James Cook University **April 28, 2005**

Faculty of Medicine, Health and Molecular Sciences

Issues for inclusion in preliminary submission to Productivity Commission Health Workforce Review

Response to Issues and Questions paper.

i) Workforce planning

- Tensions between the funding source for the provision of health professional training and the ultimate end users, e.g. most basic health professional training and education funded by Federal government through DEST payments to universities, but high proportion of health professionals employed by State governments.

- Who is responsible for training? – responsibility of different jurisdictions for the different professions, e.g. Medical training is mostly a federal responsibility, compared to the training of nurses which used to be seen more of a State responsibility, and at postgraduate level, probably still is.

ii) Education and training

- "Teaching Health System " as opposed to the existing "Teaching Hospital System" - what is required to develop health **systems** that are committed to education, training and research. Increasingly, more health care is occurring in community-based settings; therefore training also needs to occur in these settings. What are the resources required to support this??
  - infrastructure requirements
  - staffing
  - funding
  - roles of government, private and NGO sectors

- Overall funding for health programs in inadequate and based on an historical model (Relative Funding Model) that was developed over 15 years ago – doesn't recognize the real costs of training a modern health workforce

- CGS funding for health programs at Cluster 6 delivers less money per student than foreign languages, Visual and Performing Arts; is this a reflection of the importance the federal government places on the development of a modern, appropriately trained national health workforce??

- Education and training is responsive to changing health needs, but it costs money to develop new curricula and change existing curricula; hence Medicine manages to do this because of higher funding levels, but other less well funded health professions struggle.

- Issue of the DEST retention model that only funds 75% (compounded annually) of an initial cohort of students, on the presumption of student attrition rates that never eventuate – most health professional programs have student retention rates approaching 85 – 95% over the life of the program – hence most health professional programs are teaching many more students than they are funded for

- Placement in rural areas costs more because smaller and more geographically dispersed placement sites increases the costs per student to provide adequate training; there are fewer opportunities for economies of scale. However it is in the national interest to encourage training in regional/ rural/remote locations for long-term workforce retention in these areas.

- Need for private sector to be an integral part of the education and training of all health professionals across all training levels, including access to private patients. Private health system needs to acknowledge their responsibility to training the nation health workforce given the large public subsidies it receives.

vi) Productivity

- The more health care knowledge is democratized, the more the demand for services will increase.
- e-health – will probably increase demand for services.
- Less restrictive delineation of work responsibilities – will improve access to services but at a potentially lower quality of care – not yet determined if this will be cheaper.

viii) Regional, remote and Indigenous

- Need to determine what is the quantum of health care available as a right - may vary depending on population size.

- What then is the level of health service provision required to provide that quantum – what is the staffing level and mix, what is the appropriate level of resourcing and the training required to deliver the workforce.

- Issue for all communities including outer metropolitan/regional/rural. What services can a small rural community expect? What services can a regional centre expect; or an outer metropolitan area?

- Need to revitalize concept of "generalist specialist" and specific training required, i.e. requires a different method of rotations, e.g. based in a regional health service with rotations to the larger metropolitan hospitals, not the other way around as presently occurs.

- Recognition of Rural Medicine as a specialty, with a focus on the importance of the generalist physician/ generalist surgeon, including appropriate training programs
    - critical for providing a postgraduate rural training stream for rural medical students who want to practice competently as rural generalists.

- Flow of student numbers to universities and perverse incentives inherent in current funding for rural students – metropolitan universities attract regional, rural and Indigenous students to the large cities to fill their rural quotas, whilst all existing evidence indicates that training rural/regional students in a metropolitan environment greatly increases the chance of those students STAYING in the metropolitan area.

- Universities are not always recruiting from their own areas.

- What are the incentives for the provision of training programs (at all levels), in regional/rural areas to enhance the retention of the rural/regional workforce

- What are the mechanisms to ensure adequate Intern/Registrar/Training places for rural/regional health services once the increased numbers of medical graduates start to flow through – real danger of losing the opportunity to provide an adequate regional/rural workforce by not providing adequate training places

- Telemedicine – limited role in ability to greatly improve health services to rural/remote areas