Productivity Commission Health Workforce Study

Initial Scoping Paper from the Australian Government Department of Health and Ageing

1. Introduction

Australia's health workforce is the key to the effective delivery of quality health services to the community.

The Australian Government undertakes a wide range of programs to support and enhance health services. By far the largest of these is Medicare which is designed to make health care more affordable for all Australians. An adequate workforce is key to ensuring that patients have suitable access to the services that Medicare provides.

Against this background, this paper discusses issues that ensure that:

- there is an adequate number of health professionals to meet population need now and into the future;
- the health workforce is appropriately distributed to meet that need; and
- suitable education and training arrangements are put in place for the health workforce.

A list of relevant literature on health workforce issues is attached to the paper.

2. Health Workforce Supply Issues

Health Workforce Planning

In Australia, the medical workforce became subject to detailed national planning in 1996 with the establishment by the Australian Health Ministers' Advisory Council of the Australian Medical Workforce Advisory Committee (AMWAC). In 2000 the Australian Health Workforce Advisory Committee (AHWAC) was established to consider other national health workforce requirements.

There are a number of challenges in seeking to use national health workforce planning mechanisms to maintain an adequate supply of health workforce professionals. These include:

- What constitutes an adequate level of the various health services provided by health professionals, given that there will always be not only demand for more services from the community but also financial limitations on government. There are no agreed benchmarks for the number of health professionals required to provide specific health services.
- The impact of the main policy drivers have significant lead times because they involve education and training. This is particularly the case for medical training, where it takes 10-15 years to move from the point of entry as a medical student to full qualification as a general practitioner or medical specialist. As a result,

there can be a substantial lag from the time a health workforce shortage becomes apparent to the time when new workers can be trained to fill the gap.

- There are significant time lags and deficiencies in the available national health workforce data, particularly for a number of the allied health professions.
- Workforce planning to date has largely been conducted on a profession specific basis, rather than looking at the needs of all of the professions required to deliver specific health services. However, for the latter approach to be effective, some agreement is needed about suitable models of care for the delivery of particular health services.

Workforce Shortages

During the late 1980s and early 1990s there was a concern about oversupply in some health professions. For example, during this period there was a view among policy makers that there was an oversupply of medical practitioners in a range of areas. Steps were taken to reduce student numbers, to limit the number of doctors entering some sectors of the medical profession, and to constrain the number of overseas trained doctors entering the medical workforce.

As a consequence of the significant time lags between medical education decisions and their effect in terms of delivery of services on the ground, the decisions in this area in the early to mid-1990s have only filtered through the workforce in the last five or six years.

The latest data indicates that the overall number of health professionals has grown strongly in recent years[1]. The health workforce grew by 11.4 per cent between 1996-2001 compared with population growth of 6 per cent over this period. Most of the key health professional groups shared in this growth, with the exception of nursing which experienced a modest growth of 2.4 per cent over the period.

Notwithstanding this growth, a range of health professions are experiencing and/or predicting significant health workforce shortages. Almost all studies of individual medical specialties undertaken by AMWAC in recent years have recommended further, often significant, increases in the number of vocational training places for the specialties concerned[2]. A recently released AMWAC report on the public hospital workforce[3] also identified workforce shortages as an important issue.

Recent studies have suggested significant current shortages in nursing, growing considerably over time[4]. Other studies and/ or data collections have suggested significant current and/ or predicted shortages in dentistry, pharmacy and some allied health professions.[5]

From an international perspective, similar workforce shortages are being experienced in most developed countries that have similar health systems to Australia, and where trained health professionals have been sourced for Australia.

Health Workforce Shortages: The Key Drivers

On the supply side, a key factor contributing to shortages in some health professions has been a reduction in the average hours worked. This has been particularly important in the medical profession, where the average hours worked dropped from 48.1 in 1996 to 44.4 in 2002 despite strong growth in overall numbers (12 per cent). This meant that the full time equivalent medical workforce failed to keep up with population growth over this period, falling from 278 per 100,000 population in 1996 to 271 per 100,000 in 2002[6]. Even a small reduction in hours worked has a significant impact in terms of medical workforce capacity, with a reduction of 30 minutes in average weekly working hours translating into a reduction of around 530 full time equivalent doctors.

The reasons behind the fall in working hours are complex and not fully understood. It would appear to be a combination of factors including a generational shift in attitudes towards the balance between work and other aspects of life, changes in the role and standing of doctors in the community, and, importantly, increasing feminisation of the workforce. Female doctors are on average more likely to want to work part-time than their male counterparts and are less likely to want to own a practice.

Average hours worked by nurses also declined over the period 1995 to 2001 from 32.4 to 30.5, contributing to a slight decrease in the overall level of workforce capacity from 1,127 full time equivalent nurses per 100,000 population to 1,024[7].

There are also a number of pressures adding to the demand for health professionals:

- Growth and ageing of the population;
- Increasing economic prosperity, with the demand for health services growing more than proportionately as real incomes rise;
- Greater consumer expectations of the health system; and
- A range of new treatments and technologies. For example there have been major advancements in the treatment of cardiac disease over the past 20 years which have significantly increased the requirement for cardiac specialists and other health professionals servicing cardiac patients.

Government Initiatives to Increase Health Workforce Supply

The main policy lever which can be used to increase health workforce supply over time is further investment in education and training. Health workforce policy in Australia has always been in favour of a predominance of Australian trained health professionals but it has not always been possible to match the numbers going through the training system with current and future demand.

The Australian Government is making a major investment in the education and training of the health workforce in order to assist in meeting future needs. The number of publicly funded medical school places across the tertiary sector has increased by more than 25 per cent since 2000. Five new medical schools have been established since that time and three new medical schools are being established over the next few years. These initiatives will expand the number of publicly funded students completing university medical studies from approximately 1300 in 2005 to approximately 1900 in 2010, an increase of over 45 per cent[8].

From 2004, the Government has also expanded the number of commencing vocational training places available for general practitioners from 450 to 600, an increase of one third.

Significant increases in publicly funded undergraduate places are also being provided in some other health disciplines. For example, in July 2004, the Minister for Education, Science and Training announced that 4000 new publicly funded university nursing places will be made available over the period 2005 to 2008[9], as well as over 1500 places in a range of fields such as dentistry, pharmacy, physiotherapy, radiography and occupational therapy.

Another shorter term policy lever which the Australian Government is using to increase health workforce supply is through the migration of medical professionals. Employment of suitable overseas trained doctors avoids the considerable time lag involved in educating and training a doctor in Australia.

Overseas trained doctors have, for a number of years, been a significant means of supplementing Australia's medical workforce. Currently, about 10,000 or 20 per cent of Australia's medical workforce is overseas trained.

The Government's Strengthening Medicare package, announced in November 2003, includes a range of initiatives to increase the opportunities for appropriately qualified overseas trained doctors in Australia. These include international recruitment strategies, opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements and improved training arrangements and additional support programs. As a result of these initiatives an additional 725 appropriately qualified overseas trained doctors are expected to be working in Australia by 2007[10].

The issue of the ethics of recruiting doctors from developing countries has received significant attention. Australian Government international recruitment strategies are targeted only at developed countries. The Australian Government supports the Commonwealth Code of Practice for the International Recruitment of Health Workers, which provides an ethical framework for international recruitment. The purpose of the code is to prevent aggressive recruitment of health workers from developing countries which are themselves experiencing significant shortages. The Code also acknowledges an individual's right to seek employment in another country.

Issues

Health workforce supply issues which the Department of Health and Ageing considers should be examined by the Productivity Commission include:

- Policies to increase the productivity of the health workforce. The Productivity of the health workforce primarily depends on the length and efficiency of training, increased throughput, efficiency of practice including the adoption of new technology, and the length of working life and retirement age. Improvements in any of these factors will improve the workforce situation in Australia provided that they are not taken to the point where quality of service is compromised.

- Policies to add to health workforce capacity through changes to traditional health workforce roles and the development of new categories of health worker. In regard to the Australian Government health programs this is already occurring to a limited extent, for example, through the development of new categories of aged care worker in residential aged care facilities, and the development of the practice nurse role in general practice. The Commission should consider policies to further facilitate developments of this kind.
- Policies to reduce the degree of regulation of the health workforce and improve the consistency and transparency of the regulatory framework.
- Policies which might be put in place to lift, or prevent further reductions in, the average hours worked by medical practitioners.
- Policies to further improve turnover and retention rates in some health workforces eg. nursing. Improvements in this area have the potential to significantly increase health workforce capacity.

3. Distribution Issues for the Health Workforce

Current Health Workforce Distribution

The available data on the distribution of health occupations indicates that there is significant maldistribution across a range of health occupations[11]. The medical profession is an area that has been subject to considerable maldistribution problems. A major focus of the Australian Government's health policies has been on attempting to redress that imbalance.

In aggregate terms Australia has a relatively high number of doctors compared to other OECD countries. For example, we have 1.4 GPs per thousand population compared to an OECD average of just under 0.9. These statistics indicate that Australia's medical workforce shortages are in some cases more related to distribution problems, rather than an overall lack of numbers.

In 2002, 66 per cent of Australians lived in major cities where 80 per cent of medical practitioners provide services. In inner regional areas comparable numbers were 21 per cent of population and 14 per cent of doctors. Outer regional areas accounted for 10 per cent of the population and 6 per cent of the doctors. Remote areas had 1.7 per cent of the population and only 0.8 per cent of the doctors.[12].

There is also maldistribution of the workforce within the major cities, with inner metropolitan areas generally being significantly better serviced than outer metropolitan areas.

Australian Government Policies to Improve Health Workforce Distribution

The Australian Government has in place a range of regulatory, education and training and financial mechanisms designed to improve the distribution of the medical workforce.

The regulatory mechanisms include restrictions placed on overseas trained doctors who enter Australia to practice either as temporary or permanent residents. These doctors are required to practise in districts of workforce shortage in order to obtain access to the Medicare Benefits system. Eligible districts of workforce shortage have traditionally been rural and remote areas, but more recently have included regional centres and outer metropolitan areas of capital cities.

This policy has been effective in distributing significant numbers of doctors to areas of high need. For example in remote areas of Australia, overseas trained doctors now account for more than 30 per cent of the general practice workforce. In April 2005, there were 2,447 overseas trained doctors Australia-wide with restricted access to Medicare approvals, allowing them to work in areas of workforce shortage. This represented an increase of 528 or 21.6 per cent over the previous 12 months.

It is clear that, without the presence of overseas trained doctors who are required to work in areas of need, the national doctor distribution would be significantly more uneven.

It is important that overseas trained doctors have in place adequate training and support mechanisms to make an effective transition to working in Australia, particularly given that much of their work is undertaken in relatively isolated rural and regional areas. A number of training and support initiatives are being introduced under the Strengthening Medicare package.

It is also important that the State and Territory Medical Boards maintain assessment processes for overseas trained doctors that are robust and transparent in order to ensure that these doctors meet appropriate quality standards before practising in Australia. The Department of Health and Ageing is currently working with the Medical Boards and other key stakeholders to ensure a robust nationally consistent approach in this area.

The Australian Government has also made considerable use of education and training initiatives to promote the improved distribution of the medical workforce over the medium to longer term. These strategies are based on a link between student background (in particular rural background), location of medical education and training, and where doctors decide to enter practice in completion of their training. The strategies comprise:

- Supporting medical students from rural backgrounds, through the Rural Undergraduate Support and Coordination (RUSC) Program and the Rural Australian Medical Undergraduate Scholarship (RAMUS) Scheme;
- Providing improved rural and regional training infrastructure through the Rural Clincal Schools (RCS) program and the University Departments of Rural Health Program;
- Bonding of medical students through the Medical Rural Bonded Scholarship Scheme (MRBSS) and the Bonded Medical Places (BMP) Scheme. Under these

schemes, from 2004 around 20 per cent of commencing medical school students are bonded to work in rural, regional or outer metropolitan areas of workforce shortage for a minimum of 6 years on completion of their training.

It is too early to judge the success of these educational and training initiatives. However, the measures, taken together, have the potential to significantly improve the distribution of the medical workforce over time.

The Australian Government also offers a range of financial incentives to encourage doctors to provide services where they are needed most. In particular, general practitioners in rural and remote regions are able to access a number of additional payments in addition to their usual fee for service income. These include rural retention payments for long serving general practitioners; rural loadings to compensate for lower population numbers; rural loadings and financial assistance for procedural general practitioners; and payments to employ practice nurses.

Overall, while medical workforce distribution remains a significant problem, there is evidence of some improvement. For example, since 1996 rural general practitioner numbers have increased by more than 20 per cent, including an 11.5 per cent increase in the last 3 years.

Issues

Health workforce distribution issues which the Department of Health and Ageing considers should be examined by the Productivity Commission include:

- An assessment of the effectiveness of current Australian, State and Territory government programs to improve the distribution of the medical workforce, and a discussion of what further strategies could be put in place.
- Policies to add to health workforce capacity in rural and remote areas by changing traditional health workforce roles (eg. practice nurses, nurse practitioners and Aboriginal Health Workers conducting more medical functions) and by creating new health workforce roles in these areas which combine some of the functions of individual health professions.
- New models of delivery of health services to rural and remote areas which could make more effective use of the available health workforce.

4. Education and Training Arrangements

The current health education and training system is, for a number of reasons, not fully meeting health workforce needs. Improvements in the efficiency and effectiveness of these arrangements have the potential to significantly improve the health workforce situation over time, and should be a major focus of the Productivity Commission's study.

For example, the current medical education structure has served Australia well but is now subject to significant stresses. Medical education issues which the Department of

Health and Ageing considers should be examined by the Productivity Commission include:

- Ways to better coordinate and integrate the three separate tiers for educating a doctor: undergraduate, pre-vocational training in a public hospital, and vocational training. Medical education is a continuum but, to date, each of these sectors has operated to a large extent independently of each other.
- How to better reflect the critical interdisciplinary care needs of our health system in medical education. This is not currently an area of major emphasis. However, chronic disease, which now makes up more that 80 per cent of Australia's disease burden, requires close co-operation within the interdisciplinary team within which treatment occurs – doctors, nurses, pharmacists and allied health professionals. More generally, most of the illnesses burdening today's society are too complex to be addressed by only one single health discipline.
- The scope for reducing current lengthy medical education training times (10 to 15 years to achieve Fellowship), while maintaining appropriate quality standards eg by allowing some medical students to begin to specialise in their undergraduate years, and/ or by training some doctors in narrow specialist fields and limiting their scope of practice to these areas.
- The merits of, and scope for, introducing more training providers into the vocational training of doctors, which is currently undertaken solely by specialist medical colleges.
- The need for a more robust framework for Continuing Professional Development (CPD) for doctors. Medical technology and treatment regimes are being enhanced constantly and this places a premium on individual medical professionals maintaining effective CPD programs. However, a number of the specialist medical colleges do not mandate the maintenance of an adequate CPD program as a condition of retaining Fellowship.

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