcomes and location of health services has the potential to enhance worker satisfaction, improve retention rates and increase productivity. Redesign of health care delivery models could identify a much broader range of health workers with different skill sets to function in ways that would enhance the working environment for staff and improve access for patients.

NSW is leading the nation in redesigning the way that care is delivered. The Clinical Skills redesign program is looking at redesign from a patient journey approach. As well as improving the patient experience and removing blockages, it will also identify what

skills are needed for quality care. Traditionally professional boundaries have determined the type of care that can be provided. Learning and work environments must foster health care teams centred on patients not professionals.

4.2.2. Consumer expectations

There is an increasing level of consumer expectation that the full range of health care services should be available at all times in all locations. Often this can be at odds with ensuring adequate levels of safe, effective and efficient care delivered by a team with appropriate skills and experience.

Where services are preserved in areas of low utilisation, the operating costs are significantly higher than for similar services elsewhere. There should be increased transparency around these costs and funding models should reflect this disparity.

4.3. WORKFORCE DISTRIBUTION

In addition to shortages, the distribution of the health workforce in Australia inhibits the ability to respond to needs with maximum effectiveness. The most obvious reason for this in NSW is the State's size and geography, covering regional centres, large towns, small towns and remote localities.

Rural NSW had an estimated population at June 1999 of 1,447,164 and a projected population for 2011 of 1,561,240. These population changes vary by geographical location with coastal areas experiencing significant population increases with an anticipated decrease in the Far West. (Rural Health Report 2002)

The projected increase and redistribution in population is not matched by a similar increase and redistribution of health professionals, with many disincentives to moving away from the inner metropolitan areas.

Oral Health Workforce: Number of Dentists per 100,000 population

Health Service	Number in 2002	NSW Population in 2000	Dentists per 100,000 population
Total Metropolitan Areas	2395	5,015,268	47.75
Total Rural Health Services	399	1,447,231	27.57
Total NSW	**2794**	**6,462,499**	**43.23**

Source: Dentist Labour Force in NSW – 2002 and CHO Report 2002

Workforce distribution varies between metropolitan and rural areas and between rural areas, with coastal sites (particularly North Coast) reporting less difficulty in recruiting and retaining health professionals than inland and remote sites. This variation in distribution necessarily results in differential levels of access to services for rural residents as evidenced by the table above.

FACT	**In 2002, 66.3% of Australians lived in major cities serviced by 79.5% of medical practitioners.** **13.7% of medical practitioners service 20.8% of Australians in outer metropolitan Australia.** **6.7% of medical practitioners provide services to 12.9% of the Australian population in regional and remote areas[5].**
ISSUE	*There is no incentive for doctors to move to outer metropolitan or regional areas where there may be sufficient work in the public sector but little work in the private sector, reducing viability of their private practice.*

4.3.1. MBS and Pharmaceutical Benefits Scheme (PBS) allocation

There is great potential for better use of the MBS and PBS systems to align the health workforce with community need. The concept of using geographic based provider numbers to adjust for poor distribution of existing medical staff should be explored. Further, there is potential to expand the role of nurse practitioners with access to MBS and PBS systems to allow the health care needs of the community to be met more effectively.

4.3.2. General practice

Severe general practice workforce shortages are impacting on the health system's ability to meet demand and provide appropriate services. There is an under-supply of general practitioners working in rural and remote NSW, as is the case in other parts of Australia. This workforce shortage is spreading from rural to outer metropolitan and some inner metropolitan areas. This situation is exacerbated due to an increased demand for general practice services as the result of changing population demographics.

The development of integrated primary health care services provided in the community is an example of alternative model of general practice service delivery that address workforce issues and provide more contemporary care.

NSW Health is currently developing integrated primary care services across NSW. The services will integrate GPs, community health workers and other clinicians to provide multidisciplinary care, to ensure early diagnosis and prevention and better management of chronic and complex conditions.

Fifteen integrated primary health services are to be established across NSW over the next three years in partnership with general practitioners, rural doctors, community and allied health.

These general practice led services will provide:
- A co-located centre and/or network of related services providing comprehensive and accessible primary health and community care service to the population

[5] *Australian Government; AIHW Medical Labour Force 2002, p10/11*

- Comprehensive multi-disciplinary care - including all or a combination of: GPs, practice manager/s, practice nurses, pharmacy, pathology collection facility, nurses and health workers, allied health facilities, an education facility and other services
- Links with other GPs and health professionals outside of network to ensure coordinated care for individual patients
- Strong linkages with the hospital sector to ensure continuity of care and prevent readmission.

This model of service delivery will increase the capacity of the health system to provide local communities with accessible and appropriate primary and community health care, preventing unnecessary admission/readmissions to acute care. It will provide opportunities for health professionals, in particular, general practitioners, to work in multi-disciplinary team environments that provide comprehensive and coordinated care throughout the patient's journey. An example is the North Wyong Primary Care Network that has been established under the General Practice-Emergency Department Integration Demonstration Sites Program.

Summary /Conclusion

Key mechanisms for enhancing the health workforce in NSW are likely to arise from addressing a number of structural disconnects and related arrangements. The capacity of the NSW health system to address workforce reform will result from having greater influence over:

- workplace practices which emerge from awards which encourage flexible design, and improved regulatory mechanisms for professional registration.

- better collaboration to deal with the impediments to education and training of the health workforce.

- strategies for improved models of care which meet community needs.

- superannuation reform, and other incentives to encourage older workers to remain in the workplace are areas for improvement in facing workforce challenges.