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AUSTRALIAN HEALTH WORKFORCE SYSTEM PRODUCTIVITY COMMISSION STUDY

INITIAL AHMAC SUBMISSION

Overview

Worsening shortages of key components of the health workforce stands out as the most serious challenge to Australia's capacity to deliver high quality health care across the nation.

Health workforce issues are characterised by many of the challenges confronting the health system - the issues are multifaceted and interactive, and there are complex interdependencies between elements of the system.

Like many structures/systems which have evolved, the health workforce system, and the outcomes it produces, is organic, ad hoc and disconnected, rather than connected, cohesive and effective.

AHMAC's initial submission focuses on key issues within the Terms of Reference, rather than addressing each term of reference in detail, or commenting on every aspect of material issued by the Productivity Commission.

Key Outcome

AHMAC's key concern is to enable the continued delivery of safe, quality health services to the Australian community. This requires a sufficient, quality, productive health workforce, trained and equipped to respond flexibly to changing health care requirements. A truly effective health workforce system will be one which exhibits the ability to respond quickly and continuously to changes in the broader health sector. AHMAC therefore considers that the Productivity Commission should not focus solely on addressing the issues of today, but should also look for ways to build a stronger capacity for 'self-adjustment' into the future health workforce system.

The key outcome that AHMAC is seeking from the study is the identification of the structural, regulatory and funding arrangements and reforms that will ensure the availability of this workforce.

AHMAC considers that future health service delivery will be placed at risk in terms of access and quality and safety if these issues are not effectively addressed.

Key Issues

The workforce shortages that currently exist across most of the key professions compromise the capacity of any other strategies to address current and forecast workforce challenges. All projections to date indicate a widening gap between supply and demand into the future. Unless strategies are put in place to improve and sustain supply, it will be impossible to address some of the most basic issues of improving the distribution of the workforce into areas of need.

However, changing patterns of care, workforce participation trends, and ongoing requirements to improve flexibility and efficiency suggest a much stronger future emphasis on matching workforce roles (and underlying skills/competencies) to service delivery needs rather than more of the same.

Thus, a major challenge for the Productivity Commission is to understand how structural, regulatory and funding arrangements (along with the activities of professional bodies) at both a state and national level contribute to current shortages and the necessary changes to enable supply to better match demand into the future.

Within this context of current shortages and increasing demand, key issues impeding the development of solutions to current health workforce challenges also relate to:

- Distribution;
- Productivity - workforce flexibility; and
- Structural issues pertaining to training, regulatory and funding models.

Supply and Demand Issues

This study occurs against a context of existing health workforce shortages and supply constraints, and these are anticipated to worsen in the future without effective solutions. Health workforce shortages have been a significant and emerging challenge for the health sector for some time. The reasons for the shortages are complex, and solutions require a multi-faceted approach. Failure to effectively address the shortages will impact on the ability to deliver necessary health care to the community.

An adequate supply of work-ready health workers is critical to the continued functioning of the health system and the capacity to deliver high quality, safe care and is thus a key issue for the study.

There are a range of sources of supply:

- Graduates of health workforce education and training;
- Re-entry of health workers who have left the health sector;
- Overseas trained workforce;
- Unskilled labour

Other relevant factors are the retention and productivity of the current workforce.

Alongside acknowledged shortages of key health professionals is the reality that many education and training programs have regulated intakes and/or have significant unmet demand for places.

A related issue is the increasing demand for health services, which will exacerbate existing and projected workforce shortages. Community perceptions and expectations are a significant driver of demand.

A key question is the extent to which demand management strategies, such as better investment in public health to improve the health status of the population, could impact on demand for health services and thus the type and structure of the health workforce.

Distribution

A key issue for the health sector is the gap between consumer expectations that health care should be accessible when and where it is sought, and the difficulty in attracting and retaining health workers in particular geographic areas and fields of practice.

The expectation that a certain level of public sector services should, in the main, be universally and uniformly accessible poses particular challenges for States and Territories. Those challenges can be particularly acute when staff have the option of alternative, private sector work. But 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.

The existence of a vibrant private sector in health offers many advantages but, from a workforce perspective, it also creates problems. Specifically, it weakens public sector employers' control over distribution and, by providing plentiful opportunities for self-employment, it means that individual professionals' choices as to where, when and how they practice may not be well-aligned with patterns of population need.

As with most components of the workforce, health workers are able to choose their location and area of work, particularly in times of chronic shortage. They are also increasingly able to choose the number of hours they wish to work, and when those hours are worked.

Public health services operate 24 hours a day, 7 days a week. Outer metropolitan, rural and remote locations face enormous challenges. Likewise the Commonwealth, which is obliged to rely heavily on subsidies and incentive payments, can sometimes struggle to maintain a balance between workforce supply and service demand in some parts of the country.

Current health worker shortages exacerbate these difficulties.

Currently a wide range of measures has been put in place by all Governments in order to tackle problems of workforce distribution, or to minimise their impacts. Those measures are having some positive impacts, but there is still heavy reliance on overseas trained staff to deliver services in some locations. Provided qualifications and competence are verified, and ethical recruitment processes, which take account of the needs of 'exporting' nations, are followed, use of overseas trained staff can deliver benefits both for the staff themselves, for the countries they come from and for the Australian communities where they work. However, Health Ministers have endorsed the principle that Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.

There are a range of possible solutions to distribution issues:

- The identification of effective levers to improve distribution of the health workforce which takes account of the public and private sector contexts and environments. Including the frequency of workers practising across both sectors in rural and remote areas;
- Development of new service delivery models (and potentially workforce roles) in geographic areas and fields in need; and
- Changing community attitudes about the range of services that should be available in particular geographic locations.

A key issue to be addressed is the extent, and conditions under which, increasing supply could ultimately improve distribution.

Productivity

In considering health workforce productivity, AHMAC highlights that the context and relevant factors may change, depending on the setting (private or public sector, inner urban or outer metropolitan or remote). For example, any conclusions drawn from growth rates in surgery undertaken in the public versus private sectors need to recognise that the types of surgery and complexity of consumer conditions are often significantly different across these sectors.

Improving health workforce retention and turnover has the potential to increase productivity. Staff attrition and turnover affects productivity because of the time necessary to adjust to new workplaces and practices. Health workplaces are rapidly changing environments, with health service delivery constantly evolving. Health workforce shortages, inflexibility and turnover contribute to workplace pressures and the ability to retain and recruit staff.

Workforce Flexibility

A key challenge for the Productivity Commission is to develop advice on how best to align task, training and experience to ensure the scarce and expensive labour resource is deployed as efficiently as possible.

The concept is not intended to alter the quality of care - simply to make the best, and most productive use, of the available workforce and resources. Translating this concept into action would impact on traditional scopes of practice and role boundaries, and require health care workers to work in different teams and service delivery models. It will require role redesign. It would also require careful change management and education of consumers.

The goal is not only relevant to service provision, but also to the nature and focus of health worker education, and could influence the number of participants in courses and the actual courses offered. Exploring the concept further should include consideration of how all education providers can be more effectively used in preparing and training health workers.

Consideration would also need to be given to industrial determinations, ensuring that award or industrial provisions promote, rather than impede the flexible use of the health workforce. Professional organisations would also need to recognise and apply this concept in their deliberations and practice.

Structural Disconnection

Current structures, responsibilities and inter-sectoral arrangements impede, rather than facilitate, a sustainable, quality, productive 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.

There are a range of disconnects but the most critical relate to the health/education and training interface and regulatory arrangements in the broad sense.

Regulatory Issues

- Complexity (and in particular, the lack of national consistency)
- Peer review (and inherent tension between minimum safe practice and best practice)
- The limited opportunities for market forces to affect outcomes

Health work is heavily regulated compared to many other sectors. The regulatory framework within which health workers operate is not only extensive but complex. For example, the practice of a registered health worker may be subject to:

- Primary and delegated legislation (Registration, Poisons Act etc);
- Registration Board guidelines and policies;
- Professional association policies (including those relating to supervision, delegation and support/assistant roles);
- Industrial organisation policies (including those relating to supervision, delegation and support/assistant roles);
- Institutional credentialing; and
- State and Federal Industrial awards and Enterprise Bargaining Agreements.

The health sector is characterised by traditional role delineations, which are reinforced by the regulatory framework which focuses on individual occupations and tends not to reflect the team nature of most health care work. Workplace culture underpins this delineation of roles, and this may impede the delivery of seamless health care for patients across settings.

Australian health practitioner legislation is based on a concept of protecting the public through peer review. Most health practitioner legislation has been subject to National Competition Policy (NCP) assessments, and generally covers:

- Qualifications required for practice (may include an accreditation role for a national organisation);
- Additional standards for registration (such as periods of supervised practice); and
- Professional standards of practice, including complaint and disciplinary proceedings and often incorporating the power to issue mandatory guidelines.

However, NCP reviews have focused on whether regulation per se is in the public interest, rather than the model of regulation and whether a system of regulation administered by individual professions best serves the community. Whilst expert input is important to practitioner regulation, there are issues about a profession based group determining the qualifications for practice, issues of professional scope of practice, supervision, support/assistant roles etc, relevant to that profession. These regulatory roles involve complex balancing of competing issues such as protection of the public and the particular professional traditions and perspectives.

A profession-based regulatory approach necessarily focuses on traditional role delineations, and does not always maximise opportunities for a broader range of expert input into decisions relating to professional competence. Alternatives might include regulation based on a suite of competencies from which roles, including new roles, are built/ constructed. This might also provide opportunities for a broader range of expert input into decisions relating to professional competence

Registration boards and professional organisations generally set the criteria for accreditation of health courses including clinical education requirements. In effect, this means the profession has a significant influence on course content. Approaching accreditation on a profession by profession basis contributes to the multiplicity of accreditation arrangements that characterise health education and training.

This individual profession-based approach also precludes a "whole of health system and health workforce" approach to curricula. There is no forum to consider whether there is particular core knowledge that should be common to all, or most health courses eg Information Management and Information Communication Technology, quality and safety, Aboriginal and Torres Strait Islander health etc. The current approach also does not facilitate the evolution of curricula in an integrated and holistic way to respond to changing health service delivery and consumer needs. Similarly, the existing system prevents consideration of how limitations on practice established through regulatory systems impact on broader workforce availability, cost and the roles of other professions.

The extent of regulation has also created a health workforce which is characterised by a certain rigidity and limited capacity to adapt to a changing environment and 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 changes whilst providing a workforce which delivers high quality, safe care. AHMAC is also interested in an exploration of how employers and/or funders could play a greater role in shaping regulatory arrangements.

Education and Training/ Health Interface

Key challenges involve:

- Lack of coordination between decisions in the education and training sector and the impact on the health workforce;
- Funding issues;
- Length of time to educate health workers; and
- Model of health education and clinical education.

<u>Uncoordinated Decision-making</u>

Although the health and education and training sectors intersect at various points, there is little coordination between decisions made in each sector which impact on the other.

Public sector health institutions largely provide the setting for the clinical education component of tertiary and Vocational Education and Training health courses. The health sector is obviously the major employer of health course graduates.

However, except for institutional linkages in relation to clinical education, the health sector has 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 misalignment between service and client needs and the skills, knowledge and attributes imparted through existing training models and curriculum.

Nationally, the Department of Education, Science and Training (DEST) has policy responsibility for higher education. There are no formal linkages between State and Territory health agencies and DEST. DEST's primary relationship is with universities and State and Territory Education and Training agencies, and health is only one of many external stakeholders. Engagement of DEST on health workforce issues through State and Territory Education and Training agencies has had limited success (as health sector issues may be diluted in translation).

Ministerial and Senior Official Forums

Health Ministers met with Minister Nelson in July 2004 because of their concerns about the health/education and training interface and decision making on health workforce issues.

Representatives of AHMAC and the Australian Education Senior Officials Committee met to consider issues such as:

- University autonomy in relation to course offerings, closures and numbers of places;
- Need for DEST to confirm clinical placement capacity with employers; and
- Attrition amongst undergraduates and recent graduates of health courses.

This is a positive development however, the fact that such meetings are required suggests the limitations of current arrangements. A functional interface between the health and education and training sectors could be expected to have clear, embedded mechanisms to address issues of mutual concern such as the need for new or revised curricula or courses, intakes into health courses, confirmation of clinical placement capacity, course closures, etc.

Course closures provide a specific example of difficulties in the health/education and training sector interface. Despite the fact that there is a documented national shortage of podiatrists (Department of Employment and Workplace Relations), one university recently attempted to close its podiatry course and another suspended its course for two years. The arrangements between DEST and universities at that time did not prevent this course of action and required no consultation with health agencies.

Funding Issues

Health education and training involves responsibilities divided between:

- Federal and State and Territory Governments,
- The health and education and training sectors, and

- The institutions that provide health services and clinical education and those that deliver health courses.

The education of a health worker can involve:

- Vocational education and training sector courses from Certificate I through to Diploma level funded nationally and at a state/territory level and as part of the apprenticeship system;
- Undergraduate education in a tertiary institution (undergraduate pays HECS or full fees to tertiary institution who also receives federal funding);
- Undergraduate clinical placements in a health facility;
- Post-entry training delivered by a university, Professional College (including a component of pro bono teaching and possibly a teaching component covered by the relevant industrial award -College receives fees, trainee pays fees to College), or other educational provider; and
- Work undertaken in a health facility whilst completing post-entry training, with time allocated to education activities (health facility pays salary to trainee).

As a result of the complexity of these arrangements, it is difficult to clearly identify the different contributions to health education and training and the associated costs and benefits. Accordingly, there are questions about whether the distribution of costs across those who benefit from health education and training (workers, employers, institutions (health service delivery and educational) is optimal. For example, the public sector contributes most clinical education and training settings, whilst the private sector derives its workforce from the same courses, but only make a limited contribution to clinical education.

Funding arrangements also impact on individuals' career choices. While health professionals are often motivated by non-financial considerations such as a desire to serve the public and the intellectual satisfaction of particular fields of practice, the fact that some areas of specialisation offer significantly higher financial rewards can lead to localised imbalances between supply and demand. Such imbalances can become particularly acute when there is an overall shortage of qualified staff and, as a consequence, individuals have access to a wider variety of possible career paths.

In addition, many health professionals are now entering the workforce with outstanding HECS debts and, in future, some may be doing so having paid full fees for their academic training. Those are factors which have the potential to bias individuals' career choices further towards financial, as opposed to other, forms of compensation.

Funding arrangements in the tertiary sector do not support the sector's responsiveness to the changing needs of health services. Universities must self-fund or obtain external funding if they are not to bear the substantial cost of developing new courses or curricula.

Length of Time to Educate Health Workers

The length of health courses has a direct impact on health workforce supply. However, health course length is generally determined by institutions, professional associations and accrediting bodies with little influence exerted by health sector employers.

There have been a range of occupations that have unilaterally decided to extend course length by up to two years, with seemingly little consideration of the impact on the health workforce and in the absence of any robust workforce planning approach. In some cases, the public health sector has been asked to provide additional training positions as a result of such unilateral decisions. This impacts on costs and decreases supply.

There has also been little consideration of how the education and training sector could expedite new workforce entrants, whether through streamlining existing courses eg commencing medical specialist training in undergraduate courses, recognition of prior learning that matches the skills required in a position, or providing advanced standing to health workers wanting to retrain.

The focus on accreditation of courses and credentials tends to focus on meeting established practice rather than focusing on competency to undertake training. Handson experience in a similar field/occupation may not be as recognised as the actual ability to undertake the course/training.

Model of Health Education and Clinical Education

Models of clinical education has changed little in the past decades despite health service delivery changing significantly. For example, as a result of changes to length of stay, teaching hospitals now care for more acutely ill patients. The current model of clinical education is stretching the capacity of service delivery to cope with service delivery and students.

A characteristic of many graduates is that they present for work under-prepared for the challenges and significant investment is required by health services in making graduates work ready.

Similarly, continued reliance on the apprenticeship model of clinical education, especially medical specialist, places limits on education and training capacity. Further, the current model does not facilitate interdisciplinary, team based work.

What is the connection between the focus of health workforce education and training and clinical education settings. Traditionally the health sector has focused on education and training for acute care but increasingly better health outcomes are being sought through primary health care. Clinical education settings should reflect this trend.

AHMAC is interested in exploring innovative approaches or ways to better support the current approaches which would reduce pressure on the health system.

Funding

The funding of health services and remuneration of health workers contain a range of inherent incentives and disincentives which impact on:

- Distribution of the health workforce geographically, and across the public/private sectors;

- The level of training that individuals complete, and thus the overall training costs/burden to the health system; and
- The attractiveness of certain specialities, fields of practice and practice settings.

As in all industries there are wide disparities in earning capacity across the health sector in terms of occupations, specialisations and between the public and private sector: these varying remuneration levels influence health workers' career decisions in a variety of ways with a range of consequences.

The remuneration of any individual health worker reflects a range of factors, some of which are within the health sector's control or influence and some of which are not. For example, a practitioner's income can comprise basic salary and allowances (state based industrial arrangements), ability to access additional income streams through private practice and the Medical Benefits Scheme, subsidies and grants while outgoings can comprise living costs, tax, superannuation, and costs of practice such as indemnity insurance.

On entering practice, the cost of education is likely to influence whether remuneration is the primary determinant of, or one of a range of factors impacting on, an individual practitioner's choice of location and area of practice.

Conclusion

AHMAC awaits with interest the PC discussion paper and welcomes the comprehensive and independent analysis that will inform its final report AHMAC anticipates expanding on these issues and other aspects of the terms of reference in its July submission.