Australian Health Association Submission Productivity Commission Health Workforce Study

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About the Australian Healthcare Association

AHA's role

The Australian Healthcare Association (AHA) is the national industry body for the public healthcare sector including hospitals and other healthcare organisations, aged and extended care facilities, primary care and community health.

AHA has been a major contributor to Australia's health policy for over 50 years. AHA's members include the governing bodies of Area and District Health Services, Regional Health Authorities, Community Health Services and Hospitals as well as a number of associate and individual members. AHA is governed by an elected National Council. Councillors are senior health care executives, clinicians, academics and industry leaders from across Australia.

AHA provides high-level advocacy and representation, publishes the quarterly Australian Health Review, a peer reviewed health policy journal, and the Healthcare Brief newsletter, in a weekly electronic format as well as an informative quarterly newsletter. AHA also convenes the Australian Health Think Tank of senior policy makers, administrators, clinicians and academics and an Annual Conference covering a broad range of health sector issues as well as other seminars and workshops on specific issues.

AHA's vision

All Australians will have access to effective healthcare services that are appropriate and responsive to their needs in all settings, delivered safely by capable personnel providing continuity across the spectrum of healthcare settings (home, residential facility or hospital). Those services must be efficiently delivered and adequately resourced to ensure their sustainability.

AHA's mission

- To advance excellence in Australian public healthcare services in all settings by promoting the development and implementation of well-resourced evidence-based policies;
- To support a national industry network of hospital and healthcare organisations and to provide high-level representation and information for members;
- To be an independent source of advice, input and analysis for government agencies, media, other industry groups and the community on issues affecting the delivery of healthcare;
- To create a stimulating environment for analysis, review and development of health policy and practice through strategic planning alliances with stakeholders.

Introduction

A nation's health policy should aim for optimal health for every member of its population. This will be achieved through integrating both the traditional approach to curing individual illness and the population health approach aimed at early intervention, promoting healthy lifestyles and reducing illness and disability among high-risk populations.

A national focus on health system policy, including workforce planning and management, is integral to ensuring these goals are met. The health workforce must have the appropriate skills and numbers required to meet current and emerging healthcare needs of the population.

For the purposes of this paper, AHA has defined the health workforce broadly to include senior executives and administrators, policy makers, program managers and other clerical staff who provide support to clinicians in health facilities as well as those employed in professional health occupations. Together, these groups total 557,781 (356,088 in health occupations and 201,693 in non-clinical occupations) [AIWH Australia's Health 2004].

Workforce pressures

It is increasingly apparent that the workforce as currently constituted will struggle to cope with the growing pressures of a changing health system, as indicated by a number of high profile system failures which have impacted adversely on the safety of patients.

It is useful to describe these pressures because their presence and/or resolution provide useful insights into the characteristics that will be required of the health workforce in the future.

They include:

Government policies and practices

1. A focus, by all Australian governments, on cost reduction in the public healthcare sector, rather than the cost-effectiveness either of individual institutions or of the whole health sector. For example, funding of public hospitals dropped to 26.7% of recurrent expenditure on health in 2001-02 from 30.7% 10 years earlier in 1991-92 [AIWH Australia's Health 2004].
2. Lack of a national healthcare strategy (including a primary health care strategy described as the cornerstone of a health system and the 'gatekeeper' for specialist services) to support:
   - A needs-based and equitable distribution of high quality services,
   - Community involvement in decision-making;
   - A focus on early diagnosis and prevention;
   - Appropriate use of technology;
   - A multi-sectorial and multi-disciplinary approach; and

- A safe and continuous improvement environment.

3. The tendency for governments to 'blame' senior managers for system failures instead of adopting an approach that encourages open disclosure and reform of systems according to the evidence collected from appropriate analysis.

Demographic impact

4. An ageing workforce. About 39% of people employed in health occupations were aged 45 years or more, up from 31% in 1996.
5. An ageing population. The proportion of Australia's population aged 65 years and over increased from 12.1% in 1996 to 12.6% in 2001. This trend is projected to continue, increasing demand for health services due to the concomitant increase in chronic disease and disability.
6. Sustained low birth rate, resulting in proportionally fewer young people in the population. This has the double effect of reducing the workforce and increasing demand as well as shifting the tax burden for health costs on to fewer people.
7. Poorer health experienced by disadvantaged groups, particularly Indigenous people whose life expectancy is about 20 years less than non-Indigenous people. The socio-economically most disadvantaged fifth of the population are also expected to have a reduced life expectancy of between 2-4 years compared to the rest of the population [AIWH Australia's Health 2004].

Epidemiological impact

8. The emergence of new diseases, such as severe acute respiratory syndrome (SARS) and avian influenza (bird flu). During the 2003 SARS outbreak, a substantial proportion of the over 8000 people infected were health workers.
9. Increasing prevalence of mental illness.
10. Increased life expectancy - now 80 years (average) - but Australians can now expect to suffer disability or illness for about 10% of their life, placing additional pressure on health services [AIHW 2004].

Impact of new technologies

11. An expanding array of new treatments and sophisticated medical technologies which augment demand for care and, in general, do not reduce the need for staff numbers in this highly labour intensive industry.
12. Growth in information/communication technologies.
13. Emerging e-health initiatives.

Impact of attitudes in the workplace

14. The distinct roles, cultures, educational curricula and regulatory structures maintained by professional and other healthcare workers, which create strict demarcations and impede flexible and efficient service delivery.
15. Changing attitudes to work and shifting employment patterns, particularly the trend to work fewer hours and/or part-time. Between 1996 and 2001, there was an overall decrease in the average hours worked from 30.9 to 30.8 per week. This decrease was more marked for doctors (a decrease from 48.1 in 1996 to 45.4 in 2001) and

nurses (a decrease from 32.2 in 1995 to 30.5 in 2001) [AIWH Australia's Health 2004].

16. A greater tendency towards litigation, which discourages practitioners in specialties considered to be high-risk such as obstetrics.
17. Workforce shortages coupled with a reluctance to move into outer metropolitan and rural/remote regions, particularly among doctors, leading to a growing number of 'areas of need'. The concentration of medical practitioners is higher in major cities (296 per 100,000 population) than in all other geographic areas, with remote areas having only about one-third the rate of major cities (108 per 100,000) and very remote areas having less than one-quarter (73 per 100,000). The rate of other health workers decreased with increasing remoteness even more sharply than medical practitioners. However, nurses and primary care practitioners are more evenly spread and the numbers of people employed in community health centres actually increased with remoteness [AIWH Australia's Health 2004].

In summary AHA believes Australia now has outmoded treatment modalities and workforce structures which will struggle to deal with epidemiological and demographic changes. Effective handling of these changes requires an increased focus on longer-term care in community settings utilising multi-disciplinary teams rather than the short-term, intensive and more medically-focussed interventions that have dominated our system in the past.

The exponential advance in surgical techniques and medical practices allow for much shorter hospital stays than in the past. Most rehabilitation and convalescing now takes place in the community, either at home or in step-down facilities. This creates increased pressures on both the hospital system, which has to deal with a higher level of patient acuity, and on community-based services such as general practice, which have to provide care for patients coming out of hospital with more complex needs. As well, new technologies and new ways of providing care will create options for new types of health care worker.

The resolution of these issues will require a concerted health system planning effort at the national level. The inter-connectedness of health system and workforce planning cannot be over-emphasised. The size and characteristics of the health workforce are totally dependent on the nature of the health services and the way services are organised and funded.

Health system context

The AHA believes Australia's current system of funding and delivering health services is far from optimum if we want to achieve an efficient and effective system which promotes continuity of care for the patient/client.

The responsibility for planning, funding and delivery of services involves Commonwealth, state and territory governments. This division of responsibilities is expensive. University of Canberra researcher, Mark Drummond, has calculated that Australian governments could save $2.4 billion a year in public spending by eradicating duplication and overlap in their responsibilities for health and education, with $1.04 billion of savings in health. These savings could be better directed to solving the workforce shortage and assisting

our health system to meet the rising demand for health care in an environment which requires high standards of safety and quality.

The division of responsibilities also creates major barriers to continuity of care. Ideally, incentives should be in place to ensure that care is given in the most appropriate setting by the most appropriate provider. All services should be linked to form a single, integrated service system that attains effective linkages between services, both over time and across boundaries (service, geographical or state/territory).

Simply meeting these goals would require major structural reform to this current system of dual funding for healthcare services. While a number of reform options could be considered, the AHA's preferred model is to have the Commonwealth Government as the single funding body for healthcare services, while devolving responsibility for service delivery to the full extent feasible, to states/territories and/or regions.

Workforce planning context

Fragmentation of health system planning impedes health workforce 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.

Many organisations are involved in sustaining this arrangement, profoundly influencing the structure and size of the workforce and determining the skills of entrants, thus impeding efficient adaptation of the workforce. However, often these organisations carry no responsibility or accountability for ensuring their recommendations are implemented or for ensuring that the staff they train have the skills required for the emerging health system.

This observation is relevant to many autonomous entities such as medical colleges, as well as government funded national advisory committees; for example, the Australian Health Workforce Advisory Committee (AMWAC), covering the nursing, midwifery and allied health workforces, and the Australian Medical Workforce Advisory Committee (AMWAC) which provides advice to governments on medical workforce issues.

In particular, AHA believes that 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.

This structure of occupational monopolies has also inhibited government-led innovations in health policy development, particularly since the end of the Second World War. A turning point in Australian health policy was the replacement of a national health policy vision, in 1949, with strategies that merely concentrated on subsidising the existing pattern of health services so as not to challenge the medical profession's control over supply of these services [Gillespie JA (1991*). The price of health: Australian governments and medical politics 1910-1960*. Cambridge University Press, Australia]. At the time, advocates of

the national health policy had proposed a broad and innovative public health program, nationally coordinated by the Commonwealth Department of Health.

It is time that this broad agenda for change be revived in order to meet the health system challenges of this century.

The AHA has contributed to and participated in many processes seeking to improve the efficiency and organisation of the health system over the last two decades. It seems the broad thrust of findings of all these processes has been similar. What has not emerged is a political process for effecting real change, a process that can accommodate the demands of the different levels of government involved and the demands of private funders and providers.

To achieve this, the AHA strongly believes that all Australian governments must adopt a national health workforce strategy incorporating a nation-wide approach to workforce planning and management and a direct connection to health system planning. AHA urges the Productivity Commission to initiate a way forward.

Recommendation 1

AHA recommends the establishment of a 'National Commission on the Health System and Workforce'. This Commission of experts would make recommendations to the Council of Australian Governments and Australian Health Ministers' Conference. Members would include experienced policy makers and planners, senior administrators and clinicians and academics from Australia and overseas. It is envisaged that the Terms of Reference of the Commission would give it a mandate to examine international systems and recommend creative and innovative options to the Australian Governments within a prescribed timeframe. Members of the AHA's Australian Health Think Tank have the skills and expertise to input to such a Commission.

Health workforce planning and the education system

In addition, it is essential that Australia's education and vocational training facilities produce appropriate numbers and classifications of healthcare professionals to meet the needs of the community in the context of a changing healthcare system. While Australian Government tertiary education and vocational training policies are developed to maximise revenue in that sector without reference to the requirements of the health portfolio, Australia will never be able to accurately plan for a health workforce to suit the 21st century.

Recommendation 2

The AHA urges the establishment of a Ministerial Council representing the Health, Education and Vocational Training sectors to establish a common approach to planning for the health workforce including:

- ***Developing a consensus on the optimal number and ratio of health professionals necessary to meet the population's health care needs, taking into account changing demography, advances in technology and patterns of service delivery;***
- ***Determining the extent of funding required for undergraduate and postgraduate education of health professionals and other workers;***
- ***Developing strategies to ensure effective use of available infrastructure for clinical training;***
- ***Coordinating a nationally funded incentive and scholarship program aimed at recruitment and retention of a skilled workforce in targeted areas; and***
- ***Developing a strategy for rationalising professional registration and accreditation requirements across states/territories.***

Principles for an effective health workforce reform

For safe and effective care, patients must be seen by the most appropriate healthcare professional, at the right time, in the most appropriate setting, and with the right skills and support networks. Taking into account the recommendations above, the AHA has developed a set of principles to underpin a national workforce reform process and recommends that these principles be adopted as minimum requirements for an effective health workforce.

Adequate resourcing

The health workforce must be sufficiently resourced, following national agreement to ensure workforce numbers are appropriate to providing access to safe and sustainable services for all Australians. This will require the services to be arranged and distributed so that they overcome workforce maldistribution, with particular concern for people in areas of need and/or with socio-economic disadvantage. It is critical that Australia achieves national self-sufficiency in health workforce supply. This will not only aid efficient planning but militate against the exploitation of developing nations by western nations through recruiting their medical and nursing staff.

National agreement on workforce data collection

Although there is wide acknowledgement of a shortage of health professionals to meet the demands of new technologies and an ageing population, there is no consensus on the size of the shortfall in this new healthcare environment. Australia urgently needs an approach to this issue that involves Commonwealth and State Government agreement to a national collection of relevant data, provided according to a nationally consistent minimum data set. Determining the quantum of the problem is a required prerequisite to determining a solution.

Patient/client focussed

Australia is a multicultural society. 43% of Australians were either born overseas or have at least one parent born overseas and 15% of our workforce is from a non-English speaking country. Our health workforce should reflect this diversity. Consumer

satisfaction is a key indicator of quality health care and cultural appropriateness is an important factor influencing consumers' experience of the health system. Cultural diversity in our education and training policies is essential, coupled with incentives for Australians from diverse cultural backgrounds to enter health-related professions.

In addition, Australia also needs specific strategies to address the shortage of health professionals from Aboriginal and Torres Strait Islander populations.

There is also a need for formal programs that prepare overseas trained doctors who are already in Australia for the Australian Medical Council's examination. There are thousands of overseas doctors in the country who have passed the first part of the Australian Medical Council's examinations. Their skills are under-utilised because they cannot access training programs that focus on medicine in the Australian environment. Many of these doctors come from countries with significant immigrant populations already settled in Australia. It will benefit our system if we ensure that their valuable medical and language skills are used to provide culturally appropriate medical care to meet the needs of the Australian community.

Adaptability and flexibility

As institutional care services are increasingly replaced with community services, new models of care will be a challenge for the health workforce. It is important that practitioners acquire and maintain new knowledge, skills and attitudes to provide quality services in the new environment.

Workforce re-alignment and re-training will be required to break down the barriers between professional groups and to ensure the workforce has the adaptability to accept flexible roles in the delivery of services, according to competency levels rather than by professional demarcation. Such a workforce will be better structured to overcome access problems resulting from shortages and maldistribution of health professionals.

Multi-skilling should also make work more attractive and satisfying and workers may not have to leave to explore new clinical areas or working arrangements.

Education

Every health worker should be appropriately educated and provided with opportunities and resources to continually improve his/her competency levels through continuing education. Staff development and training can be achieved on the job through mentoring and integrated learning programs.

Undergraduate and postgraduate training must be coordinated across public and private sectors and state/territory jurisdictions to maximise clinical placements and teaching opportunities.

The education and training of health professionals should be arranged to promote a multidisciplinary team approach to healthcare. Such an approach will have an immediate and significant impact on the workforce problem, breaking down demarcation barriers between classifications and creating more flexible roles in the delivery of

services, thus allowing increased responsiveness to changes in workforce availability and consumer demand.

Registration/credentialling and conditions

Registration/credentialling and working conditions should be coordinated nationally to facilitate interstate and cross-sector movement, thus maximising the overall flexibility of the workforce.

Recruitment in the public health system will always remain a difficult issue while salaries remain non-competitive compared with the private sector. Government policies to increase subsidies to the private system without equivalent increases to public hospital funding will attract scarce resources, such as medical specialists, away from the public system. This will result in longer waiting times for public patients and restrict the ability of the public sector to provide high quality care.

Recruitment and retention

A nationally coordinated recruitment and retention strategy (including the selection of overseas trained professionals where it occurs) is essential if Australia is to address service shortfalls due to staff shortages or geographical mal-distribution.

Rising turnover rates suggests dissatisfaction with wages, working conditions or both. In addition to the financial consequences of a high turnover and reduced productivity, quality of care suffers. All health workers should be valued and supported by their employing healthcare organisations and should enjoy good working conditions including appropriate remuneration, flexibility, career advancement opportunities and continuing educational opportunities. High morale and job satisfaction not only reduces attrition but also enhances the experience of the patient/client.

Rural and remote

Without specific policies and programs targeting the rural health workforce, Australia will not be able to meet the health care needs of its rural communities. Examples of innovative schemes are: government supported locum services; rotation schemes to regional/metropolitan health services; assistance to resume career opportunities on return to regional/metropolitan work; and assistance to undertake continuing education including the opportunity to undertake formal qualifications and training through flexible delivery mechanisms such as distance learning and innovative IT solutions.

Evaluation

The workforce must be subject to dynamic evaluation processes that ensure strategies remain valid and that objectives are being met as measured in terms of patient outcomes.

Recommendation 3

AHA recommends that the principles outlined above be adopted as minimum requirements for effective health workforce reform.

Issues impacting on executive/administrative staff and specialist medical staff

AHA would like to specifically draw the Commission's attention to two current issues affecting the workforce.

Administrative and executive staff

The dedicated administrative and executive staff who work in the institutions AHA represents are concerned by some rather simplistic and ill-informed criticism of the numbers of administrators and their roles. For example there have been some quite gratuitous comments made at the Bundaberg Hospital Inquiry about the numbers of administrators in the system.

Such comments do little for an already over-stressed and somewhat demoralised managerial workforce. It is too easy and too often convenient to blame administrators if something goes wrong when the reality is that administrators, along with clinical staff, are struggling to make an under-funded and somewhat dysfunctional system work.

It is worth pointing out that the very dysfunctionality of the funding arrangements creates a need for staff in public institutions who must seek, sometimes through contrived arrangements, funding from a variety of sources such as private insurers and Medicare. This is on top of the ever-increasing administrative burdens imposed on institutions as they strive to put in place systems to meet new requirements such as stringent quality assurance regimens and to achieve accreditation by external bodies.

Specialist medical staff

A frequent workforce tension for public sector administrators is attracting and retaining specialist medical staff. It is important that the Commission understands all aspects of this issue. There is a complex dynamic between the private and public sectors. A commitment to a public sector institution, particularly for acute procedural specialists, can mean a commitment to be available at nights and weekends to manage often difficult situations, for example, dealing with major accidents, drunks, serious injuries etc. The community simply assumes acute high standard public facilities will be there when and if needed. AHA appreciates that such facilities could not function without dedicated medical staff.

However, the reality is that for many specialists the attractions of private practice are great and promise a much more manageable and lucrative lifestyle doing mainly elective work. The attractiveness of such a choice is supported by growing treatment options as technology expands and by a growing private insurance and hospital system that partly reflect sympathetic policy settings and subsidies provided by the Federal government. In

larger cities attachment to public institutions offers doctors many career advantages, such as teaching opportunities, which may not be available in smaller regional cities.

The general point is that attracting specialists can be a thankless task for public institutions in a climate of shortage in many disciplines and when the private option is so attractive. Simply "blaming" administrators when the problem is much more complex is once again the easy but the wrong option.

GP Clinics

The Commission has specifically asked for comment on the benefits or otherwise of GP clinics close to hospital emergency departments.

This is a controversial issue and there are many different views in the health sector on the merits of GP clinics. However, if implemented with the involvement of all stakeholders, and restricted to providing care after hours, the AHA believes that 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.

This will not reduce bed block in public hospitals, as GP-type patients are unlikely to require a hospital bed. However, it 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.

Conclusion

There is no doubt that workforce issues are among the most challenging facing Australia's health system. However, through a national approach, Australia can develop clear and effective strategies to meet these challenges and ensure our health system can continue to provide high quality care.

However, health workforce planning is very long-term. It takes at least ten years for changes to have an impact, even longer in medicine.

Furthermore, Australia cannot rely on simply training more health professionals in the existing categories as demographic and epidemiological environments change. Workforce redesign is required to break down barriers between professional groups in order to create a more flexible approach to healthcare delivery with education and training programs being organised to support these changes..

To support these strategies the AHA recommends, in summary:

- A creative approach to national health system reform through the establishment of an expert Commission to advise all governments at the highest levels on appropriate structures to meet emerging healthcare needs;
- A joint Commonwealth and State approach to health workforce planning which is supported by liaison with the Education and Vocational Training sectors directed by a Ministerial Council;
- Adoption of a set of principles that underpin workforce reform, including robust research and modelling providing hard data on the numbers of health professionals we will need to meet current and future demand; and
- A workplace environment that values the work of all healthcare professionals including executive and administrative staff.

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