Productivity Commission Study into the Health Workforce

Victorian Government Submission

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Victoria
The Place To Be

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Contents

1 Executive summary

The Australian health workforce operates within an environment characterised by a wide range of funding, governance and regulatory structures that impact upon its composition, supply and distribution.

A fundamental undersupply of health places has contributed to current and forecast workforce shortages. At the same time, differences between the public and private nature of health services and existing funding structures have created a range of perverse incentives for practitioners (particularly medical providers) that are exacerbating workforce maldistribution and impeding optimal use of available workforce skills. Similarly, the existence of fragmented, profession-specific regulatory and accreditation schemes are reinforcing professional 'silos.' As currently structured, such bodies afford limited opportunities for external scrutiny and provide few incentives to progress broader workforce change.

Health education and training is inextricably linked to service delivery. Current funding and governance structures do not actively align allocation of health places to forecast service needs, nor recognise the full costs of clinical training. They also prevent optimal use of education and training resources and reduce capacity for innovation.

In Victoria, without substantial reform, there is evidence that it will not be possible to meet even the most conservative estimates of future service demand. For example, since 2000, the local supply of new medical graduates has, on average, only represented 52 per cent of workforce retirements. Net growth has been achieved through a decline in the number of practitioners leaving the state and increased numbers of international medical graduates gaining general registration. Similarly, forecasts suggest an additional 9,113 nurses will be required by 2011-12. Such trends pose substantial challenges, particularly given many locations and clinical specialities are already experiencing significant difficulty recruiting qualified staff.

Problems of this magnitude require more than changes at the margins. Efforts by state and commonwealth governments have typically focused on individual elements of the problem and/or sought solutions at one level of government. Such approaches have had limited success. This reflects the multiplicity of factors that contribute to current health workforce problems and the need for a national, coherent approach that involves both state and national reform.

The challenge for the Productivity Commission and workforce stakeholders will be to identify the combination of reforms that best progress greater efficiency and effectiveness in the training, distribution, and regulation of the health workforce, while preserving accountability, public protection and management of financial risks.

This submission proposes a new approach. Although, much can and should be done at a state and territory level to address some of the problems contributing to workforce shortages, Victoria believes that a number of national solutions are necessary and should be pursued as a matter of priority. Given the interconnected nature of the health and education systems, health professionals and regulatory authorities, these solutions must be interlocking in order to progress reform.

Solutions must also encompass a mixture of short, medium and long term strategies targeted at workforce supply and demand to effect real and sustainable change. Victoria therefore proposes a range of national reforms including:

- Establishing mechanisms that enable States/Territories to control the numbers and allocation of health training places in order to align health places with forecast service demands and to progress educational innovation and reform.
- Using current MBS and PBS structures to improve workforce distribution and support job redesign.
- Promoting interdisciplinary, national approaches to the accreditation of health education and assessment of international practitioners.

Victoria also proposes a range of strategies to improve workforce supply and distribution, recognising that, without addressing the undersupply, the capacity to effect long term, sustainable workforce change will be limited. An overview of the identified problems and solutions proposed by Victoria is provided in Chapter 2 and the specific recommendations from this submission follow

Summary of Recommendations

Supplying the workforce to meet demand

1. *That the numbers of undergraduate health places available within a state or territory be increased and allocated based on planned and identified need for that state or territory.*

2. *That, until the numbers of locally trained health practitioners meet demand, transitional Commonwealth funding is provided to public health services to meet the additional costs associated with recruiting, assessing the suitability of, and training of internationally trained health practitioners.*

3. *That the Commonwealth lead the development of a national scheme for the assessment of the qualifications and skill of internationally trained practitioners, focussing on medicine in the first instance.*

4. *That the Commonwealth, together with States and Territories, review current strategies for attracting qualified staff back into the health labour market with a view to introducing successful strategies more broadly.*

5. *That the Commonwealth increase funding for VET health places, based on planned and identified need for that state or territory.*

6. *That the Commonwealth review eligibility criteria for New Apprenticeships incentives to take into account industry priorities and competencies, rather than focusing on duration of training.*

Influencing the distribution of the workforce

7. *That the Commonwealth explore options for providing subsidies to students undertaking rural clinical placements to encourage greater uptake.*

8. *That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges mandatory rural rotations of 6 months or more for vocational trainees.*

9. *That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges to develop incentives in their training programs to encourage rural rotations.*

10. *That the Commonwealth, States and Territories agree to a common approach to program evaluation and sharing of learnings to inform future national and jurisdictional policy and program development in rural recruitment and retention.*

11. *That the Commonwealth trial limited access to medical and pharmaceutical benefit entitlements for non-medical practitioners in areas of designated GP shortage.*

12. *That the Commonwealth review MBS funding of speciality services to remove disincentives, particularly for areas of known specialty shortage.*

13. *That the Commonwealth consider a range of changes to fringe benefits tax exemptions to increase the attractiveness to health professionals of working in areas of designated workforce shortage.*

14. *That the Commonwealth, States and Territories explore more flexible funding arrangements that explicitly recognise the interdependency between private rural general practices and smaller rural and regional health services.*

Improving workforce planning

15. *That the existing national health workforce planning committees, AMWAC and AHWAC, be replaced by a National Health Workforce Planning Council, reporting to Australian Health Ministers through the Australian Health Ministers' Advisory Council. The role of the National Council would include national whole-of-health workforce planning and leading reforms in workforce data collection and analysis.*

Creating a more responsive education and training system

16. *That the Commonwealth, States and Territories review the funding relativities for health professional education, to ensure that the full costs of clinical education are covered by the Commonwealth allocation.*

17. *That the Commonwealth, States and Territories work together to develop a national scheme that provides fiscally efficient mechanisms for recouping subsidies to health professional education that leads to private sector employment.*

18. *That the Commonwealth, States and Territories work together to explore options for a national scheme that ensures graduates who do not work in the public sector either contribute towards the cost of clinical training, or treat public patients in their private practice for a defined period after graduation.*

19. *That Commonwealth responsibility for health education be streamlined through better integration between DEST and DOHA.*

20. *That the Commonwealth, States and Territories work together to explore options to reconfigure the funding and allocation model for health education and training (for both VET and Higher Education), with the objective of the Commonwealth providing State and Territory control over the allocation and purchase of health education places.*

21. *That the Commonwealth seek a nominee from the Australian Health Ministers Advisory Council to sit on the National Industry Skills Committee.*

Enabling workforce flexibility and productivity

22. *That the Commonwealth, States and Territories work together to explore establishment of a multidisciplinary model for national course accreditation, curriculum leadership and the assessment of international practitioners. Such a national multidisciplinary model should provide an integrated system for the:*

    - *Identification of service stream competencies required for both entry level and more specialised practice across the health workforce.*
    - *Review and streamlining of recognition of prior learning and structures introduced to increase utilisation of these processes.*
    - *Assessment and accreditation of courses for health practitioners seeking to enter (or re-enter) the health workforce.*
    - *Development of standards and guidelines about the criteria and processes for course accreditation and assessment of international practitioners following consultation with key stakeholders such as educational institutions, professional bodies, consumers and government.*
    - *Assessment of courses and determination of equivalence of overseas courses for accreditation purposes.*
    - *Assessment of qualifications of international practitioners and determination of additional requirements (if any) for purposes of registration in any category.*
    - *Progression of innovation in clinical training, to identify opportunities to maximise use of existing capacity and implement innovative training models to complement the existing, apprenticeship model.*
    - *Provision of leadership on national reforms and implement policy directions that allow the education and training system to respond to emerging health industry needs.*

23. *That the Commonwealth, States and Territories work together to explore the establishment of a national scheme for health practitioner regulation. This would provide:*

    - *The establishment and maintenance of a national register listing members of each regulated profession.*
    - *Common categories of registration across Australia.*
    - *National codes of guidance governing the regulated health professions, including any mandatory requirements for assessment by health services prior to commencement of practice.*
    - *Qualification and training requirements for registration.*
    - *Requirements for establishing that applicants are of good health and character and requirements regarding maintenance of professional competence.*
    - *Locally based processes for investigations into the performance/competence, health and conduct of registered health practitioners. The national scheme would act on the findings from these locally based investigations, including removing practitioners from the register.*

After hours GP clinics

24. *That the Commonwealth work with States and Territories to identify successful models for attracting GPs to work in clinics co-located with public hospitals.*

25. *That the Commonwealth work with States and Territories to establish co-located GP clinics in those hospitals experiencing high primary care type patient demand.*

2 The Victorian proposal for integrated reform

Many health workforce issues face governments and stakeholders. Most have been highlighted in the Productivity Commission's Issues Paper for this study, including:

- An undersupply of locally trained practitioners in most health disciplines, with the impacts of workforce ageing over the next 10 years likely to exacerbate this situation.
- Constraints on university training places and tightening eligibility for MBS provider numbers. These constraints have been primarily driven by budgetary rather than quality considerations.
- Poor alignment between funded undergraduate places with forecast service and client needs. In some areas, there is a misalignment between level of training and the complexity of role.
- Despite advances in technology leading to increasing capital intensity, health is likely to remain heavily labour intensive.
- Health workforce shortages currently restrict service delivery in some geographic and clinical areas in ways that are largely random and inefficient.
- The public health sector competes with the private health sector for health workforce.
- The cost of education and training in health is largely borne by governments. Yet many health professionals, particularly medical graduates, may choose to specialise in fields where they have significant private practice rights and can access higher remuneration rates, status and life style opportunities. Medical specialists-in-training currently face few price signals reflecting training costs.
- There has been a fall in the average number of hours worked in most health professions and increasing difficulty recruiting and retaining staff in public health services.
- Existing registration and qualification accreditation systems are profession-dominated. They reinforce profession-specific approaches and cultures and impede and compromise cost-effectiveness, workforce flexibility, innovation and cross border labour flows. As currently structured, there are limited opportunities for external scrutiny and few incentives to progress broader workforce change.
- The complexity of existing responsibilities for the training and employment of health workers - which cross the health and education portfolios at both a state and commonwealth level and include a wide range of public and private stakeholders – makes reform to education and training slow and highly contested and minimises the capacity to leverage government investment.
- Current governance and funding structures for VET and higher education limit the capacity to alter the relative mix and distribution of health places between these two sectors in response to emerging service needs.
- Current education models involve long training periods, which make it difficult to effectively undertake workforce planning or respond to emerging service needs.

To date, multiple strategies and programs have been pursued by different parts of the health sector to incrementally tackle those issues within their direct control. For its part, Victoria has initiated a range of state based strategies to address the identified workforce issues, including:

- Substantial investments in initiatives to support workforce education, training, recruitment and retention (over $150 million per annum).
- Establishment of innovative models to improve workforce distribution, such as training consortia.
- Development and implementation of a strategy to explore opportunities for job redesign in health.
- Development of strategies to leverage current investment in education and training to progress health workforce priorities.
- Increased emphasis on influencing the education and training sector.
- A review of the system of Victorian health practitioners regulation, to improve transparency, flexibility and consistency.

Although these initiatives have had varying levels of success, many factors that contribute to current health workforce problems are outside the control of individual states and territories. A broader, systems-approach to reform is needed in order to achieve real and sustainable change. Pivotal to such reform is an understanding of the context within which the health workforce operates and the interrelationships between factors influencing the workforce and broader public policy objectives.

The health system in context

Economic problems of the health sector

The health sector is characterised by a complex web of interrelationships. Health care practitioners often play multiple roles within the system, participating not just in patient care but also policy development, practitioner regulation, credentialing and a range of other processes that influence both workforce composition and professional roles. Such involvement reflects high levels of clinical expertise, however, it can also impede cultural change and wider workforce reform.

The health sector has special economic problems that constrain the application of the traditional competitive model. Key among these are:

- An individual's need for health services is irregular and unpredictable. Apart from preventative health services, health services are generally consumed at a time of illness.
- Health services, and their subsequent consumption, are associated with risk, including death or impairment.
- A consumer is unable to 'test' health services before consumption. There is generally a high degree of trust in the relationship between health professional and patient.
- Information asymmetry – the health professional knows vastly more about a disease and its treatment than a patient.
- Ensuring workforce quality has led to barriers to entry to the health workforce. This includes restrictions on the number of individuals able to train and the licensing requirements for professionals.

These problems are used as a rationale for a range of government interventions. These include funding medical services and products and regulating minimum standards for health service facilities, health devices and products, health practitioners, service quality and health information.

Economic analysis of the health workforce problem

The economic problems currently being experienced in the Australian health workforce are quite distinct. In particular, they can be characterized as a market disequilibrium between labour demand and supply, that is, the quantity of skill supplied by the workforce and the quantity demanded by employers diverge under existing market conditions. This disequilibrium is not a market failure, rather it indicates that a range of factors are preventing workforce supply and demand from aligning.

In analysing the health workforce problem it is useful to consider how a competitive market would adjust to a disequilibrium. In such a market, the only government involvement in the health workforce would be in the licensing of health professionals. Possible solutions in a competitive, unregulated would include:

- Adjusting the price paid for labour, with price representing employment conditions (i.e. hourly wage, hours worked, time of work, family friendly hours, fringe benefits etc).
- Substitution between labour and capital, and between types of labour.
- Reducing the demand for health services being providing by labour through price signals.

A competitive market would be unable to address market disequilibrium through some of the policy tools currently being used, including:

- Adjusting the supply of labour through migration. A competitive market would already have a free flow of labour between countries.
- Increasing the number of training places. Government would not be involved in training other than setting minimum entrance requirements. In such a scenario, demand and supply for training places would already be in equilibrium, subject to minimum entrance requirements. An increase in the number of trainees would be at the cost of a reduction in trainee quality below existing standards.

Health is a significant cost to governments, representing approximately 17.5 per cent of Australian general government expenditure in 2003-04 and forecast to grow. In the face of this outlook, cost containment measures such as restrictions on which health services and products are eligible for public subsidies, and measures to increase utilisation of privately funded services, remain important policy instruments to manage the financial risk to governments.

The Australian health workforce therefore operates within an environment in which existing funding, governance and regulatory structures impede efficient operation of traditional market based approaches and public expectations of access to, and safety of health services limit the capacity to remove such barriers. In addition, the complexity of governance arrangements, in which there are structural disconnects between key areas such as responsibility for funding of health services and education and few, if any, incentives for providers of these services to work co-operatively, militate against optimal use of available resources and reduce government capacity to leverage its investment.

This impacts significantly on the composition, supply and distribution of the Australian health workforce and ultimately, its capacity to meet future health service needs by restricting who can provide services and the cost of these to consumers. Several socio-demographic factors are forecast to further exacerbate existing problems:

- Increasing demand for health services. In Victoria, this is forecast to continue to grow significantly over the coming decades as a result of overall population growth, the increasing proportion of older people, technological advances, improved treatment options, and higher community expectations of, and interest in, health services.
- Ageing of the current health workforce, with a large proportion due to retire in the next 20 years.
- Changing participation rates, with health professionals choosing to work shorter hours or part-time.
- Continued workforce attrition or job wastage rates.

In addition:

- Growth in the private health sector has seen shifts in the relative mix of public/private provision with flow on impacts upon workforce distribution, training models and associated costs.
- The changing burden of disease, coupled with technological developments has seen significant shifts in the conditions treated, the workforce required to do so and public expectations.

The role of government

Service delivery capability can be jeopardised either by overall undersupply of particular workforce groups or by uneven supply across geographic areas or service sectors. In individual services, such circumstances constitute challenges for service managers and other service delivery staff. When such issues become widespread they constitute system level crises involving not only service providers but the community, staff representative bodies and ultimately government.

The World Health Organisation[1] has identified four key functions for health policy makers: providing services; generating the human and physical resources that make service delivery possible; raising and pooling the resources used to pay for health care and, stewardship:

> *The government is particularly called on to play the role of a steward, because it spends revenues that people are required to pay through taxes and social insurance, and because it makes many of the rules that are followed in private and voluntary transactions.... Private insurers and practitioners, however, perform this function in only a slightly restricted degree, and part of the state's task as the overall steward or trustee of the system is to see that private organisations and actors also act carefully and responsibly. A large part of stewardship consists of regulation, whether undertaken by the government or by private bodies which regulate their members, often under general rules determined by government. But the concept embraces more than just regulation, and when properly conducted has a pervasive influence on all working of the system.*

It has been suggested that the identified problems in the health workforce are exacerbated by too much government intervention and that these would be resolved by largely deregulating the health labour market. Whilst some might consider this to represent an economically rational solution, it does not take into account public expectations of government in relation to health, nor recognise the linkages of other government interventions in the health sector to the health workforce. For example, the MBS payments system provides many disincentives to health workforce behaviours that could, if addressed, reduce the magnitude of the health workforce problems.

There also remains a strong public protection argument supporting a high level of involvement in health workforce issues. Indeed, much of the regulation that impacts upon the health workforce has been subject to the national competition policy public benefit test and shown to provide a net public benefit. Even if this were not the case, public accountability demands government involvement, and cases such as Bristol and Shipman in the UK and more recent events in Queensland have illustrated that, if anything, governments are being held more accountable for ensuring there is an adequately trained workforce to support service delivery.

This is particularly evident in relation to regulation of health professionals, where traditional approaches that have largely left operation of regulatory systems to the professions being regulated are being replaced by schemes that emphasise higher levels of accountability, independence from the professions and a greater role for government in scrutinizing their operation.

[1] *The World Health Report 2000. Health Systems: Improving Performance*. Geneva, Switzerland.

Reform proposal

Seeking broad deregulation within this environment is not a pragmatic or practical option. However, the current dynamic environment necessitates active approaches in order to ensure that there is an adequate and appropriately skilled workforce to sustain future health services. This is likely to require significant changes to the composition of the workforce and how it is deployed, which in turn will necessitate changes to the nature, scope and distribution of health education and training and rethinking of how both VET and higher education sectors can most effectively contribute to this goal.

The challenge is thus to identify reforms that could promote greater efficiency and effectiveness in the training, distribution, and regulation of the health workforce, yet do so in a manner that recognises the need to preserve those elements essential to broader public policy objectives such as accountability, public protection and management of heath and financial risks.

This submission identifies opportunities to remove negative incentives and, where possible, restructure governance, regulatory and funding mechanisms to establish/expand positive incentives for stakeholders to progress workforce reform. This approach seeks to establish new working relationships between key participants in the education, funding and regulation of the health workforce and in doing so, clarify roles and responsibilities of health and education departments at both a State and Commonwealth level.

This submission also recognises that future approaches to workforce planning and leadership must include a greater role for the private sector, given its increasing role in health service provision. Failure to deliver services in either sector will, as a consequence, place pressure on the other. As the provider of last resort, it is in the interest of the public sector that private providers remain viable and continue to deliver services. Indeed, it is essential that governments at all levels work in partnership with key stakeholders to develop sustainable health workforce solutions, in particular with public sector service providers and their workforces.

A truly effective health workforce system will be one that responds quickly and continuously to changes in the broader health sector. Within the context of current workforce shortages and increasing demand, key health workforce challenges relate to:

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

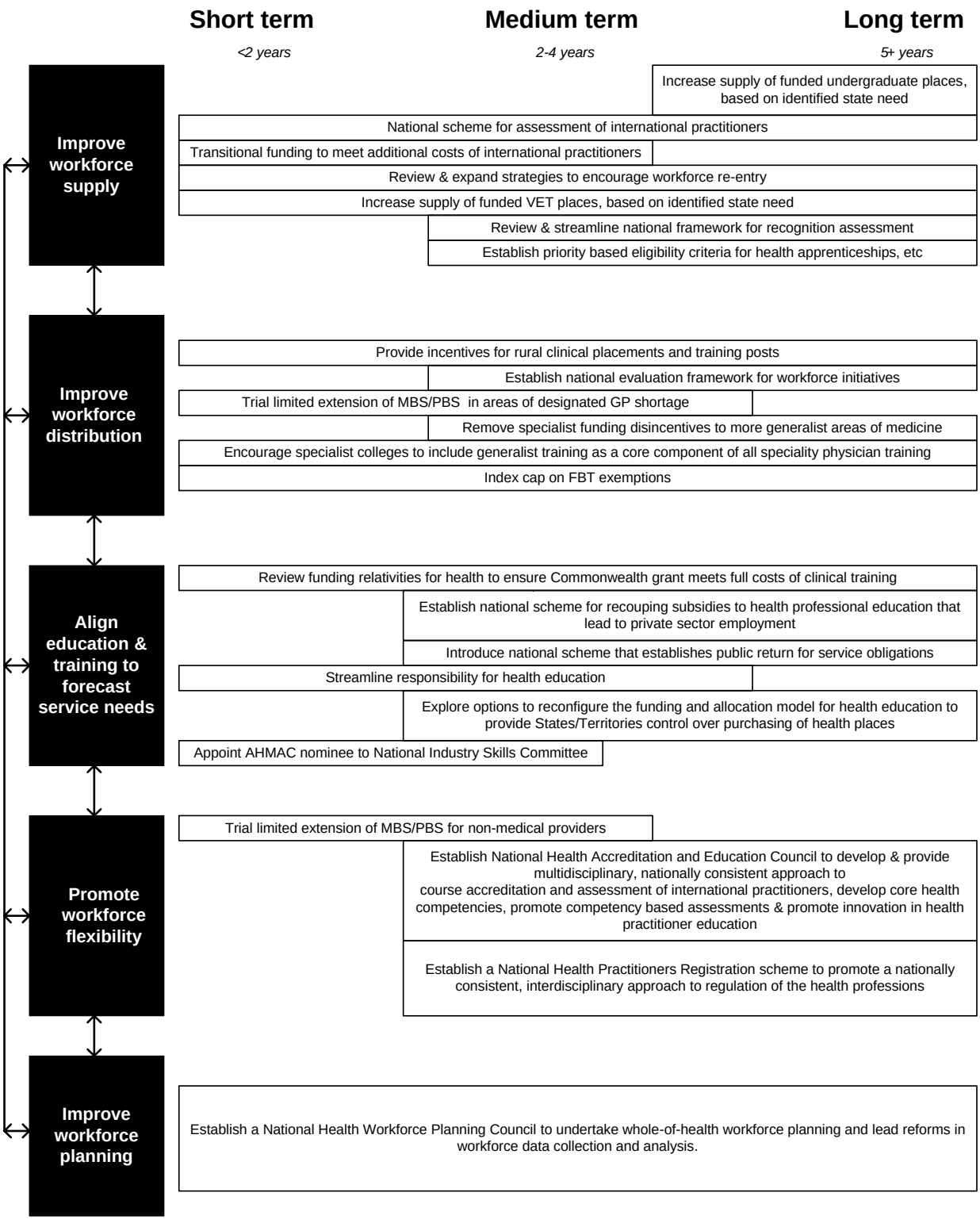
Reform of the systems that underlie the supply, education and regulation of the workforce must ensure that:

- Workforce planning is integrated with service planning and program development and that rigorous analyses of workforce issues inform policy, planning and budgetary processes.
- Significantly greater capacity for evidence-based decision making is developed, including an improved ability to monitor changes in supply and demand across program boundaries and professions.
- The impact of broad trends in health workforce, including those from new technology and emerging models of care are identified, understood and responded to.
- There is maximum return on investment of public monies.
- Where regulation exists, it operates in a responsible and cost effective manner and balances public interest with protection from risk.
- There is flexibility in the workforce, based on an understanding of the required competencies to meet service needs and enhance clinical practice.
- There are strategies in place to effectively promote competition and markets where necessary.
- Unnecessary and illogical boundary issues arising from Commonwealth, State and Territory investment and management of the health and health eduction sectors are resolved.
- Governments partner with stakeholders to identify and address workforce issues.

Given the interconnected nature of the health and education systems, health professionals and regulatory authorities, solutions must be interlocking in order to drive reform to enable supply to better match demand into the future. Victoria also recognises that a mixture of short, medium and long term strategies will be necessary to effect real and sustainable change.

The proposed reforms are aimed at improving the efficiency and effectiveness of schemes that underpin the training, regulation, assessment and accreditation of the Australian health workforce, recognising that these are key enablers to achieving greater flexibility and improving the alignment between training outcomes and service needs.

The submission also proposes strategies to improve workforce supply and distribution, recognising that, without addressing the fundamental undersupply, the capacity to effect long term, sustainable workforce change will be limited. An overview of the proposed reforms by Victoria is provided in the following diagram.


Short term
<2 years
Medium term
2-4 years
Long term
5+ years
Improve workforce supply
Increase supply of funded undergraduate places, based on identified state need
National scheme for assessment of international practitioners
Transitional funding to meet additional costs of international practitioners
Review & expand strategies to encourage workforce re-entry
Increase supply of funded VET places, based on identified state need
Review & streamline national framework for recognition assessment
Establish priority based eligibility criteria for health apprenticeships, etc
Improve workforce distribution
Provide incentives for rural clinical placements and training posts
Establish national evaluation framework for workforce initiatives
Trial limited extension of MBS/PBS in areas of designated GP shortage
Remove specialist funding disincentives to more generalist areas of medicine
Encourage specialist colleges to include generalist training as a core component of all speciality physician training
Index cap on FBT exemptions
Align education & training to forecast service needs
Review funding relativities for health to ensure Commonwealth grant meets full costs of clinical training
Establish national scheme for recouping subsidies to health professional education that lead to private sector employment
Introduce national scheme that establishes public return for service obligations
Streamline responsibility for health education
Explore options to reconfigure the funding and allocation model for health education to provide States/Territories control over purchasing of health places
Appoint AHMAC nominee to National Industry Skills Committee
Promote workforce flexibility
Trial limited extension of MBS/PBS for non-medical providers
Establish National Health Accreditation and Education Council to develop & provide multidisciplinary, nationally consistent approach to course accreditation and assessment of international practitioners, develop core health competencies, promote competency based assessments & promote innovation in health practitioner education
Establish a National Health Practitioners Registration scheme to promote a nationally consistent, interdisciplinary approach to regulation of the health professions
Improve workforce planning
Establish a National Health Workforce Planning Council to undertake whole-of-health workforce planning and lead reforms in workforce data collection and analysis.

3 Understanding and managing demand for services

Demand for public health services is continuing to increase largely driven by:

- Increases in population, including, a growing proportion of older people.
- A changing mix and nature of services provided by public hospitals, in response to a decreasing prevalence of conditions such as infectious disease and an increasing prevalence of cancers and chronic and complex disease conditions.
- Technological change that is continuing to drive the use of increasingly sophisticated investigation and treatment modalities. These new technologies, drugs and medical and surgical techniques are changing which conditions can be treated and the way many are managed.
- Changes to clinical practice and models of care, with less reliance on bed-based services and increased same-day, ambulatory or community based service options. This is changing the traditional roles of hospitals and community and primary care providers.

In addition, other factors have emerged to challenge the delivery of contemporary health services:

- A decline in the number of clinical practitioners with the skills and capacity to meet demand for procedural work in some geographic and clinical specialty areas. This has led to an increased concentration of treatment in larger regional and metropolitan centres.
- Community perceptions that changing service mix and reduced reliance on inpatient beds mean that health services are deteriorating, despite significant and increasing investment.
- Tight budgets that have made efficient and effective service delivery a priority.

The Victorian Department of Human Services (DHS) undertakes extensive work to forecast service demand for the purposes of planning service delivery into the future. DHS uses a model that analyses past trends of service activity and, taking into consideration future population growth, including ageing and differences in geographical growth areas, forecasts utilisation rates.

Forecasts in the major areas of the health system indicate substantial growth in demand over the next decade and beyond (Fig.1):

- *Public Hospital inpatient services*

  Victorian public hospitals are treating a growing number of people. Since 1999-2000, separations for admitted patients alone have increased by 17 per cent. Through to 2018, they are forecast to increase by a further 3.2 per annum or a total of 63 per cent. This does not take into account the significant growth in non-admitted services (such as, outpatient, rehabilitation and geriatric evaluation and management) increasingly delivered by hospitals to Victorians.

- *Aged Care*

  Demand for aged care services, as measured by the number of aged beds (although this number is capped by the Commonwealth), has grown by approximately 2 per cent per annum since 2002. Through to 2018, demand is forecast to grow a further 32.5 per cent.

- *Community Health*

  Forecast demand for community health services through to 2018, as measured by occasions of service, is expected to grow by 3.8 per cent per annum, or a total of 78 per cent over 2001-02 service levels.

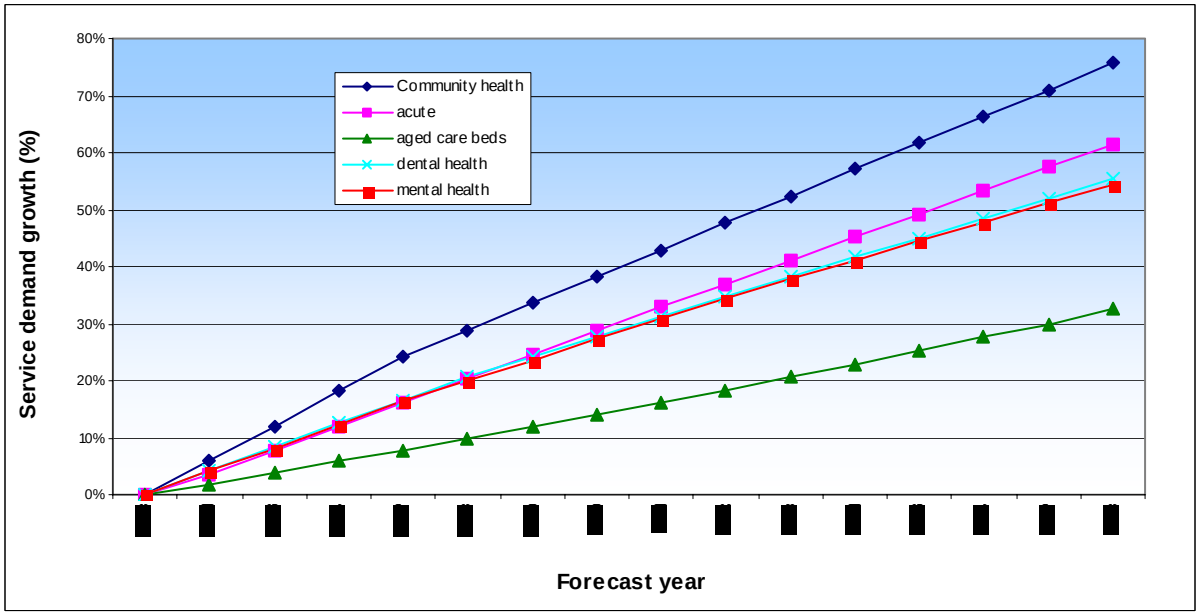
- *Mental Health*

  The number of occasions of service for registered public mental health clients is forecast to grow at 3 per cent per annum from 2001-02 to 2016-17. Bed based services are forecast to increase at 2.9 per cent per annum.

- *Dental Health*

  The number of occasions of service for public dental health care is forecast to grow by 3 per cent per annum for the period 2001-02 to 2016-17.

Figure1 Service demand forecasts to 2018, Victoria



Source: Victorian Department of Human Services

3.1 Private-public share of health care

Demand pressures on public hospital services have not been dampened by the growth in private sector provision.

Data indicate that:

- Despite the increased uptake in private health insurance coverage and changes in hospital utilisation patterns, private hospital services are not substituting for public hospital services.
  - Sundararajan, V et al. (2004) found that in Victoria the public hospital sector is providing the greater proportion of emergency and medical care and treating a higher proportion of older patients and those with more severe disease levels; the private hospital sector is providing more elective surgical care.
  - Increasing use of hospital bypass by private hospitals in Victoria at a time when levels of bypass remain low in the public sector. The level of private hospital bypass was 13.5 per cent of available operating time for the June quarter 2004-05 compared to 1.3 per cent for public hospitals.
  - Of the 60 private hospitals in metropolitan Melbourne, only six offer 24-hour emergency departments – Cabrini, the Epworth, Freemasons, John Fawkner, the Valley and Knox.
- Overall demand for health services in Australia is increasing. Public hospital separations have grown at an average of 2.1 per cent per annum since 1999-00, despite a growth in private hospital separations of 6.8 per cent over this same period (*Australian Hospital Statistics,* AIHW, 2003-04).

In the current environment of increasing demand for health services across both the public and private hospital sectors, competition for qualified health professionals will increase, further exacerbating workforce shortages.

3.2 Directions for Victoria's health system

The overarching policy direction for the Victorian health system is to build capacity for care in community settings thereby facilitating a better balance between primary, preventive care and acute hospital care.

The objectives are to:

- Enable the health system to deliver the most appropriate and cost-effective mix of care.
- Better position the health care system to manage future demand pressures.
- Ensure the sustainability of the health system in the longer term.

The population is ageing and with this comes an increase in chronic diseases and multiple co-morbidities. This has changed the patient groups who present to the emergency department and/or are admitted to hospitals. In 2003-04, 4 per cent of patients managing chronic and complex conditions were responsible for 15 per cent of emergency separations totalling 68,000 attendances.

Many hospitalisations for patients with chronic and complex conditions are considered avoidable with better preventive care and early disease management. Much of this care could be provided in community settings. The current service structure does not support the integration of services and best outcomes for patients.

Victoria has directed investment in recent years to help ensure this policy direction is achieved. A number of major Victorian government policy documents detail the approach, including:

- Directions for your health system: Metropolitan Health Strategy.
- Community Health Services: creating a healthier Victoria.
- Primary Care Partnerships – Strategic Directions 2004 to 2007.
- Improving the Care of Older Persons.
- Integrated Cancer Services Framework.
- Future Directions for Victoria's Maternity Services.
- Hospital Demand Management Strategy, including the Hospital Admission Risk Program.

Victoria is relatively well-placed in respect of infrastructure with its:

- Statewide networks of:
  - Centres Promoting Health Independence, which provide community based rehabilitation.
  - 100 Community Health Services.
- Health Precinct model with three new Super Clinics scheduled to open in 2006-07.

Over the next few years, Victoria will be working to:

- Develop system structures and processes to link the component parts of the health system.
- Ensure financial incentives support a better mix of early intervention, preventive approaches and hospital care.
- Ensure organisational structures support the delivery of an optimum mix of services.

3.3 Managing service demand

Victoria has adopted a multi-pronged strategy for managing service demand.

Productivity improvements

Technical advances have allowed many surgical procedures to move from multi-day to same-day treatment, reducing the overall length of stay for people in hospitals. The proportion of patients admitted for same-day treatment in public hospitals has increased from 48 per cent in 1999-2000 to 53 per cent in 2003-04.

Expansion of community based service options

Victoria has invested heavily in expanding community based health care options, including:

- Hospital in the home.
- Post-acute care program.
- Interim care for people waiting for residential aged care.
- Sub-acute services, including community rehabilitation, outpatient services, home-based rehabilitation or therapy services, and specialist clinics.
- Most recently, a range of innovative models of care funded under the Hospital At Risk Program (HARP).

Early intervention and hospital 'at risk' programs

The health status of Victorians is high. Increasingly affluent and keenly aware of the perceived benefits of improved medical treatments and technologies, Victorians have come to expect a high standard of public health service provision and immediate access to new technologies. In the context of fiscal and health workforce pressures, such expectations may be unrealistic.

Victoria has taken some initial steps in shaping expectations about the way in which health services are delivered, with increasing emphasis on illness prevention and self-management:

- An additional $4.7 million ($19.5 million over four years) has been allocated in 2005-06 to new early intervention programs in community health services. Early intervention services will target people with chronic illness and complex co-morbidities who are at risk of hospitalisation. This initiative will fund multidisciplinary chronic disease management teams in targeted regional centres to provide integrated care management, nursing, allied health and chronic disease self-management courses. The primary care partnerships covering the catchment areas will be given additional resources to develop chronic

disease care pathways, including engaging GPs, implementing e-Referral and coordinating access to self-management programs within their catchment areas.

- Over the period 2001-02 to 2004-05, Victoria allocated $150 million to pilot HARP. HARP was established to address sustained increases in demand on the public hospital system. The program provided comprehensive community based services to frequent hospital users to help them stay well.

  Successful initiatives are being extended statewide in 2005-06 with additional funding of $11 million ($45.6 million over four years). The target population for the new Victorian Chronic and Complex Care Program will be frequent hospital attendees with:

  - Chronic heart disease.
  - Chronic respiratory disease.
  - Complex needs.
  - Complex psychosocial needs.

Improving future health outcomes, however, will require the health system to adopt a greater prevention and primary care focus. The Council of Australian Governments (COAG) reform agenda needs to develop a national health workforce strategy that addresses today's problems, while developing the ability of labour market arrangements to support the health workforce of the future.

4 Supplying the workforce to meet demand

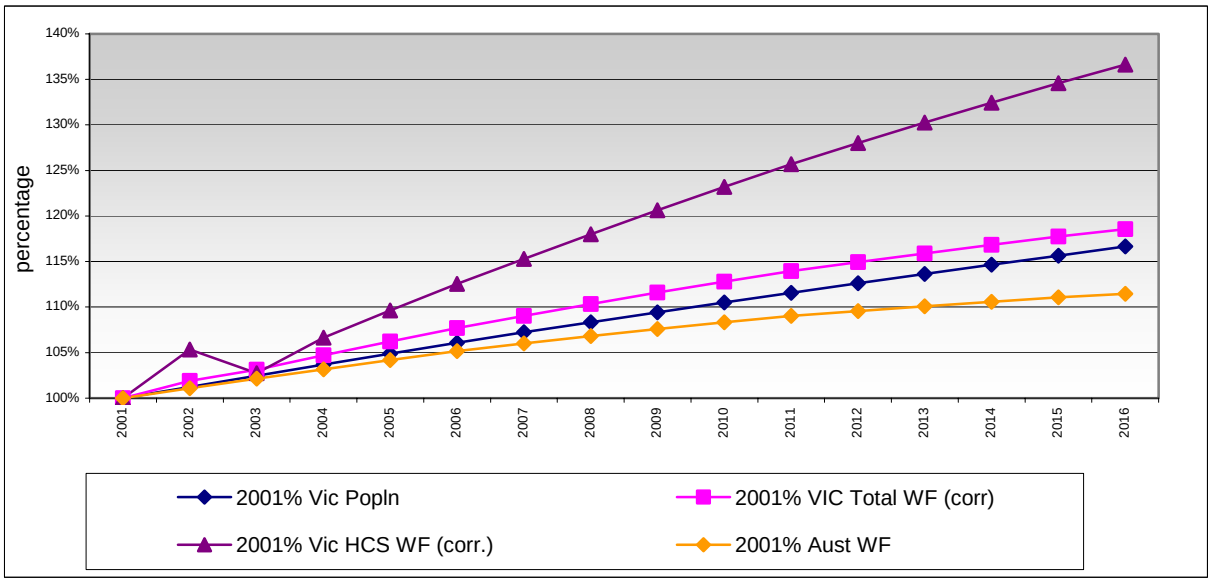
Approximately 70 per cent of health expenditure is on labour costs. Unlike other industries, where advances in technology have led to increasing capital intensity, health is likely to remain heavily labour intensive.

Employment in health has been expanding at 3 per cent per annum nationally over the last ten years - one and a half times the rate of employment growth for industry overall.[2] In 2003, there were 692,600 people employed in health services across Australia, with occupations in the hospital sector accounting for 62 per cent of employment. Of these, 47 per cent had qualifications delivered by the higher education system.[3]

In Victoria, in the year to August 2004, the growth in health sector jobs increased by 10.2 per cent, while hospital and nursing home employment rose 6.3 per cent[4].

Based on current supply patterns, the proportion of the Victorian workforce employed in health services is forecast to grow through to 2016 by 37 per cent, much higher than forecast growth of the Victorian population or its workforce (18 per cent) (Fig.2).

Figure 2 Projected workforce growth, Victoria, 2001-2016



The forecast rate of service growth is projected to exceed this overall workforce growth. As noted earlier, the following service growths are predicted to 2016 should past trends in service utilisation continue:

- Acute inpatients 63 per cent
- Aged Care 32.5 per cent
- Community Health 78 per cent
- Mental health 42 per cent
- Dental health 55 per cent

4.1 Reductions to the supply pool

4.1.1 Ageing of the workforce

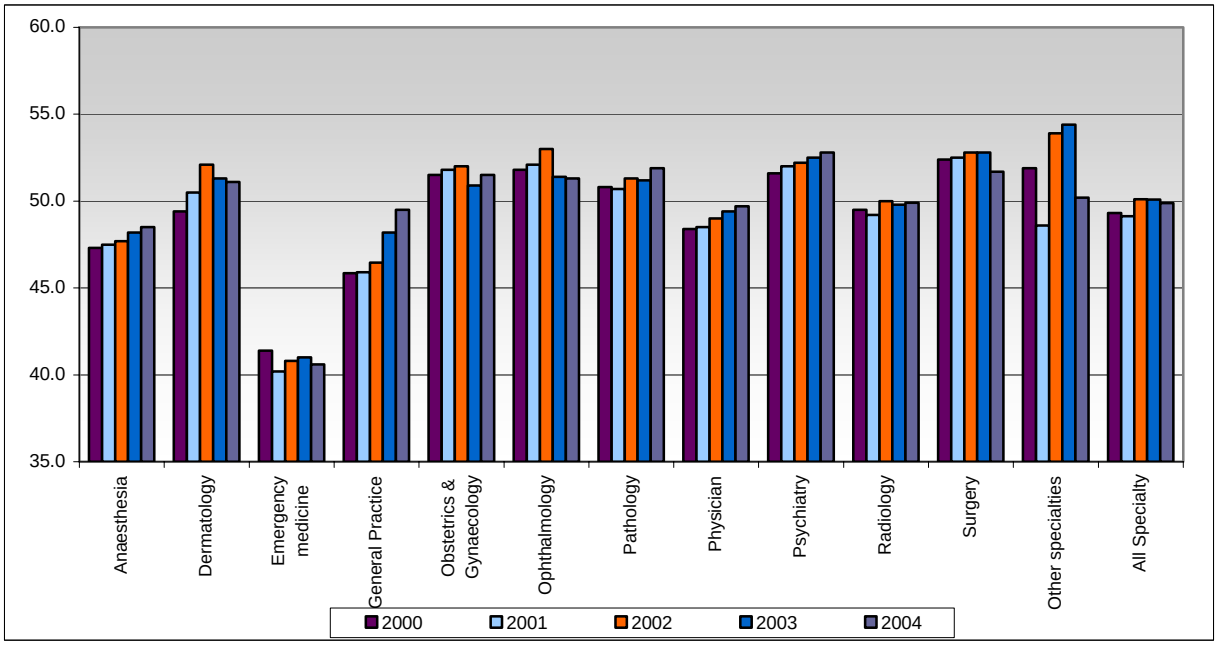
Australia's total labour force participation rate is projected to decline in the coming decades as the proportion of the population aged over 65 years increases. The impacts, however, are already being felt. In 2005, 35 per cent of the workforce will be aged over 45 years with the proportion of new entrants into the workforce declining. An ageing workforce has the potential to accelerate losses to the overall workforce supply pool.[5]

[2] Community Services and Health Industry Skills Council *Industry Skills Report*, May 2005 p 2.
[3] Community Services and Health Industry Skills Council *Industry Skills Report*, May 2005 p 16
[4] The Age Employment Forecast December 2004-February 2005.
[5] Australian Bureau of Statistics Cat No. 6291.0.55.001, Labour Force, Australia

Medical

Data from the Victorian Medical Labour Force Surveys conducted from 2000 to 2005 indicate a general upward trend in average age. The specialty showing the greatest increase was General Practitioners whose average age increased from 45.9 years to 49.5 years over this period (Fig 3).

Figure 3 Average age by Medical Specialty, Victoria 2000- 2004

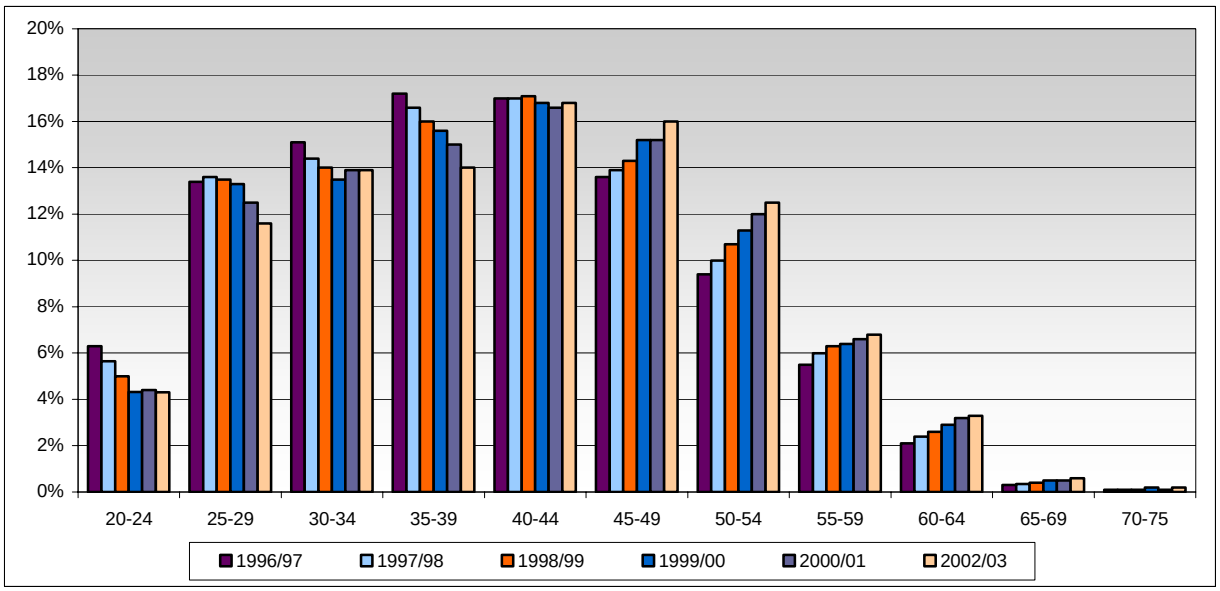


Source: Victorian Medical Labour Force Surveys, 2000 to 2004

Nursing

Data from the Victorian Nurse Labour Force Surveys conducted from 1996-97 to 2002-03 indicate that the average age of Division 1 nurses increased from 38.6 years in 1996 to 41.2 years in 2002 (Fig 4). Over this same period, the average age of Division 2 nurses increased from 38.7 years to 42.9 years.

Figure 4 Average age, Division 1 Nurses, Victoria, 1996-97 to 2002-03



Source: Victorian Nurse Labour Force Surveys, 1996 to 2002. There is no data for 2001-02.

4.1.2 Changing working patterns

Workforce shortages are also exacerbated by changing workforce values and priorities, such as preferences for shorter working hours, earlier retirement and more flexible working arrangements, including part time work and job sharing. There has been a decline in average weekly hours worked across all age groups and all major occupation categories, that is, specialists, primary care practitioners, specialists in training and hospital non-specialists.

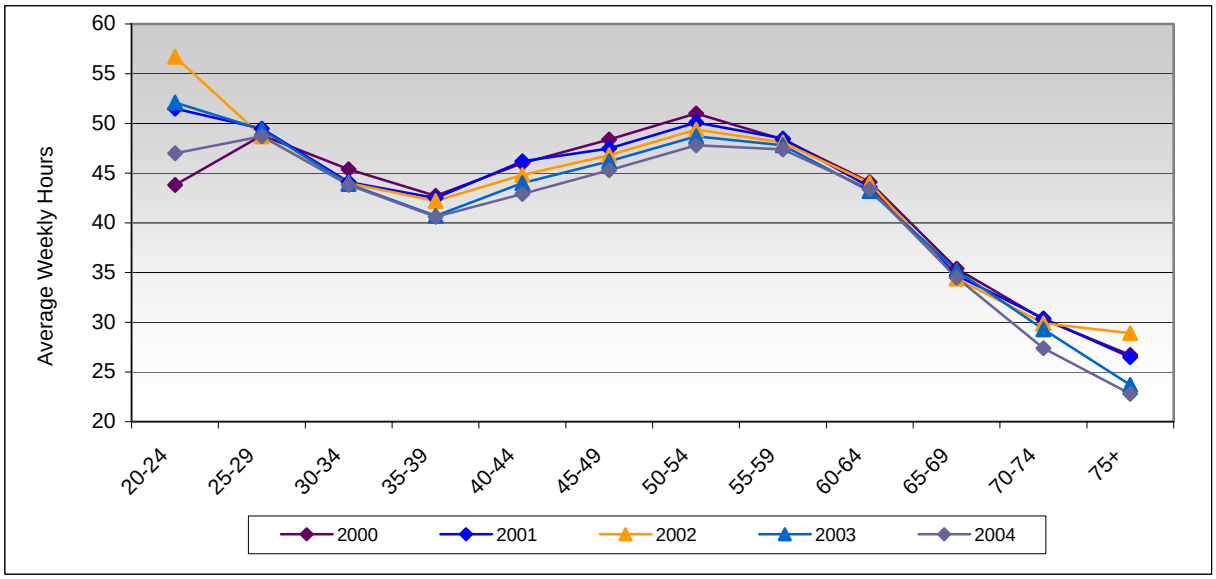
Medicine

Nationally, the average weekly hours worked by all doctors declined from 48.1 hours in 1996 to 44.4 hours in 2002. Clinical hours worked per week fell from an average of 45.4 hours in 1996 to an average of 42.0 hours in 2002. Most significantly, there has been a decline in the hours worked by male doctors (51.1 hours in 1996 down to 47.4 in 2002) although female doctor's hours have also declined (40.2 hours in 1996 down to 37.3 hours in 2002). This reduction in hours worked equates to approximately 4,800 FTE per annum[6].

In part, this reduction has been attributed to increasing feminization of the workforce. In part, the reduction is due to younger doctors working fewer hours and employers recognizing the value of 'safe hours', consistent with the AMA's National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors. In Victoria, health services have agreed that the AMA National Code is a suitable framework under which to consider rostering or working hour issues.

Victorian data indicate a decrease in hours worked. Over the period 2000-2004, the average hours worked by all medical practitioners declined from 44.9 hours 43.0 hours. The decline was evident across all age cohorts, with the greatest decline seen in the 40-44 years, 45-49 years and 50-54 years age groups (Fig. 5). This reduction equates to a loss of 561.2 medical FTE per annum.

Figure 5 Average weekly hours by age of all medical practitioners, Victoria, 2000-2004

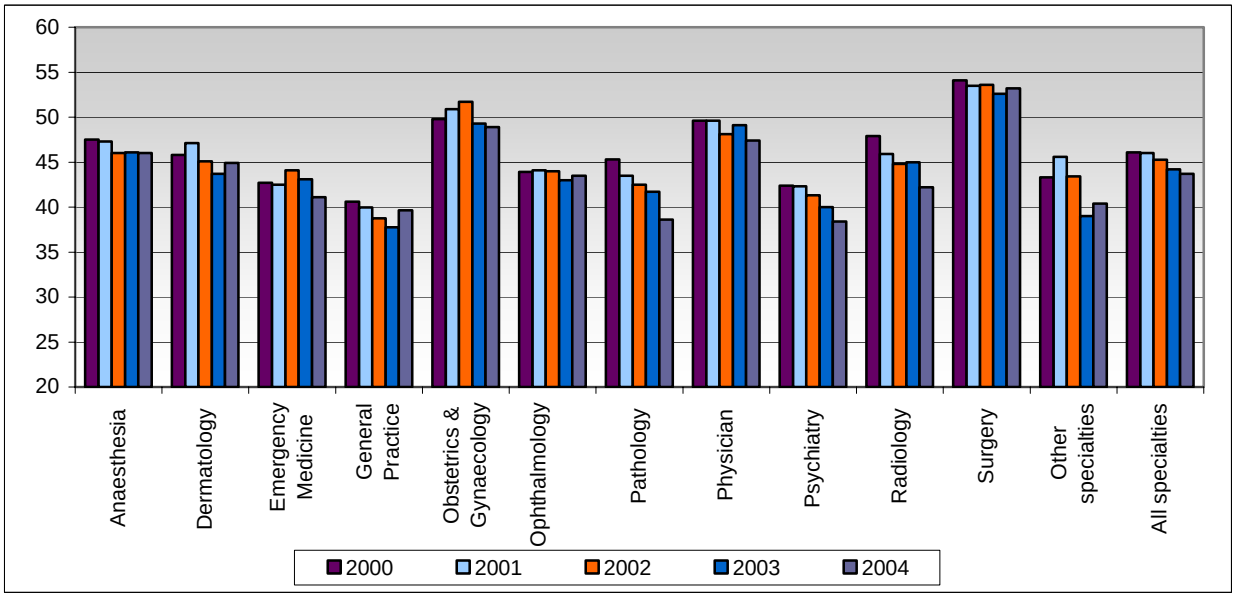


Source: Victorian Medical Labour Force Surveys, 2000 to 2004

6 Australian Medical Workforce Advisory Committee, Annual Report 2003-04 AMWAC, November 2004

The greatest decline was in the medical specialties: radiology and pathology, where the average hours worked decreased by 6.7 and 5.7 hours per week respectively over the period 2000-2004 (Fig 6).

Figure 6 Average weekly hours by medical specialty in Victoria, 2000-2004



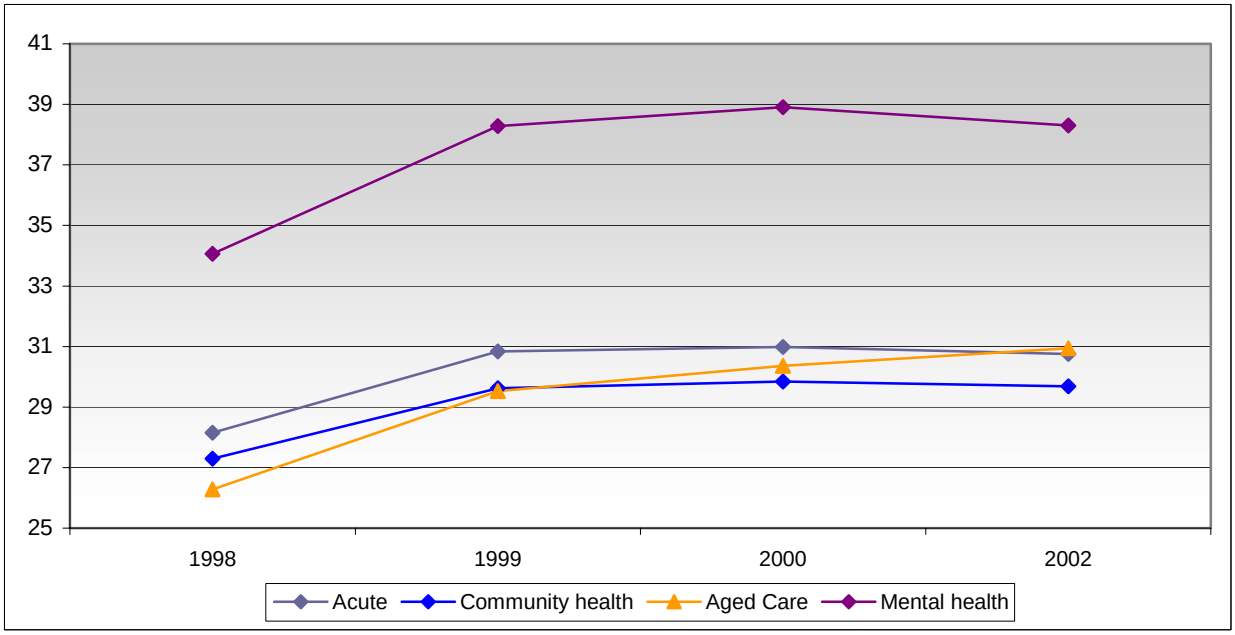
Source: Victorian Medical Labour Force Surveys, 2000 to 2004

Nursing

Nationally, the average hours worked by nurses decreased from 32.4 hours in 1995 to 30.5 hours in 2001, a reduction of 1.9 hours. Although a relatively small decrease, given the size of the workforce, this equated to a loss of approximately 26,500 FTE per annum.

Victorian data, however, did not follow this trend. Data from the Victorian Nurse Labour Force surveys indicate that the hours worked by nurses in Victoria have generally remained steady since 2000 (Fig. 7). This may be attributable to the Victorian Nurse Recruitment and Retention campaign, introduced in 2000.

Figure 7 Division 1 Public Sector Nurses, Average Working Hours, Victoria, 1997-98 to 2002-03

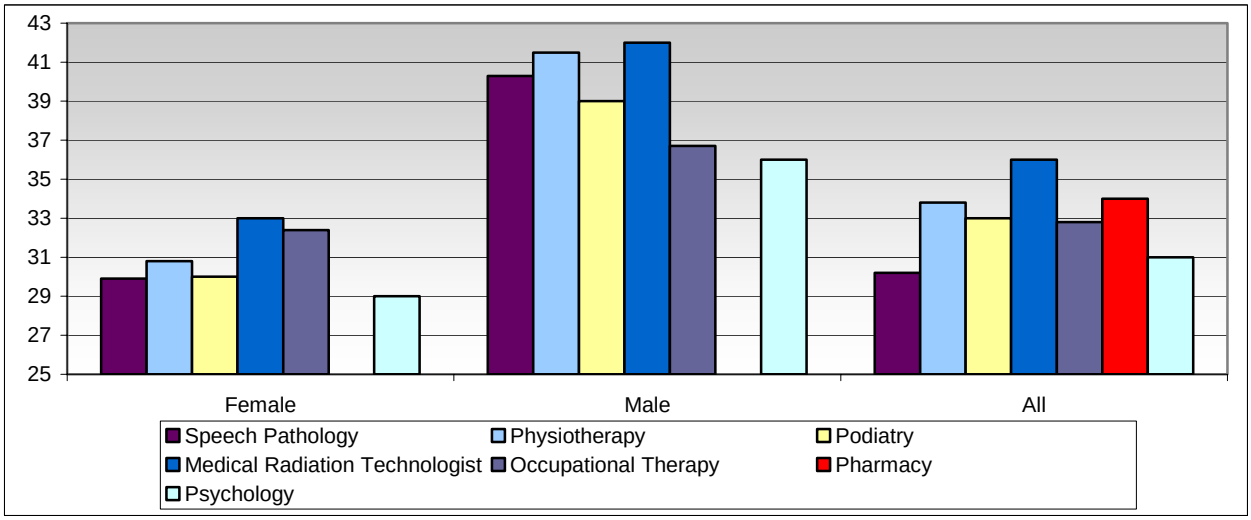


Source: Victorian Nurse Labour Force Surveys, 1997-98 to 2002-03. There is no data for 2001-02.

Allied Health

In 2003-04, the average weekly hours worked by allied health professionals in Victoria were 33 hours (female: 30.9 hours; males: 39.2 hours). The specialty that worked the shortest hours was psychology (females: 29 hours; males: 36 hours). The specialty that worked the longest hours was medical radiation technologists (female: 33 hours; males: 42 hours) (Fig. 8).

Figure 8 Average weekly hours, allied health, Victoria, 2003-04



Source: Allied Health Labour Force Surveys, 2003-04.

4.1.3 Workforce exits

The size of the workforce supply pool is influenced by the rate of exits. Generally, exits are due to retirement from the workforce, attrition (such as career change) or emigration. Victoria collects some data on medical workforce exits and has commenced collecting information on allied health professional's work intentions.

While sufficient data are not available to project trends accurately, it is clear that without any policy intervention, given the increasing average age across all professions, retirement rates will likely increase, substantially diminishing the labour force supply pool.

Medicine

The total medical workforce with general registration in Victoria (not including overseas trained doctors not yet able to gain general registration) has grown on average by 3 per cent each year (less than 500 per year) since 2000. A substantial contributor to this low growth has been the retirement rate each year, ranging from 541 to 713 practitioners, or 3.5 per cent to 4.7 per cent per annum (Table 1).

New entrants from Victorian medical schools have ranged from 330 to 373 per annum (2.4 per cent to 2.9 per cent). Local supply of new graduates is therefore not matching workforce exits. Net growth has been mainly achieved through a decline in the number of practitioners working interstate or overseas and a growth in the numbers of international medical graduates gaining general registration.

Table 1 Total medical workforce with medical registration, 2000- 2004, Victoria

	2000	2001	2002	2003	2004
Working in Victoria	12,852	13,301	13,560	13,999	14,581
Working only in other States	534	509	489	507	431
Working in medicine overseas	593	602	646	467	428
Total working in medicine	**13,979**	**14,412**	**14,695**	**14,973**	**15,440**
Retired in that year	637	630	618	713	541
Proportion retied in that year (per cent)	4.5	4.4	3.7	4.7	3.5

Source: Victorian Medical Labour Force Surveys, 2000 to 2004

Allied Health

The 2004 Victorian Allied Health Labour force survey queried future work intentions. The data indicate:

Physiotherapy

- 30 per cent of physiotherapists indicated that they planned to leave the physiotherapy labour force within the next 5 years.

Medical Radiation Technologists

- 37 per cent of Medical Radiation Technologists aged less than 26 years of age indicated that they planned to leave the medical radiation technology labour force within the next 10 years.
- 29 per cent of Medical Radiation Technologists aged between 26-30 years indicated that they would no longer be working as a medical radiation technologist within the next 10 years.
- 49 per cent of Medical Radiation Technologists aged 46-50 years of age who responded did not believe that they would still be working in 10 years.

Podiatry

- 59 per cent of podiatrists aged between 18-25 years of age indicated they would no longer be working as a podiatrist in 10 years.
- 48 per cent of podiatrists aged between 26-30 years believed that they would no longer be working as a podiatrist in 10 years.

4.2 Supply Requirements

4.2.1 Medicine

Since 2000, the number of Commonwealth supported medical students graduating from Victorian universities has only been able to replace 52 per cent of the number of medical practitioners exiting the system. The shortfall is made up by a combination of additional state funded intern positions in hospitals offered to interstate and New Zealand graduates (115 posts since 2001) and international medical graduates (up from 1,021 in 2000 to 1,379 in 2004). The majority of these work in public hospitals, have specific (limited) registration and are not able to undertake medical specialist training.

Almost all national studies of individual medical specialties undertaken in recent years have recommended further, often significant, increases in the number of vocational training places for the specialties concerned. A recently released national report on the public hospital workforce also identified workforce shortages as important[7].

Table 2 uses the most recent national modelling available and Victoria's own modelling to identify the additional medical graduates that need to be trained annually just to meet current demand for medical specialist consultants in Victoria.

Table 2 Additional number of medical graduates required per annum in Victoria

Specialty	Additional number required per annum in Victoria
Anaesthesia	8
Emergency Medicine	5
General Practice	43
Geriatric Medicine	10
Obstetrics & Gynaecology	11
Ophthalmology	7
Psychiatry	10
Pathology	25
Rehabilitation Medicine	4
Surgery (all specialties)	22
Thoracic Medicine	3
Total	148

Source: AMWAC, 2004, Medical Training and Review Panel, 2004

The demand for general practitioners, however, is only based on current training requirements. An AMWAC study[8] examining this issue identified that from 2007 onwards Victoria requires 270 entrants per annum into the general practitioner workforce.

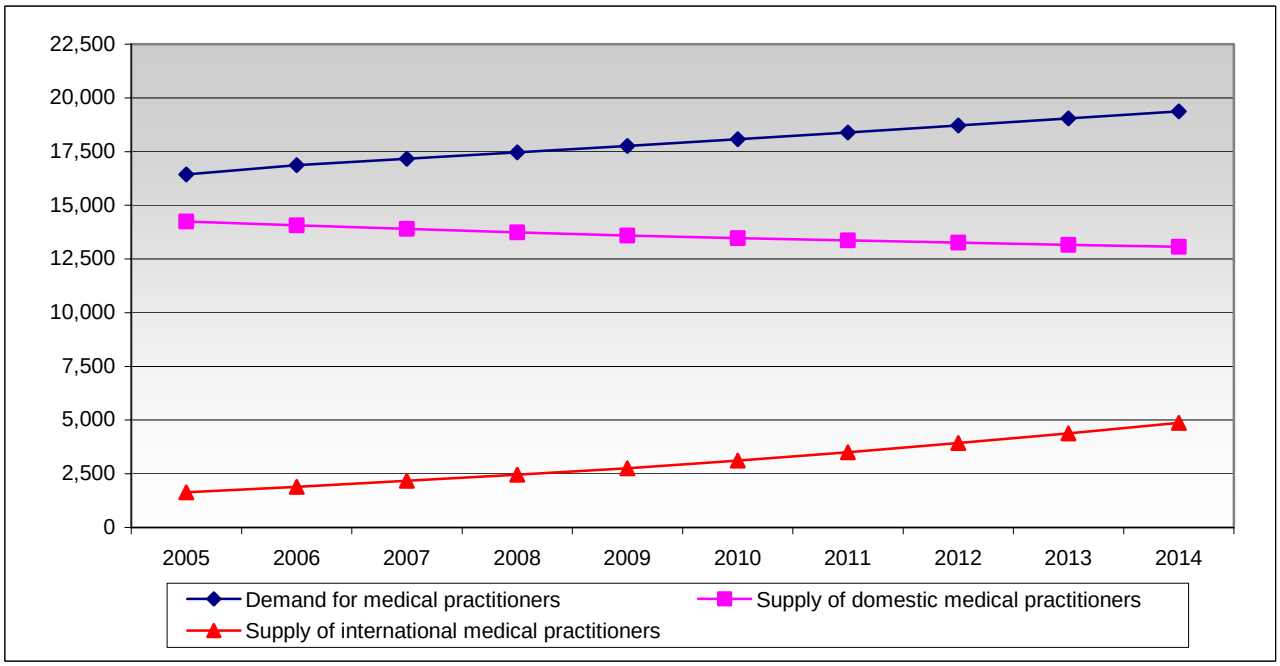
The need for medical specialists, however, does not take account of the requirements for the core hospital workforce. Taking a broader assessment of the overall requirement across all health service types, Victoria has mapped current and past supply of medical practitioners against total health service activity, then modelled projected service growth against projected supply trends and workforce exits. A 1.5 per cent per annum productivity improvement has been applied to take account of changes in technology and service delivery. Balanced against this, the current growth rate in use of international medical practitioners has been

[7] Australian Medical Workforce Advisory Committee, Annual Report 2003-04 AMWAC, November 2004
[8] Australian Medical Workforce Advisory Committee, draft study, June 2005

held at 7.8 per cent per annum and it has been assumed that all potential domestic and international full paying will enter the Victorian health system.

Even under this optimistic scenario, the modelling identifies a shortfall of entrants to the medical profession escalating rapidly from 2006 at 1.4 per cent per annum and peaking in 2012 at 1,523 (Fig 9, Table 3).

Figure 9 Forecasts of medical workforce requirements, Victoria



Source: Department of Human Services, Victoria

Table 3 Forecasts of medical workforce requirements, Victoria

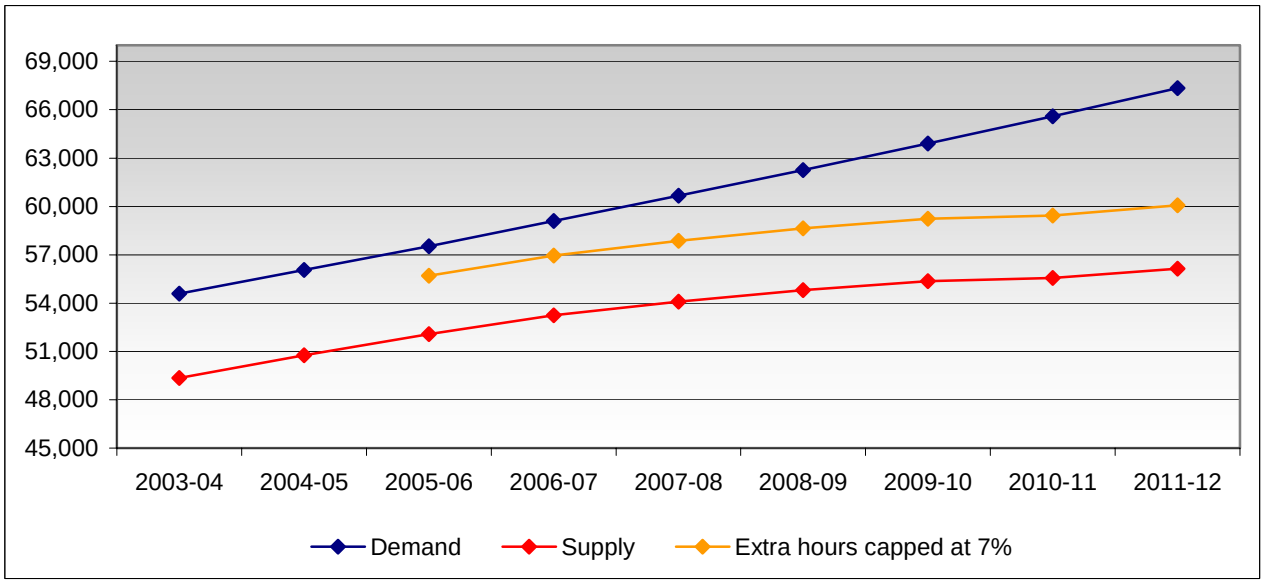
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Gain:										
Medical practitioners domestic	14,416	14,238	14,066	13,901	13,742	13,588	13,475	13,367	13,262	13,161
Medical graduates domestic	353	353	353	353	353	353	353	353	353	353
Medical graduates domestic full fee	0	0	0	0	0	35	35	35	35	35
Total Domestic	**14,769**	**14,591**	**14,419**	**14,254**	**14,095**	**13,976**	**13,863**	**13,755**	**13,650**	**13,549**
Medical graduates international full fee	82	141	135	116	116	160	160	160	160	160
Medical practitioners international	1,560	1,765	2,048	2,345	2,645	2,966	3,359	3,781	4,235	4,722
Total International	**1,642**	**1,906**	**2,183**	**2,461**	**2,761**	**3,126**	**3,519**	**3,941**	**4,395**	**4,882**
Loss:										
Domestic medical practitioners	531	525	518	512	506	501	497	493	489	485
International medical practitioners	5	6	7	8	9	10	12	13	15	16
Total Out	**537**	**531**	**525**	**520**	**516**	**511**	**508**	**506**	**503**	**501**
Supply:										
Domestic medical practitioners	14,238	14,066	13,901	13,742	13,588	13,475	13,367	13,262	13,161	13,064
International medical practitioners	1,637	1,899	2,176	2,453	2,752	3,116	3,508	3,928	4,380	4,866
Supply total medical practitioners	**15,875**	**15,966**	**16,076**	**16,195**	**16,340**	**16,591**	**16,874**	**17,190**	**17,542**	**17,930**
Demand for medical practitioners	16,437	16,870	17,164	17,463	17,768	18,077	18,393	18,713	19,040	19,372
Shortfall of medical practitioners	562	904	1,087	1,268	1,428	1,486	1,518	1,523	1,498	1,442

Source: Department of Human Services, Victoria

4.2.2 Nursing

The 2003 Victorian study into supply and demand for nurses analysed and projected the workforce required to meet that present and future service growth. The study concluded that demand will rise progressively over the forecast period, with the nursing shortfall expected to be approximately 7,200 FTE or 9,113 nurses additional nurses required by 2011-12 (assuming an overtime rate of 7 per cent per FTE) (Fig. 10; Table 4).

Figure 10 Nurse demand versus supply, Victoria, 2003-04 to 2011-12



Source: Department of Human Services, Victoria

Table 4 Nurse demand versus supply, Victoria, 2003-04 to 2011-12

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Demand	54,592	56,063	57,537	59,091	60,661	62,263	63,907	65,595	67,343
Supply									
Base	49,355	50,756	52,066	53,236	54,090	54,801	55,363	55,555	56,140
Extra hours capped at 7 per cent			55,711	56,962	57,876	58,637	59,239	59,444	60,070
Shortfall / (Surplus)									
Base	5,237	5,308	5,471	5,855	6,572	7,462	8,544	10,039	11,203
Extra hours capped at 7 per cent			1,827	2,129	2,785	3,626	4,669	6,151	7,273

Source: Department of Human Services, Victoria

4.2.3 Allied Health

Supply and demand data for allied health professionals is less robust - a result of the non-availability of consistent supply data and the lack of available workforce benchmarks on which to measure the required workforce to deliver a defined service.

Based on available data, Table 5 outlines the number of additional allied health professionals that would be required to enter the workforce in Victoria annually.

Table 5 Additional allied health graduates required per annum, Victoria

Profession	Additional numbers required per annum in Victoria
Dental therapy	20
Dentistry	25
Occupational therapy	30
Ambulance paramedics	20
Physiotherapy	55
Podiatry	25
Radiography	20
Social Work	45

Source: Department of Human Services, Victoria

Case study: Mental health

In Victoria, a recent study[9] identified that, as at 30 June 2002, there were over 5000 people employed in direct care clinical roles in Victorian public mental health services, with nurses representing 68 per cent of total FTE.

The study found a range of issues facing the mental health workforce, including:

Difficulties recruiting sufficient numbers of locally qualified staff. Some services had experienced difficulties filling funded early graduate nursing positions in psychiatric services there was a relatively high reliance on medical staff with international qualifications (11 per cent of psychiatrists and 16 per cent of psychiatry registrars and trainees who responded to the study indicated they were temporary residents).

Maldistribution of the workforce relative to client population. Only 11 per cent of medical staff and 16 per cent of Division 2 nurses worked in rural areas.

High staff mobility, particularly amongst younger staff in rural areas: annual staff turnover was estimated to be up to 22 per cent in some occupational groups.

Workforce Ageing. As at 30 June 2002, 41 per cent of staff employed within public mental health were aged 45 or over, and only 12 per cent were aged under 30 (compared to 30.9 per cent of the Australian health and community services workforce[10]).

Increasing workforce demand. Based on past utilisation trends, it is estimated that a 31 per cent increase in medical FTE, 25 per cent increase in Division1/3 FTE, an 18 per cent increase in Division 2 (enrolled) nurses and 25 per cent increase in allied health FTE will be needed to meet the projected service growth in mental health to 2011-12. This projected increase will occur at the same time as the supply of potential workers decreases, placing increased pressure on mental health to compete for a limited supply of health workers.

4.3 Supply solutions

Although skills shortages and supply issues are driven by a range of factors, the current undersupply or under production of health practitioners is the single major contributor to the workforce shortages experienced in Victoria.

States and territories have introduced a range of initiatives to improve the attractiveness of work and reduce turnover in the health sector. For its part, the Victorian government has also made substantial investments in supporting the education and training of doctors, nurses and other professionals in its public health services. In addition to the Nurse Workforce strategy, which resulted in over 5,000 nurses returning to the Victorian public hospital system:

- In 2001-02, Victoria funded 608 Graduate Medical Positions (Post Graduate Year 1 and 2) rat a cost of $21.2 million. By 2004-05 the number of funded places had increased to 837, at an additional cost of $8 million.
- In 2001-02, 980 Graduate Nurse Positions were funded at a cost of $12.2 million. By 2004-05 the number of funded places had increased to 1285, at an additional cost of $5 million in funding.
- Victoria has committed $8.4 million over four years to support health services to meet growth in clinical placements for undergraduate students across a range of disciplines.

Victoria has also continued to fund early graduate positions for a range of allied health occupations in settings such as public hospitals and mental health services.

However these alone cannot address the broader supply shortfalls in the number of undergraduate places. Increased Commonwealth investment in education and training is pivotal to achieving sustainability in the health workforce. Under the current policy parameters, substantial and growing workforce shortages persist.

4.3.1 Commonwealth supported undergraduate places

The National Health Workforce Strategic Framework has identified local self sufficiency in health workforce supply as a priority area. Increasing the number of local Commonwealth funded undergraduate places in medicine, nursing and allied health is an essential component of any strategy to meet workforce demand.

Although there were an additional 234 medical places made available nationally in 2003, Victoria was allocated only 10 of these places, which took its share to 20.7 per cent of all places, rather than its population share of 24.8 per cent. By contrast, Queensland, Tasmania, South Australia/Northern Territory and Western Australia all received a greater proportion of places than their population share in the 2003 round. If current levels of undergraduate medical places remain unchanged, Victoria will make the lowest contribution to the future medical workforce (equivalent to 54 practitioners per 100,000 head of population).

[9] Department of Human Services Victoria (2005) Victoria's direct care mental health workers: the public mental health workforce study, 2003-04 to 2011-12.
[10] Australian Institute of Health and Welfare (2003) Health and Community Services Labour Force (2001) AIHW Cat. No. HWL 27 and ABS Cat No. 8936.0 Canberra: AIHW (National Labour Force Services) No. 27

Nursing places will also increase by an additional 291 (including an additional 100 places announced as part of the recent Commonwealth aged care package) in 2005. However, this is still well short of the 1,300 nursing places required per annum if Victoria is to achieve self sufficiency.

Victoria believes that self sufficiency needs to be achieved at a state rather than national level. Data from its labour force surveys strongly supports the view that local graduates remain and practise locally:

- In 2004, 73.3 per cent of practising medical practitioners in Victoria had obtained their initial qualification here, 15.1 per cent had trained overseas and less than 10 per cent had trained interstate (Table 6).
- The majority of allied health graduates who obtained their initial qualification in Victoria remained in Victoria to work (Table 7).

Table 6 Clinicians by medical specialty and location of initial medical qualification, 2003-04

	Victoria (%)	Interstate (%)	Overseas (%)
Anaesthesia	81.0	10.0	9.0
Dermatology	87.1	8.0	4.9
Emergency Medicine	82.5	10.1	7.4
General Practice	70.2	8.5	21.3
Obstetrics & Gynaecology	80.0	10.2	9.8
Ophthalmology	82.0	11.0	7.0
Pathology	60.3	20.6	19.1
Physician	77.0	12.6	10.4
Psychiatry	68.0	10.2	21.8
Radiology	70.7	13.0	16.3
Surgery	83.0	8.5	8.5
All specialties	**73.3**	**9.8**	**16.9**

Source: Victorian Medical Labour Force Surveys, 2003-04

Table 7 Location of initial qualification, allied health, Victoria 2003-04

Allied Health	Victoria (%)	Interstate (%)	Overseas (%)
Physiotherapy	77.0	12.4	10.6
Medical Radiation Therapist	70.0	12.0	18.0
Podiatry	81.6	11.2	7.2
Speech Pathology	85.9	11.3	2.8
Occupational Therapy	77.1	17.4	5.5
Pharmacy	84.2	7.7	8.2
Psychology	85.8	6.3	7.9

Source: Victorian Allied Health Labour Force Survey, 2003-04

Employment of medical interns for 2006 highlights the immediacy of the local supply problem. Victoria has been growing the number of funded medical intern (Post Graduate Year 1) positions in hospitals each year to try to increase the available medical workforce pool. In 2006, there will be 406 such posts and the first round of matching of prospective graduates to such posts has just concluded. Only 330 Commonwealth funded Victorian graduates were able to be matched to positions, with the shortfall needing to be made up by interstate, New Zealand and international medical graduates. This problem is expected to escalate rapidly in coming years as Victoria continues to grow the number of interns to meet service demand, while Commonwealth funded undergraduate places are capped at 353 per year (which will be reached in 2008).

Victoria has been lobbying the Commonwealth for over two years for an increase to the number of funded undergraduate medial places with no success. The most recent response from the Minister for Education, Science and Training advises that no additional places will be provided and that the Productivity Commission inquiry will consider issues relating to the demand for and supply of medical practitioners.
(Refer Appendix A)

Substantial increases are required in the number of undergraduate university places in health disciplines. These increases need to take into account the supply and demand planning frameworks outlined in Section 6 and implemented through the revised governance and funding mechanisms outlined in Section 7. Determining the numbers of places needs to be dynamic so that existing health workforce shortages are addressed and new shortages do not emerge.

Recommendation

1. ***That the numbers of undergraduate health places available within a state or territory be increased and allocated based on planned and identified need for that state or territory.***

4.3.2 Overseas trained health practitioners

Given the long lead times associated with training practitioners such as doctors, recruiting overseas trained health practitioners is one of the short term strategies available to meet immediate workforce requirements.

In the absence of substantial increases in locally trained individuals, Victoria's reliance on internationally trained practitioners will remain and potentially increase. For example, in 2005, 8.5 per cent of the overall Victorian medical workforce are internationally-trained graduates, up by 35 per cent since 2000.

Although addressing short term workforce shortages, use of internationally trained practitioners raises other issues:

- Evidence suggests that the pool of suitable overseas practitioners wanting to work in Australia is shrinking. A world wide shortage of doctors and nurses and aggressive recruitment campaigns in the United Kingdom, United States of America and Canada means Australia is competing for a diminishing pool.

  Since its inception in 2001, Victoria's experience with the national Five Year Scheme has been that, as at 30 June 2005, of the 155 International Medical Graduates approved as suitable for the Scheme, only 74 are in practice in Scheme-approved locations. Over the past three years, recruitment to this Scheme has been increasingly difficult, with limited numbers of suitable applicants applying and the number of additional doctors in practice decreasing from 26 in 2002-03 to 25 in 2003-04 and 18 in 2004-05.
- Recruitment of overseas trained practitioners tends to attract practitioners from developing countries. Although supporting ethical recruiting and complying with the Commonwealth of Nations voluntary Code of Practice for the International Recruitment of Health Workers and the Code of Practice for the International Recruitment of Health Care Professionals, Victoria may have little option than to recruit from these countries. The United Kingdom and the United States are already targeting developing nations such as India. The consequential workforce losses, from countries least able to afford them, is a concern.
- Public health services are not currently funded to meet the significant costs in recruiting, assessing the suitability of, and training and supervising international practitioners, which effectively shifts the cost of medical training from the Commonwealth to the States and Territories.

Use of overseas trained practitioners provides a cost saving to the education system. In the absence of improving local supply, or as an interim measure whilst new graduates are trained, Commonwealth funding to public health services should reflect the additional costs associated with utilising overseas trained practitioners.

Recent events in Queensland have highlighted the need for systems that adequately assess qualifications as well as the clinical skills of practitioners. Victoria has developed a "safe practice assessment" model, which tests the clinical skills, and medical knowledge of international medical graduates prior to registration.

Individual state and or medical specialist college based schemes to assess doctors are in place, however, these are sub optimal as each applies different standards Refer Appendix B). This requires practitioners to have to undergo multiple assessment processes if they move interstate. It also may encourage practitioners to shop across jurisdictions to find the least stringent entry requirements.

A model should be developed that allows a consistent standard to be applied across Australia for the assessment of both qualifications and clinical skills. Victoria provided its model of assessment to the Commonwealth in March 2004 and is strongly supportive of establishing national standards. A mechanism for achieving greater consistency is discussed in section 8.2.

Recommendations

2. ***That, until the numbers of locally trained health practitioners meet demand, transitional Commonwealth funding is provided to public health services to meet the additional costs associated with recruiting, assessing the suitability of, and training of internationally trained health practitioners.***
3. ***That the Commonwealth lead the development of a national scheme for the assessment of the qualifications and skill of internationally trained practitioners, focussing on medicine in the first instance.***

4.3.3 Re-entry programs

Another strategy to address immediate workforce shortages is attracting qualified staff back into the health workforce. These professionals will generally require education and training support to re-enter the workforce. These pools, however, are small.

To date, experience in Victoria with nursing suggests that such initiatives can be an effective means of achieving increases in supply. Available data regarding a range of health professions currently in demand in health services suggest there are non-working pools that could potentially be attracted through similar campaigns.

Medical Practitioners

In 2004, there were 16,198 medical practitioners who held general registration in Victoria and of these 218 (1.3 per cent) were not currently working, approximately 75 per cent citing 'change in career' or 'family responsibilities' as the main reason (Table 8).

Table 8 Non working pool, medical practitioners, Victoria

	2000	2001	2002	2003	2004
Currently not working	259	284	346	222	218
Proportion of labour force pool	1.7	1.9	2.2	1.4	1.3

Source: Victorian Medical Labour Force surveys

Nursing

In 2003, there were 70,012 nurses registered in Victoria and of these, 1,325 (1.9 per cent) were either on extended leave, looking for work in nursing and registered but not working as a nurse, down from 5.7 per cent in 1999 (Table 9).

Table 9 Non working pool, Division 1 and 2 nurses, Victoria

	1999	2001	2003
In the Victorian nurse labour force	65,069	68,019	70,012
Employed in nursing, solely or mainly in Victoria	61,342	63,807	68,687
On extended leave	1,152	985	212
Looking for work in nursing	1,389	1,027	658
Currently not working in nursing and not looking for work as a nurse	1,186	2,200	455

Source: Victorian Nursing Labour force surveys

The reduction in the non working pool is as a result of direct government action.

In 2000-01, the Victorian Government implemented a state-wide Nurse Recruitment and Retention Campaign. A key initiative was the provision of refresher/re-entry/supervised practice programs to encourage nurses to return to the workforce. The strategy proved to be successful, with approximately 2,300 nurses returning to the public health care system to date, from that campaign alone (Refer Appendix C).

Funds are allocated to health services to develop and provide individualised programs for former nurses. The refresher/re-entry program makes funds available in two installments: 50 per cent on course commencement and 50 per cent on commencement of employment. A rural bonus is available in recognition of the distance travelled by nurses working in rural areas. Programs are provided free-of–charge to the nurse.

The initiative has been extended and funding to support refresher/re-entry/supervised practice programs up to a total of 240 nurses per annum has been made available until 30 June 2005.

Allied health professionals

National data for July/August 2004 indicate that:

- 5 per cent of medical radiation technologists were currently not working in medical radiation technology. Of these, 1.2 per cent indicated that they were 'currently not working' in any capacity. The major reason given was 'family responsibilities'.
- 2.6 per cent of medical radiation technologists indicated that they were 'currently working but not in medical radiation technology'. The main reason cited was 'change in career'. The majority indicated that they did not intend to re-enter the medical radiation technology.

Data from the 2003 Victorian Labour Force Surveys indicate that:

- 3.5 per cent of the occupational therapy workforce was 'currently not working'. A further 3.5 per cent indicated that they were 'currently working, not in occupational therapy'. Of those 'not working', 37 per cent were under 31 years of age, with a further 33.3 per cent aged between 31 and 40 years.
- 118 physiotherapists (5.5 per cent of the overall workforce) were either 'currently not working' or 'currently working, but not in physiotherapy'. The main reason cited for 'currently working but not in physiotherapy' was a career change. Of these individuals over half did not intend to return to physiotherapy. The two major reasons for 'currently not working' were 'family responsibilities' and 'retirement'.
- 7 per cent of podiatrists were 'currently not working' or 'currently working, but not in podiatry'. The major reasons for their absence from the workforce were family responsibilities and retirement.

Incentives to encourage skilled staff to re-enter the health workforce will be increasingly important. In addition to incentives offered by states and territories (such as subsidies to complete retraining), there is a need to consider how Commonwealth employment incentives could be best structured to complement such initiatives. Retaining staff will also be essential to achieving workforce sustainability, and once again, may necessitate a range of state and commonwealth supports, including remuneration incentives whilst training and increased access to child care for staff returning to work after family leave.

Recommendation

4. ***That the Commonwealth, together with States and Territories, review current strategies for attracting qualified staff back into the health labour market with a view to introducing successful strategies more broadly.***

4.3.4 Vocational education and training

Past approaches to health workforce recruitment and retention have largely focused on attracting young university graduates, with relatively little use made of certificate level (VET trained) staff. However, existing workforce shortfalls and forecast changes in workforce demographics[11] necessitate new approaches that expand the supply pool from which the health workforce can be drawn.

In particular, training that is accessible to individuals already in the workforce (or mature age workers who wish to enter the health sector) and that could deliver increases in supply within a relatively short time frame (compared to the longer lead times required to produce university graduates) is an important element of increasing supply.

Expanding the use of VET trained staff has the potential to achieve these goals. It could:

- Reduce demand for some university trained health professions through the better use of assistant and support roles.
- Respond more quickly to demand pressures through the shorter course length and work based approaches to training.
- Expand the supply pool from which health workers could be drawn by targeting sections of the workforce typically under-represented in health such as older workers or those who are unwilling/unable to undertake university study.
- Improve the alignment between the level of training and the tasks undertaken, by supporting the delivery of time- and cost-effective training that meets forecast service and client needs. Given the sector's focus on competency based assessment and vocational outcomes, it would be ideally placed to deliver 'work ready' staff across a range of services.
- Support competency based models that provide capacity for lifelong learning, through its structure of articulated, multiple career pathways. Evidence suggests that the return on investment includes improved productivity, an opportunity to make strategic change to work practices and improved staff retention.

Projects funded under the Victorian government's Better Skills, Best Care strategy in 2004-05 are exploring opportunities to make better use of allied health assistants and certificate trained staff in clinical support roles in rural acute/sub-acute settings (refer Section 8, Appendix D).

The challenge is for the health sector to avail itself of the significant opportunities that the VET system offers, recognising that:

- Health and community services are a relatively small industry within the broader VET sector.
- Educational models for health - with their heavy emphasis on clinical training and the development of cognitive (rather than manual) skills – are distinct from the training models for traditional trades that have historically dominated the VET sector.

[11] For example, Access Economics (2001) forecast significant reductions in the pool of new entrants to the Australian workforce and a corresponding ageing of the workforce.

The Victorian Government has continued to make substantial investments in the VET sector, and has implemented a range of strategies to respond to current and forecast industry needs. In addition to the development of a priorities framework to align publicly funded VET in Victoria to identified industry priorities, a range of programs to address specific workforce problems have been developed (Table 10).

Table 10 Examples of Current Victorian Skills Initiatives

Community Regional Industry Skills Program	A $10M program to tackle "skills" shortages and create sustainable industries and jobs across country Victoria.
Regional Migration Incentive Fund	Aims to address skills shortages in rural and regional areas through increased skilled migration.
Victorian Specialist Centres	Nineteen Specialist Centres have been established to lead the development of innovative and specialised training targeted to industry emerging skill needs, and for bringing about necessary changes within TAFE for this to occur.
Pre-Apprenticeships	The 2005-06 Victorian Budget announced $12.5M over four years for pre-apprenticeship training.
Apprenticeship completion bonus	A completion bonus scheme was introduced in 2003 to encourage apprentices and trainees to finish their training.
Parents Returning to Work Program	Assists parents to re-enter the workforce after being at home, caring for children. Assistance takes the form of a grant for training and related expenses up to the value of $1,000.

Victoria has also implemented a number of initiatives to promote the Health Training Package (HTP) and expand uptake of health courses in the VET sector. These include supporting pilot projects in health services, supporting the work of the state Industry Training Accreditation Board in promoting VET courses and negotiating two-year apprenticeships and traineeships for Certificate III qualifications.

Despite a 69.5 per cent increase in the number of training hours in Health Sciences and Acute Care delivered in Victoria over the period 2002-2004[12], a range of Commonwealth impediments to increased uptake remain. These include insufficient Commonwealth funding of VET courses, suboptimal targeting of Commonwealth incentives within New Apprenticeships, and limitations to the proposed post-ANTA national governance structures for VET (the latter is discussed in section 7.2).

Funding

While the Victorian government makes substantial contributions to the funding of VET places, its capacity to realize the full potential VET could deliver to the health system is largely contingent on the availability of sufficient Commonwealth Government funds to support expanded investment. Commonwealth funding of VET has stalled since 1997 (and has, in effect, declined in real terms), despite Victoria increasing real funding by more than 3 per cent per annum since 1997[13]. In fact, Commonwealth funding of VET has not even kept pace with inflation, increasing by only 3.9 per cent from 1997 to 2003. This is in marked contrast to the States and Territories contribution. In contrast, over this period, Victoria has increased its recurrent funding for VET by 44.3 per cent. Growth in Commonwealth funds for VET is required.

Commonwealth's priorities for VET investment also need to be re-examined. While the Commonwealth has announced it will invest $289 million over four years nationally in establishing 24 private technical colleges to promote uptake of traditional trades[14], many stakeholders argue that given health is of commensurate importance to the overall economy and represents a highly valued public good, greater Commonwealth investment is justified. Such investment would support greater use of para-professionals in health which, given current supply pressures and changing workforce demographics, will be increasingly important.

[12] Advice from Community Services and Health Industry Training Board Victoria, July 2005.
[13] Department of Premier and Cabinet Victoria (2005) *Governments working together – A new approach to workforce skills for a more prosperous Australia*, May 2005
[14] The Australian Technical Colleges will target metal and engineering, automotive, building and construction, electro technology and commercial cookery.

Traineeships and apprenticeships

Traineeships and apprenticeships provide attractive incentives for both employees and employers to enter the health workforce whilst undertaking a VET qualification. However, a recent Victorian report[15] noted that there were significant opportunities to improve their uptake by:

- Defining eligibility for traineeships and apprenticeships on the basis of competencies acquired and industry priorities rather than duration of the training. The current time-based criteria (based on a minimum duration of training of two years) prevents students in some health courses in areas that are industry priorities from qualifying for Commonwealth incentives. Time-based approaches are historically based and stem from the traditional trade industries.
- Reviewing the structure, magnitude and destination of Commonwealth incentives for health industry traineeships and apprenticeships, given that evidence suggests there is room for improvement[16].
- Identifying new structural arrangements that encourage uptake, particularly in the private sector.

Exploring strategies that best align these Commonwealth incentives to industry priorities is considered an important element of a broader approach to more effectively utilize VET trained staff in the health sector.

Recommendations

5. ***That the Commonwealth increase funding for VET health places, based on planned and identified need for that state or territory.***
6. ***That the Commonwealth review eligibility criteria for New Apprenticeships incentives to take into account industry priorities and competencies, rather than focusing on duration of training.***

[15] Department of Premier and Cabinet Victoria (2005) *Governments working together – A new approach to workforce skills for a more prosperous Australia*, p26
[16] DEST, Skills at Work: Evaluation of New Apprenticeships, December 2004.

5 Influencing the distribution of the workforce

Ensuring that the distribution of the health workforce meets the health needs of the community poses significant challenges for government. Distribution issues are heightened when a sector is facing overall workforce shortages.

Distributional shortfalls apply geographically, to streams of care and between the public and private heath sectors.

In addition to difficulties encountered in recruiting and retaining skilled staff in rural and remote areas, changes in the market for health services have resulted in increasing difficulties recruiting and retaining sufficient numbers of staff into certain areas of care (such as palliative care and geriatric medicine) and/or in public health services (particularly in areas such as psychiatry, dentistry and pharmacy). Issues such as level of remuneration, nature of client base, professional supports, indemnity issues and capacity for private practice have all been cited as factors contributing to this maldistribution.

Victorian employment data indicate that hospitals in rural areas, outer metropolitan and those in areas of low socio economic status have the most difficulty in filling posts:

- In 2005, inner metropolitan hospitals were unable to fill 4 per cent of available Post Graduate Year 2 (PGY2) medical positions, whereas outer metropolitan hospitals were unable to fill 23 per cent of available vacancies and rural hospitals, 24 per cent.
- In 2005 inner metropolitan public hospitals were unable to fill 6 per cent of available graduate nurse positions, whereas outer metropolitan public hospitals were unable to fill 8 per cent of available positions and public rural hospitals, 14 per cent.

Data from the 2004 Victorian Medical Health Labour Force survey provide information on the geographical distribution of medical practitioners in Victoria (Table 11). The data indicate that:

- Most medical practitioners practice in the metropolitan areas (79.8 per cent overall) with proportion ranging from 75.7 per cent of all GPs to 91.7 per cent of psychiatrists.
- Except for GPs, most medical specialties per 100,000 population are poorly represented in rural areas with dermatologists and ophthalmologists least likely to practice in rural areas (0.9 and 1.6 per 100,000 population respectively).

The data are consistent with the findings of a 2002 national survey of medical careers[17]. This survey reported the intentions of doctors in vocational training, namely that in 5-10 years time, 82.6 per cent of doctors would like to be practicing in a capital city, 16.4 per cent in other urban areas, 12.4 per cent in rural or remote regional centre and only 1.2 per cent in a small rural or remote town.

Table 11 Medical Practitioners by Metropolitan/Rural Location, Victoria, 2004

	Full-Time Equivalent					per 100,000 population		
	Number			Proportion				
	Metro	Rural	Total	Metro	Rural	Metro	Rural	Total
Anaesthesia	702.7	125.9	828.6	84.8	15.2	19.5	9.2	16.7
Dermatology	100.3	11.7	112.0	89.5	10.5	2.8	0.9	2.3
Emergency Medicine	152.4	27.8	180.2	84.6	15.4	4.2	2.0	3.6
General Practice	4,599.5	1,477.1	6,076.6	75.7	24.3	127.7	107.7	122.2
Obstetrics & Gynaecology	353.0	74.2	427.2	82.6	17.4	9.8	5.4	8.6
Ophthalmology	225.8	22.6	248.4	90.9	9.1	6.3	1.6	5.0
Pathology	168.5	42.6	211.1	79.8	20.2	4.7	3.1	4.2
Physician	1,490.4	274.4	1,764.8	84.5	15.5	41.4	20.0	35.5
Psychiatry	658.2	59.3	717.5	91.7	8.3	18.3	4.3	14.4
Radiology	336.9	89.0	425.9	79.1	20.9	9.4	6.5	8.6
Surgery	990.3	256.7	1,247.0	79.4	20.6	27.5	18.7	25.1
Other specialties	79.7	27.3	107.0	74.5	25.5	2.2	2.0	2.2
All specialties	**9,857.6**	**2,488.6**	**12,346.2**	**79.8**	**20.2**	**273.8**	**181.4**	**248.3**

Source: Victorian Medical Labour Force Survey, 2004

[17] AMWAC Medical Careers Survey, *Career Decision Making by Doctors in Vocational Training,* AMWAC, 2002, p119-125

Data from the 2004 Victorian Allied Health Labour Force survey also support the view that there are geographical distribution issues for allied health practitioners (Table 12). The findings indicate that:

- Most respondents across the seven allied health professions surveyed, were based in metropolitan areas. Of these, the metropolitan bias was most evident for psychologists, with only 13.4 per cent of respondents working in rural areas. The allied health professionals most likely to work in rural areas were podiatrists and occupational therapists, with more than 23 per cent of survey respondents based there.
- The survey results also indicated that allied health practitioners located in rural areas were more likely to work in the public sector. This was the case for all practitioners except pharmacists, with rurally based practitioners more likely to work in the private sector.

Table 12 Proportion of allied health practitioners working in metropolitan/rural locations, Victoria, 2004

	Public		Private		All Sectors	
	Metro (%)	Rural (%)	Metro (%)	Rural (%)	Metro (%)	Rural (%)
Medical Radiation Technology	76.2	23.8	83.1	16.9	79.8	20.2
Occupational Therapy	75.1	24.9	82.1	17.9	76.7	23.3
Pharmacy	84.0	16.0	78.7	21.3	79.8	20.2
Physiotherapy	78.6	21.4	85.6	14.4	82.2	17.8
Podiatry	68.0	32.0	81.1	18.9	76.5	23.5
Psychology	89.8	10.2	84.1	15.9	86.6	13.4
Speech Pathology	79.8	20.2	86.1	13.9	81.6	18.4

Source: Victorian Allied Health Labour Force Survey 2004

Although Victoria believes addressing the fundamental undersupply within the health workforce is essential, an increase in supply alone will not be sufficient to address these issues of workforce maldistribution. Work undertaken by the Melbourne Institute to inform this submission explored the relationship between labour supply and distribution in the health sector, taking into account available literature.

It found that 'empirical evidence…suggests that a large increase in supply of doctors would be required to alter the geographic distribution of doctors' and, taking into account the costs to society associated with such an increase, concluded that 'a policy of subsidies to alter relative expected profits across geographical areas is likely to be a more cost-effective option to change the geographic distribution' [18]. Potential strategies that Victoria believes could improve distribution follow.

5.1.1 Education and training

The strong clinical focus of health education requires significant involvement of qualified practitioners and health services in education and training.

Students reinforce their theoretical learnings in undergraduate and some post-graduate courses through clinical placements. These compulsory placements vary in length, depending on the course and year level. Their delivery also varies between "blocks" of clinical study, where the student is attending a clinical setting for a period full time, to a regular weekly or monthly visit spread across the academic year.

Although placing additional obligations on health services, studies have shown that clinical placements are an effective way of attracting staff[19]. This may be particularly important in rural areas, where adequate academic infrastructure will likely attract suitably qualified staff and thereby support clinical placements.

In addressing the issue of rural workforce maldistribution, some literature suggests that increasing the number of graduates with rural experience may attract more graduates to rural practice [20]. A literature review commissioned by Victoria supports the view that investing in course infrastructure in areas where labour is desired should provide the best returns. It has also been suggested that supporting students financially to undertake rural placements should be continued and that boosting rural contexts and rural practice examples in undergraduate courses would increase interest in rural placements[21].

[18] The University of Melbourne, Melbourne Institute of Applied Economics and Social Research, *The supply and distribution of health professionals, Final report to Department of Human Services*, July 2005. 2005, pp 3-4
[19] AMWAC, 2003, p38; DHS, 2005, pp 23-24;
[20] Lee, S. & Mackenzie, L. (2003) *Starting out in rural New South Wales: The experiences of new graduate occupational therapists.* Aust. J. Rural Health, 11, pp 36-43.
[21] McKenna, K., et al (2001) *The journey through an undergraduate occupational therapy course: Does it change students' attitudes, perceptions and career plans?*' Australian Occupational Therapy Journal, 48, pp 157-169.

Rural training

In terms of the aim to increase the participation of rural background students in undergraduate health courses, the best option is still to train in situ. The [Victorian] Workforce Planning Unit (1989) for instance in successive studies of the nursing workforce over the decade from 1980 identified an emerging problem with nurse labour in regional areas only after the introduction of [metropolitan] university based training and the loss of localised (hospital based) training programs. Prior to that, rural nurse vacancies had always been proportionately lower than metropolitan.

More persuasive evidence can be derived from pharmacy course graduate data from the regionally located Charles Sturt University (CSU). It appears that pharmacy students attending such a rural university are more likely to find employment in the local region (Giglio, 2004). The first cohort of pharmacy graduates from CSU completed their study in 1999, attended their graduation in April 2000 and completed the necessary pre-registration training by the end of 2000 (Simpson and Angel, 2003). About 60-70 per cent of students taking the course were originally from rural areas. A qualitative study by Simpson and Wilkinson (2002) showed that by the end of 2000, 62 per cent of all graduates and 88 per cent of female graduates had accepted pre-registration training places in non-metropolitan locations. In a follow-up study in May 2003, about 60 per cent of respondents were working in a rural or regional site, with the remainder in a metropolitan location (Simpson and Angel, 2003).

There is similar evidence from other universities. The Bachelor of Pharmacy course at La Trobe University, Bendigo, commenced in 1999. Of the 18 fourth year graduating students, almost all of whom were recruited from country areas, 14 continued their pre-registration year in regional/rural Victoria (La Trobe University, undated).

Recruitment and Retention of Allied Health Professionals in Victoria – A Literature Review. Human Capital Alliance. June 2005, p74.

Victoria funds a number of initiatives aimed at giving students greater exposure to rural settings as part of their training, including:

- **Rural Clinical Schools** attached to university medical faculties. Victoria contributed $9m over 3 years to the University of Melbourne and Monash University for teaching infrastructure and student accommodation. University of Melbourne sites are located at Shepparton, Ballarat and Wangaratta. Monash University sites are located at Traralgon, Bairnsdale, Sale, Warragul, Bendigo and Mildura. An additional $1.9m per annum is now being provided to rural hospitals to support these clinical schools.
- An **area-based, training consortia model** has been developed to achieve a more equitable distribution of rural training positions across Victoria. Under the model, groups of metropolitan and rural health services are clustered into consortia, with the available pool of trainee applicants allocated to these consortia.
- The **Rural Health Scholarships Scheme,** established to encourage health students to pursue rural practice through the provision of undergraduate and postgraduate scholarships for those students committed to rural practice.
- **Funded academic positions:**
  - Two Associate Professors on Rural Physiotherapy, to improve the provision of physiotherapy health care in rural communities by expanding the educational opportunities for rural students in physiotherapy and implementing recruitment/retention strategies.
  - A Senior Lecturer/Locum position, established to provide locum relief & develop education programs for physiotherapists and to provide support to undergraduate clinical placements & develop innovative strategies to attract and retain allied health staff.
- The **Secondary School Program,** promotes health careers to Victorian rural secondary school students, their parents and career teachers via regional and metropolitan interactive workshops, advocacy, career promotion events, networking, research and development of innovative materials and promotional aids.

While there are obvious benefits from expanding the current requirements to undertake rural clinical placements as part of the training experience at both undergraduate and post graduate levels, the capacity of some students to do so is limited by factors such as the cost of travel and local accommodation. Victoria believes the Commonwealth should provide a subsidy to undergraduate students to support greater uptake of rural clinical placements and training posts.

Mandatory rural rotation requirements have been one of the more effective strategies to encourage rural placements at a postgraduate level. These should be applied systematically across all vocational training programs and increased to a minimum 6-month period wherever possible. Mandatory rural rotations should also be encouraged for advanced training programs.

Trainees advise that if their broader experience gained from rural rotations (such as the clinical experience, procedural opportunities) were recognised, they would be more sympathetic to rural placements. These incentives could include priority access to sub specialty rotations and merit points towards advancement opportunities (including selection to advanced training positions in sub specialities).

Trainees believe that, despite the promoted benefits of rural training, this is not reflected in the structure of the training program. Their common perception is that rural rotations detract from career advancement (such as recruitment to sub- specialist rotations, advanced training posts) as they are removed from tertiary teaching hospitals. If the benefit of rural exposure was recognised and factored into the selection processes for advanced training and sub specialty training, trainees might consider rural rotations more favourably.

Recommendations

7. ***That the Commonwealth explore options for providing subsidies to students undertaking rural clinical placements to encourage greater uptake.***
8. ***That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges mandatory rural rotations of 6 months or more for vocational trainees.***
9. ***That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges to develop incentives in their training programs to encourage rural rotations.***

5.1.2 Incentive programs

Many initiatives developed by governments have targeted issues of geographic maldistribution. Many have been modelled on interventions operating in the UK, Canada and the USA. They include continuing professional education programs, mentoring, locum relief and scholarship schemes. Table 13 provides a summary of some of the current incentive programs funded by the Victorian government.

Table 13 Rural health workforce incentive programs funded by the Victorian government

Advanced Specialist Training Posts in Rural Areas (ASTPRA) provides funding for specialist training posts in areas such as Obstetrics & Gynaecology, Anaesthesia, General Surgery, and Emergency Medicine. The program includes long-term placements – allowing trainees to develop community connections that encourage them to stay in the area.
The **Procedural GPs Initiative** aims to increase the number of procedural GPs (surgery, anaesthetics, obstetrics and emergency medicine) in rural areas by funding training posts, improving GP access to information regarding specialised skill training opportunities and ensures that the training delivered links to service delivery needs.
The **Continuing Professional Development for Rural GPs Subsidy Program** supports rural GPs to attend educational activities to extend their skills in specialty areas such as mental health care, child protection issues, aboriginal health and palliative care.
The **Extended Skills for GPs initiative** funds training to improve clinical and research skills in identified priority areas such as procedural GPs, palliative care and allied health.
The Victorian **Overseas Trained Doctors Rural Recruitment Scheme** aims to attract, assess, place and support overseas trained general practitioners in rural and regional Victoria.
Cross Cultural Training for Overseas Trained Doctors aims to ensure that all OTDs employed in public hospitals have the skills to be able to work with women as supervisors and peers, are aware of cross cultural sensitivities and understand the doctor-patient relationship in the Australian hospital environment.
The **Rural Medical Family Network** – to support rural doctors and their families. This includes information about schools and the rural area they are moving to, career counselling, education and training for spouses.
The **Country Education Program** funds education seminars that promote inter-professional networks to help reduce the professional isolation experienced by some rural doctors.
The **Rural Workforce Strategy** aims to improve recruitment and retention of health professionals, such as doctors, nurses, physiotherapists and other allied health workers in rural and regional Victoria.
The **Rural Professional Improvement Assistance Fund** subsidises allied health professionals and nurses to attend events such as conferences and seminars that enhance rural health service planning, development and networks.
The **Victorian Allied Health Postgraduate Rural Retention Bonus** makes funds available to support skills acquisition and career development for allied health professionals. Bonuses are available to allied health professionals who have completed or are completing clinical postgraduate qualifications.
The **Continuing Professional Development (CPD) for Rural Allied Health** is an initiative that supports provision of CPD for allied health professionals practising in rural areas. The educational activities provide an opportunity for health professionals to interact & further develop inter-professional networks.
Mentorlink supports mentoring and support to new graduates, isolated and rural allied health practitioners to physiotherapists, occupational therapists, podiatrists, speech pathologists, and social workers.
The **Locum optometry project** provides a locum optometry service across all of regional Victoria designed to support the regional and rural workforce, enhance the Victorian Eyecare Service, and reduce demand on emergency departments.
The **Midwifery Upskilling project**, which has funded additional training for more than 400 rural midwives.

The Commonwealth has also implemented a number of rural practice incentive programs, primarily focusing on General Practitioners. Generally, these initiatives have been developed and implemented in isolation from each other. There is limited evidence on the impact of the initiatives, as many do not include an evaluation component. Potentially this has not made the best use of available resources nor of the learnings gained.

Victoria is currently evaluating a number of its initiatives and will use the results to develop an evaluation framework that will be applied to all its future programs.

Without a clear understanding of which factors best address health workforce maldistribution, future investment risks not being cost effective. To maximise investment outcomes at all levels of government, a common evaluation approach and a process for sharing the learnings should be adopted by all jurisdictions.

Recommendation

10. That the Commonwealth, States and Territories agree to a common approach to program evaluation and sharing of learnings to inform future national and jurisdictional policy and program development in rural recruitment and retention.

5.1.3 Structural reforms

Amend funding mechanisms to increase non-medical involvement in primary care

Under the current Medicare Benefits Schedule (MBS), rebates are predominantly limited to services provided by medical practitioners. This also applies to most medical referrals for specialist treatment. Although a limited number of Medicare rebates have been available for certain allied health services since mid 2004, even the new Chronic Disease Management Medicare items that came into effect on 1 July, 2005, continue to place the general practitioner at the centre of care. Similarly, only prescriptions written by medical practitioners attract subsidies under the Pharmaceutical Benefits Scheme (PBS).

In practice, many services provided by allied health and nurse practitioners already substitute for the work of medical practitioners. Other services that could be effectively handled by allied health and nursing professionals are often handled by general practitioners simply because the Medicare rebate would not be available if delivered by a non-medical practitioner. Segal and Robertson argue that existing funding structures encourage substitution by medical practitioners and claim that 'given the distorted incentives, it is unlikely that the optimal level, mix or location of allied health services will emerge'[22].

Although restrictions on MBS access can be a means of containing associated costs, they may actually increase costs by generating avoidable duplication of effort, delaying initiation of treatment and impeding the optimal deployment of available workforce skills. For instance, approximately 50 per cent of the caseload of general practice involves counselling, emotional support and mental health assessment. Social workers or psychologists could handle much of this.

Research commissioned by Victoria to inform this submission analysed referral patterns from general practitioners to allied health providers and estimated that for some of the more common presentations (musculoskeletal, circulatory, diabetes, psychological, digestive, ear, etc), the referral rate was less than one tenth of potential referrals that could flow from general practitioners to allied health providers[23].

The research report noted that 'rationalisation of the complex Commonwealth-State government financial arrangements at present associated with sub-optimal resource allocation between types of care, between care settings and between types of service provider offers significant opportunities for welfare gain', citing examples of physiotherapy and psychology to support this claim.

Victoria believes that changes to the MBS could be a positive incentive, particularly in areas of designated workforce shortage to:

- Improve workforce supply by allowing other practitioners (such as suitably qualified nurses and/or allied health providers) to perform substitutable services. This would also improve job satisfaction and ultimately, positively impact workforce retention.
- Encourage health professionals to set up private/public practices in areas of workforce shortage.

Duckett notes that such changes, whether direct, by increasing the number of items that do not require 'personal provision' by a medical practitioner or indirect, through introducing powers of delegation within health professional registration Acts, would provide a more efficient and effective use of available resources by freeing up the time of medical practitioners (where available) and improving access to services by improving workforce distribution[24].

[22] Segal L. and Robertson I., (2004), *Allied Health Services Planning Framework for Chronic Diseases,* Centre for Health Economics Working Paper 148, Monash University.
[23] Human Capital Alliance, 2005, *The impact of increasing access to MBS and PBS beyond the existing primary medical focus: A discussion paper.* Report for the Department of Human Services, Victoria
[24] Duckett, S.J. (2005), *Interventions to facilitate health workforce restructure*, Australia and New Zealand Health Policy, 2: 14.

Such reforms would need to be appropriately targeted and structured to meet priority service needs. Victoria believes that three criteria could be used to determine priority service areas:

- Services that currently occupy a significant proportion of general practitioner caseloads.
- Service that could be offered as efficiently by an alternative source of labour.
- Services that are difficult to access in areas of disadvantage.

Expansion of benefit coverage would ideally improve efficiency and access whilst limiting exposure to financial risk. The research identified options for how this might be achieved, including:

- Limiting access to provider numbers only under certain circumstances (such as in designated areas of workforce shortage or program specific need).
- Using service descriptions for item numbers, a mechanism that already exists for benefits paid to optometrists to:
  - Cover an episode or period of care.
  - Limit use to particular conditions or circumstances.
  - Cap their availability to individual patients for a specified period of time.

Improving access to rural maternity services

Innovative primary maternity models of care have the capacity to increase appropriate service provision to meet consumer need.

Shortages of general practitioners and obstetricians in rural areas limit women's access to antenatal, intrapartum and postnatal care. A model of care, whereby general practitioners or obstetricians working in private practice employ midwives to care for women with uncomplicated pregnancies and bill MBS on their behalf, should be seriously examined and assessed to see whether it would increase access to services locally while, at the same time, improving interdisciplinary collaboration between the professions involved in delivering maternity services and maintaining the quality of care.

Altering the Pharmaceutical Benefits Scheme (PBS) to allow non-medical practitioners to prescribe controlled substances under their jurisdiction's drugs and poisons legislation could also improve the efficiency of health care services. Halcomb et al (2005) suggests that the potential value of making MBS benefits available to non-medical providers would be compromised unless accompanied by limited PBS prescribing rights.

This position has been advocated by occupations such as optometry that argues that lack of access to PBS prescribing rights compromise efficiency. Data collected by the Optometrists Association Victoria[25] suggest that approximately one out of eight patients who required a script were referred to a medical practitioner in order to be eligible for PBS subsidies, and that any increased costs associated with making PBS available to suitably qualified optometrists would be offset by savings to Medicare.

To date, eligibility for Medicare entitlements and prescribing rights continue to require medical practitioners, except in a few instances:

- Optometrists provide a range of assessment and refraction services that attract Medicare rebates and which substitute for some of the work of ophthalmologists.
- Some dental services attract Medicare benefits and dentists are also able to write PBS prescriptions.

Given the goal is to improve access to services, consideration should be given to extending the scope of MBS and PBS entitlements to health professionals other than medical practitioners, particularly in designated areas of need. This would support retention of these health professionals in the workforce and reduce the imposition of wasteful and inefficient processes on already overstretched resources.

Recommendation

11. That the Commonwealth trial limited access to medical and pharmaceutical benefit entitlements for non-medical practitioners in areas of designated GP shortage.

Amend funding mechanisms to increase attractiveness of priority medical specialties

The present structure of MBS payments makes certain clinical specialties more attractive than others. Remuneration for procedural specialties is more generous than those for generalist specialties. This differentiation is based on the level of complexity and skill required by the procedural specialist, as well as an estimate of the time taken for the procedure. Generally physician specialties carry lower rebates than surgical specialties. Furthermore, even within surgery, cardiothoracic surgical procedures attract higher rebates than general surgery procedures. The same is seen across the physician specialties where procedures associated with gastroenterology, haematology and intensive care attract higher rebates than those associated with general medicine.

[25] Optometrists Association Victoria (2004) *Ocular Therapeutics in Victoria: the first five years, Melbourne*, downloaded from www.vicoptom.asn.au on 7 July 2005.

College data, supported by anecdotal evidence from hospitals indicate that the generalist specialties such as general medicine, geriatric medicine and general surgery are less popular amongst trainees than procedural specialties. While this cannot be wholly attributed to the financial payments system, the lower income of the generalist will be a factor in the lack of interest amongst trainees in generalist specialties.

Case studies

Paediatric orthopaedics

Paediatric orthopaedic surgeons argue that remuneration rates for paediatric orthopaedic practice are poorer compared to those for adult orthopaedic practice. They also argue that, although practice running costs and medical indemnity costs are similar for both groups, the time spent in private practice and the remuneration rate for surgical interventions is far greater for adult orthopaedics than for paediatric orthopaedics, which has a heavier consultative load.

DOHA's response to a request for a review of the CMBS fees for paediatric orthopaedics was that any review would require a cost-neutral adjustment to the adult orthopaedic fees. This was not supported by the Australian Orthopaedic Association.

Over the past 18 months, the Royal Children's Hospital has not been able to either recruit paediatric orthopaedic surgeons to replace retiring surgeons nor expand the service. In Australia, there are no orthopaedic trainees intending to specialize in paediatrics. To date, no suitable applicants from overseas have been able to be recruited. This situation is not confined to Victoria – services in other jurisdictions are also at critical thresholds.

Geriatrics

Few procedures are recognised in geriatrics. Older people often have complex multi-system medical problems that may be complicated by cognitive impairment, immobility and incontinence. A comprehensive geriatric assessment of an older frail person by a geriatrician, a specialist of 12 years training, takes a minimum of 2 hours. It requires a conventional medical assessment and cognitive, psychosocial and functional assessment. Comprehensive geriatric assessment also requires the clinician to build parallel histories from the older person's treating GP, family and carers. Geriatrician's remuneration for undertaking a comprehensive assessment is $128.05 or $64.10 (MBS Items 110 and 116 respectively.

The system of payments should be reviewed to ensure that remuneration does not discourage entry to the more generalist professions. Remuneration for MBS item numbers associated with generalist specialists could take into account the complexity of the patient and the time taken in the consultation.

Recommendations

12. That the Commonwealth review MBS funding of speciality services to remove disincentives, particularly for areas of known specialty shortage.

Increase attractiveness of employment in hard-to-staff services

Taxation and superannuation

The health workforce operates in both the public and the private sector. Health professionals working in public hospitals and state-funded ambulance services have access to exemptions from Fringe Benefits Tax (FBT) capped at $17,000. This is an important financial attraction that keeps them in the public system. That the Commonwealth Government allows this exemption indicates that it is also aware of the importance of maintaining an adequate financial remuneration for health professionals in the public hospital system.

The Commonwealth recognises the challenges of recruiting suitably qualified staff to rural and remote areas through initiatives such as housing assistance for rural and remote areas. Given the increasing difficulties a range of geographic and service areas report in recruiting staff and the ageing of the health workforce, consideration should be given to whether amending Commonwealth legislation governing employment benefits could improve health workforce distribution.

Research to identify potential opportunities in this area was commissioned by Victoria as part of developing this submission[26]. It indicates that, despite the complexity of current tax arrangements and the ongoing need to simplify these, several options could be considered in this regard:

- Introducing annual indexation to the $17,000 FBT cap for public hospitals and not-for-profit private hospitals delivering services in areas of designated workforce shortage. This would allow a higher taxable value of fringe benefits to be made available to employees who were prepared to relocate to regional, country and remote areas without the employer incurring additional FBT.
- Broadening the availability of the $17,000 FBT cap to employers other than those that currently qualify for such benefits.
- Exempting or reducing the taxable value in relation to the provision of housing. Housing benefits to employees in the health sector (for relocation purposes) could encourage more practitioners to move to and remain in regional, country or remote areas. Currently, housing benefits attract FBT in full unless the employee is working in a remote area and certain conditions are satisfied.

[26] Ernst & Young, *Options on how the Fringe Benefits Tax and superannuation taxation regimes could be used to encourage health professionals to work in areas of workforce shortage of skills*. Report to the Victorian Department of Human Services. July 2005.

- Exempting all relocation and living away from home costs from FBT. At present, only specific relocation costs are exempt and these exemptions are usually bound by specific conditions. Extending exemptions to include paying out the remainder of a rental agreement entered into prior to the relocation, costs to ensure the new house is in a suitable condition to relocate and acquisition of any additional and necessary household furniture or equipment, could provide a beneficial incentive.
- Exempting boarding fees for children of health professionals from FBT. Health care professionals with school-aged children may be reluctant to relocate to regional, country and remote areas due to the disruption of their children's education and the costs associated with placing children in a boarding school. Boarding school fees and the costs of travel between the boarding school and the regional, country or remote area could be exempted from FBT. This would likely provide comfort to health care professionals by allowing them to leave their children in the same educational environment.

The Commonwealth has recently implemented reforms associated with allowing people who are still in the workforce to access their superannuation as a non-commutable income stream once they reach their preservation age. This reform should provide an incentive for older members of the health workforce to stay in the workforce. In light of the workforce pressures facing the health sector (and other industries) it is appropriate for this reform to be reviewed to consider whether further adjustments to superannuation policy could provide additional incentives (and minimal disincentives) for people to choose to stay in the workforce post preservation age.

Recommendation

13. That the Commonwealth consider a range of changes to fringe benefits tax exemptions to increase the attractiveness to health professionals of working in areas of designated workforce shortage.

Flexible payment systems

In Victoria, medium and small rural hospitals do not have 24 hour medical cover to provide emergency and urgent medical care for non-admitted patients. This can be both within business hours and after hours.

These services are provided by the local general practitioner through an on-call arrangement. In that situation, the practitioner can incur a significant risk (financial and safe working hours) by potentially making themselves available 24 hours a day. These onerous on-call obligations are extremely difficult to sustain over the long term.

More flexible funding arrangements between States/Territories and the Commonwealth should be explored that explicitly recognise the interdependency that exists between private rural general practices and smaller rural and regional health services. Models that allow paid on-call arrangements to be partially offset by MBS payments would be an incentive to general practitioners to work with hospitals to deliver 24 hour care to rural communities.

14. That the Commonwealth, States and Territories explore more flexible funding arrangements that explicitly recognise the interdependency between private rural general practices and smaller rural and regional health services.

Indemnity arrangements

In Victoria, concern over medical indemnity has been greatly diminished through a number of initiatives introduced by both the Commonwealth and State governments. Indemnity is now less likely be a major factor in preventing practice, particularly for those practitioners working in rural locations.

The Commonwealth has implemented a series of initiatives designed to minimize the impact that large claims may have on the ability of medical indemnity insurers to continue to provide affordable indemnity cover for medical practitioners and to assist medical practitioners in meeting their medical indemnity insurance premiums. These initiatives include:

- The Premium Support Scheme in which the Commonwealth meets part of the cost of the medical indemnity premium charged to a eligible medical practitioners whose medical indemnity costs exceed 7.5 per cent of their gross private medical income.
- The Exceptional Claims Scheme in which the Commonwealth will meet the total costs of medical practitioners' private practice claims that are above the limit of their medical indemnity contracts of insurance.
- The High Costs Claims Scheme in which the Commonwealth Government reimburses medical indemnity insurers, on a per claim basis, 50 per cent of the insurance payout up to the limit of the medical practitioner's cover.

The Victorian Public Healthcare Insurance Program also provides indemnity cover for:

- All medical practitioners who are full time or part-time employees of public hospitals.
- Medical practitioners who undertake private practice within public hospitals. However, the practitioner must be employed by the hospital and participate in a Dillon or other Special Purpose Fund whereby the majority of the fee for service received is retained by the hospital.

Victoria also provides a Rural General Practitioners' Medical Indemnity Insurance Policy where rural GPs (not specialists) can purchase cover for treatment of private patients in designated public hospitals. Rural GPs do not have to be employees of the designated hospital. The cover is an affordable and generous alternative to indemnity policies offered by the medical indemnity insurers.

Along with available and affordable insurance coverage, all States and Territories have, over the last 2 to 3 years, made significant changes to tort law that have significantly diminished the capacity of injured patients to sue health professionals and hospitals.

6 Improving workforce planning

6.1 Current structures

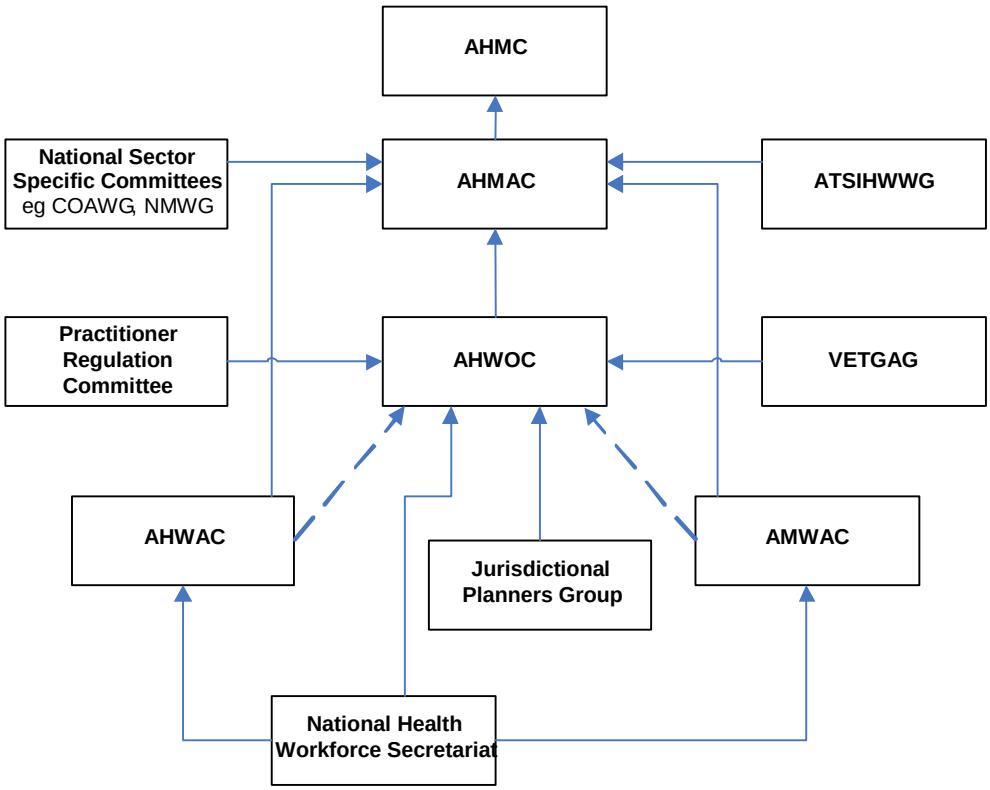
Integrated and ongoing health workforce planning is increasingly important, given the pressures on the sector. Current approaches are largely discipline specific and occur at a national, state and/or local level.

There are currently a number of national committees who undertake workforce planning and advise Health Ministers on workforce issues (Diagram 1):

- The Australian Medical Workforce Advisory Committee (AMWAC) provides advice to Health Ministers on a range of medical workforce matters, including:
  - The structure, balance and geographic distribution of the medical workforce and future supply and demand.
  - Present and future medical workforce training needs.
  - Models for describing and predicting future medical workforce requirements and supply and development of enhanced medical workforce data collections.
- The Australian Health Workforce Advisory Council (AHWAC) provides advice to Health Ministers on a range of nursing, midwifery and allied health workforce matters, including:
  - the composition, balance and distribution of the workforce and supply and demand.
  - the establishment and development of data collections concerned with the health workforce.
- The Australian Health Workforce Officials Committee (AHWOC) provides a forum for all jurisdictions to reach agreement on key national health workforce issues requiring government collaborative action and provides advice on health workforce issues to Health Ministers. It also co-ordinates the implementation of the recommendations arising from national level workforce planning including the recommendations from the workforce reports completed by the AHWAC and AMWAC.
- The Vocational Education and Training Government Advisory Group (VETGAG) provides advice to AHMAC and CSMAC on VET sector issues across the heath and community services sectors.
- Sector specific groups that look at workforce issues as part of their work (eg the Australian and Torres Strait Islanders Health Workforce Working Group and the National Mental Health Working Group).

In addition, bodies such as the Australian Institute of Health and Welfare produce reports on health workforce supply, largely based on data collected either via surveys of registrants or the ABS.

Diagram 1 National committees that currently undertake workforce planning



At a state and territory level, most jurisdictions undertake some workforce planning activities, although the scope and complexity of these vary significantly, as do the datasets and assumptions on which this planning is based.

Despite the multiplicity of workforce planning activities and the commonality of purpose, the results often vary widely. Barriers to more efficient and effective workforce planning approaches include:

- The paucity of workforce data and the limited agreement nationally on consistent data items, definitions and collections.
- The problems associated with quantifying overall demand for those professions who work in a wide range of settings (for example, psychologists, most of whom work in non-health areas).
- Planning methodologies assume existing professional roles and responsibilities will remain unchanged and do not take into account the impact of technology, changing service models and the workforce competencies required.
- Membership of many committees comprise a majority of professional members, often solely from the profession under analysis, which can reinforce existing professional norms, militate against cross disciplinary comparisons and prevent exploration of more innovative workforce models.

Health workforce planning is therefore limited to traditional occupational groups and does not take into account the full range of individuals that might provide services within a stream of care.

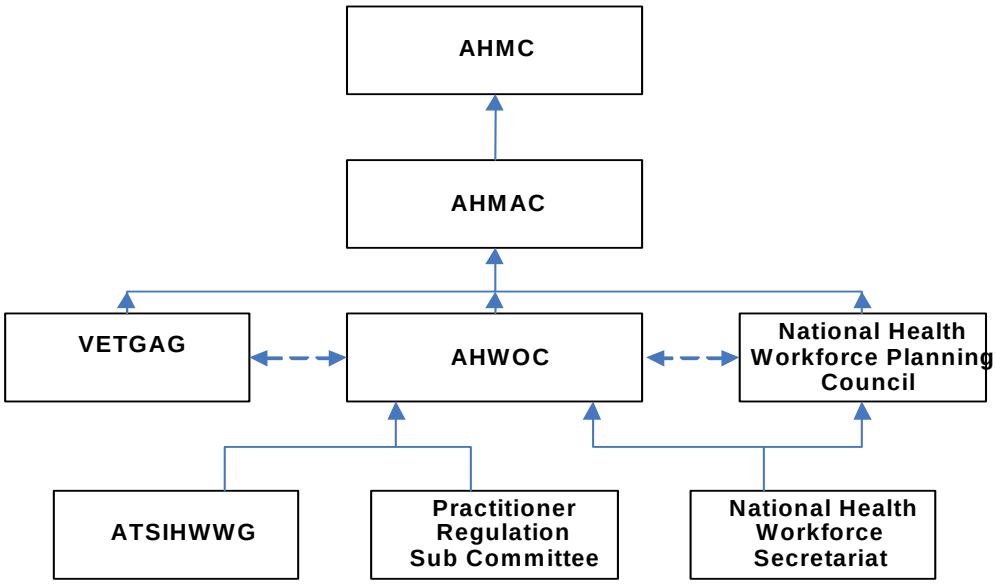
6.2 Integrated national workforce planning

Workforce planning as it currently occurs needs to be refocused and strengthened.

Victoria proposes that the existing national workforce planning committees, AMWAC and AHWAC, be replaced by a National Health Workforce Planning Council, reporting directly to Australian Health Ministers through the Australian Health Ministers' Advisory Council (Diagram 2). The role of the Council would be to:

- Establish and maintain a nationally consistent minimum health workforce dataset that would include information on workforce turnover and shortages.
- Develop planning methodologies that support innovative workforce models and work redesign.
- Undertake national whole-of-health workforce planning, including quantifying workforce supply and demand and identifying training requirements across the health workforce.
- Work with jurisdictions to establish a health workforce planning framework that interfaces with jurisdictional planning approaches.
- Establish workload measures to enable forecasting of workforce demand across jurisdictions.
- Provide advice to all jurisdictions and Ministers (health, education and immigration) regarding current workforce characteristics, forecast requirements and shortages.

Diagram 2 Proposed national planning structures



Membership of the Council would include experts in health economics and workforce planning and representatives from DOHA, DEST and jurisdictional health departments. It would establish specific sub-committees, comprising relevant health professionals and key stakeholders in pursuing its work program.

The National Health Workforce Secretariat would support the Council.

Recommendation

15. ***That the existing national health workforce planning committees, AMWAC and AHWAC, be replaced by a National Health Workforce Planning Council, reporting to Australian Health Ministers through the Australian Health Ministers' Advisory Council. The role of the National Council would include national whole-of-health workforce planning and leading reforms in workforce data collection and analysis.***

7 Creating a more responsive education and training system

The model for the education of health professionals involves an essential component of clinical training, most of which is undertaken within health services. The education model requires heavy involvement of qualified practitioners, a characteristic that sets this area of university education apart from most others.

A number of Australian studies have attempted to define and cost this clinical teaching effort. Most have concluded that a significant proportion of teaching and training activities in public hospitals are of a multiple product nature, that is, they are inextricably linked to patient care activities. A KPMG study commissioned by a consortium of Australian States and the Commonwealth concluded that "…about one quarter of clinical activity in hospitals can be described as multiple product".[27]

This means that the funding for education should not be viewed in isolation from the clinical training contribution provided by health services.

Responsibility for health education and training, however, is split across different levels of government and between health and education agencies, as well as other providers (such as the specialist medical colleges). It is evident that this division has been a substantial contributor to current shortfalls in the funding provided to support clinical training (particularly in the higher education sector) as, under budgetary pressures, the Commonwealth funded education sector has progressively withdrawn its contributions to fund the cost of clinical training in public hospitals.

Victoria has recognised the importance of improving linkages between the health and education sectors. It has established a range of initiatives to expand the evidence base, support innovation and improve working relationships between health services, universities and the VET sector. Despite this investment, problems persist due to factors that are outside the State's control.

7.1 Appropriate funding for health education

Funding of health professional education is complex, involving a mix of funding sources, including Commonwealth and State governments and students themselves. Current funding arrangements reflect clear legacies of history, both in terms of funding responsibilities and the craft/apprenticeship origins of many of the health professions.

For university students in Commonwealth supported undergraduate places, that is, students other than full-fee domestic or international:

- The Commonwealth provides a grant to each university that varies according to the discipline. In the case of students in the health professions, most students fall within one of three bands: a health sciences band, where the universities receive $7,212 per annum; a national priority band for nursing students of $9,511 per annum; and $15,057 per annum for medical students.
- Students make a differential contribution, with nursing students contributing almost $4,000 per annum and medical students almost double that. Payment of the student contribution can be made through an income-contingent loan under the Commonwealth's HECS-HELP arrangements.

The price relativities (the sum of the Commonwealth and student contribution) are essentially those established under the Relative Funding Model in the 1980s, although it was not until the 1990s that a variable student contribution, recognising differential social and private return, was introduced. The current balance between student contribution and the Commonwealth grant reflects the perceived balance between social and private returns to education, requiring a very high rate of student contribution in courses such as business studies and law, and relatively lower private contributions in other courses.

Medicine and dentistry have a student contribution about $1,200 per annum higher than health sciences. As medical education is generally a year longer than the average health sciences education, the total difference in student contribution is about $12,700. This underestimates the difference in likely private returns from medical education over other health sciences education such as occupational therapy or speech pathology.

State governments also contribute to the costs of health professional education through subsidies for clinical education. Preliminary data from a recent study commissioned for the Victorian Department of Human Services [28]suggest that clinical placements in hospitals and health services represent a significant cost to services. In some cases health services are able to charge universities for clinical placements, but there still remains a net cost to the hospitals and health services of providing the clinical placements (Table 14).

[27] "KPMG, (1996), *Costing and funding of teaching and training activates in Australian public hospitals"*), p2.
[28] HLB Mann Judd Consulting, Preliminary data, July 2005

Table 14 Funding arrangements for students preparing for health professions

Source	Scheme	Funding/Costs
Commonwealth government	Commonwealth Grants Scheme	$7,212 p.a. for health science students
		$9,511 p.a. for nursing students
		$15,047 p.a. for medical students
Student	Student contribution	Up to $6,849 p.a. for health science students
		Up to $3,842 p.a. for nursing students
		Up to $8,018 p.a. for medical students
State government/ health agency	Clinical education in public hospital	$5,740 p.a. for health science students (ranging from $2130 to $10,435 p.a.)[(a)(b)]
		$13,525 p.a. for nursing students (ranging from $8,100 to $19,764 p.a.)[(a)(b)]
		$27,701 p.a. for medical students (ranging from $19,200 to $39,600 p.a.)[(a)(b)]

(a) Average cost is the total estimated cost per student per hour during their clinical placement x average clinical hours per year (where the average number of clinical hours per year is the total number of clinical hours/length of the course (years)).
(b) Health sciences includes physiotherapy, pharmacy, dietetics, medical imaging, occupational therapy, speech pathology, audiology and social work.

Health professional education, then, can be distinguished from education in other disciplines, where either the Commonwealth or the student meets the cost of education and employers are not expected to directly contribute towards the cost of the undergraduate education of their future employees.

The costs for the clinical component of the education and training represent a shift from the Commonwealth, who has clear responsibility for university education, to the states.

To the extent that the private sector is involved in providing clinical placements, it would also be expected to bear similar costs. However, although private hospitals and private professionals provide some clinical placements, the overwhelming majority of clinical education occurs in the public sector. The private sector is a relatively small contributor to undergraduate health professional education. The Allen Consulting Group estimates that the net costs to private hospitals across Australia of providing education and training was $18.9m in 2004[29]. The report, however, does not differentiate between undergraduate education, specialist vocational training, post graduate studies or professional development.

Although the training contribution from the private sector is proportionally small, their workforce utilisation is high. The proportion of health professionals working in the public and private sectors varies across professions, with a notable private practice balance in medicine, pharmacy, podiatry and psychology. In medicine and in some of the allied health disciplines, funding mechanisms such as the MBS, PBS and private heath insurance support practitioners combining public and private practice.

Table 15 Medical FTE in the public and private sectors, Victoria, 2004

	Public	Private
Anaesthesia	407	422
Dermatology	19	93
Emergency medicine	169	12
General Practice	664	5412
Obstetrics & Gynaecology	126	301
Ophthalmology	41	208
Pathology	108	103
Physician	746	1019
Psychiatry	214	504
Radiology	179	247
Surgery	378	869
Other specialties	58	49
All specialties	**3109**	**9237**

Source: Victorian Medical Labour Force Survey, 2004

[29] Allen Consulting Group, *$20 million into the health workforce,* for the Australian Private Hospitals Association (2005)

Table 16 Number of nurses in the public and private sectors, Victoria

		2000	2001	2002	2003	2004
Division 1	**Public**	28552	27847	28772	29342	30198
	Private	11797	12832	13666	13834	14154
Division 2	**Public**	7624	7728	7803	7529	7515
	Private	3675	4103	5045	5011	4981

Source: Victorian Nursing Labour Force Surveys, 2000-2004

Table 17 Number of allied health practitioners in the public and private sector, Victoria, 2004

Allied Health	Public	Private
Medical Radiation Technology	370	419
Occupational Therapy	503	140
Pharmacy	450	1783
Physiotherapy	865	901
Podiatry	128	228
Psychology	470	617
Speech Pathology	282	108

Source: Victorian Allied Health Labour Force Survey, 2004

7.1.1 Clarifying and apportioning clinical training costs

Many attempts have been made to assess the full costs of health education, including the academic and clinical practicum requirements. The most recent is the current study undertaken in Victoria. To date, the findings support a view that the current Commonwealth grant to universities does not adequately capture the full costs of health professional education.

As clinical training is a mandatory requirement of health education, Victoria believes a comprehensive review of health education funding is required. This review should be undertaken as a joint Commonwealth/State/ Territory initiative.

Recommendation

16. That the Commonwealth, States and Territories review the funding relativities for health professional education, to ensure that the full costs of clinical education are covered by the Commonwealth allocation.

7.1.2 Private sector contribution to education and training

Under current arrangements, the public sector provides extensive support for health professional education, and in doing so, implicitly subsidises future employment in the private sector. The private sector benefits from both the undergraduate and post graduate health education, in particular medical specialist training.

The imbalance in private sector return from public sector investment in health professional education needs to be addressed. It would be appropriate for governments to require a contribution from the private sector for the implicit subsidies to their future workforce. This requirement should also cover post graduate specialist education.

A number of strategies could be pursued, including stamp duty or other levies on health insurance funds, private hospitals, or health professional registration. A national private sector levy would avoid distortions between different states and would therefore be the preferred approach. It should ideally ensure that the level of training obligation is commensurate with the private sector provision within the market. Thus in Victoria, an area such as pathology, which is largely delivered through the private sector, would have a relatively high level of training obligation compared to other disciplines that predominantly work in the public health sector, such as geriatric medicine.

The simplest strategy could be a levy on health insurance funds, as their scope includes private hospitals, gap payments for private doctors and, through ancillary insurance, a range of other private health activities including dentistry and allied health. Any such scheme should be implemented nationally.

The importance of establishing mechanisms that encourage the private sector to participate in such a scheme is also recognised. As such, it is suggested that private providers should be able to receive a rebate for any clinical education they provide so they do not meet these costs twice. Such an arrangement would place positive incentives on the private sector to engage in clinical education.

Recommendation

17. That the Commonwealth, States and Territories work together to develop a national scheme that provides fiscally efficient mechanisms for recouping subsidies to health professional education that leads to private sector employment.

7.1.3 Establish return for service obligations

The private health sector is not the only beneficiary of public sector investment in health education. Many health professionals benefit from this investment but leave the sector to work predominantly in the private sector upon graduation. A number of strategies should be considered to ensure that public sector investment in education and training is recognised, particularly for those health professions who gain substantial private practice opportunities as a result.

With the introduction of full fee paying places in health education, it is likely that a greater proportion of future graduates may choose to work in the private sector, as they will have accumulated a substantial debt burden during the course of their undergraduate career. Although literature on the impact of debt on career choice is somewhat ambiguous, it is likely that those graduates who have accumulated large educational debts will seek to recoup the debt as quickly as possible through a more remunerative career choice and may therefore be discouraged from working in the public sector.

There is little Australian information available to indicate how indebtedness may influence discipline choice. An AMWAC survey scored the importance doctors gave to a series of factors known to influence decisions about choice of discipline/training program. The survey found that those aged less than 29 years were significantly more likely ($p<0.01$) to score 'perceived financial prospects' as more important than those aged 29 years and over. Male doctors were significantly more likely to score it as 'more important' than female doctors.[30] '

Return for service obligations for health graduates would be one mechanism through which governments and the wider community could achieve a greater return on the substantial investment made in education and training. This approach could address current and forecast workforce maldistribution in a similar way to the Commonwealth government's bonded medical places. Strategies could include:

- **Increasing the student contribution.** Although the increased revenue that this would raise could be invested in additional training places, there would be little immediate impact on workforce distribution and risks encouraging graduates to pursue more remunerative career choices in private practice.
- **Requiring students to commit to work either within the public sector or to treat public patients in their private practice for a defined period after graduation.** This would immediately impact on supply and distribution, particularly in designated areas of need. The length of the public service obligation could be varied to take into account the level of prior public investment to training, the likely opportunities for private practice and the ability to achieve private returns. Graduates could avoid this obligation by repaying a determined fee, which would be used to provide additional training opportunities to future graduates. Similar schemes could also be developed to distinguish the various health sciences professions, in particular those who have a substantial internship requirements as a prerequisite for registration, such as pharmacy, clinical psychology and medical radiation.

Any scheme to offset high private returns gained through public sector training provision should be implemented nationally in order to harmonize relationships with the existing HECS arrangements and to ensure that graduates do not avoid their public responsibilities by moving from one jurisdiction to another.

Recommendation

18. That the Commonwealth, States and Territories work together to explore options for a national scheme that ensures graduates who do not work in the public sector either contribute towards the cost of clinical training, or treat public patients in their private practice for a defined period after graduation.

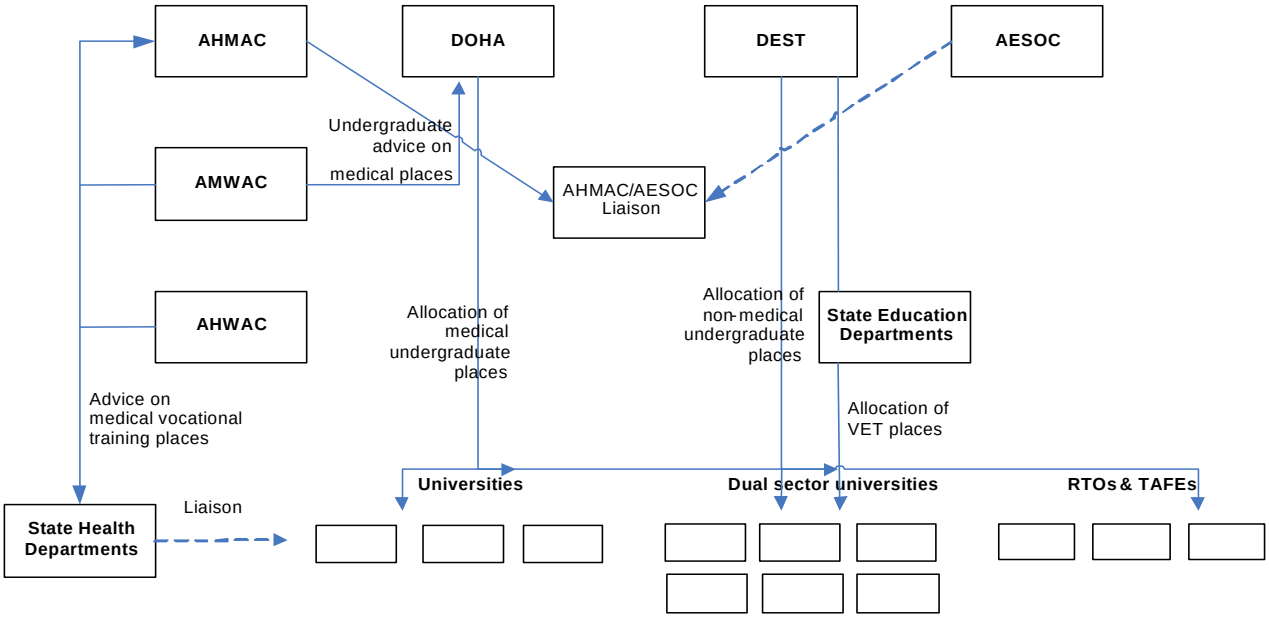
[30] Career Decision Making by Doctors in Vocational Training, AMWAC Medical Careers Survey, AMWAC (2002), p70

7.2 Education and training governance

Despite being at the forefront of health care delivery and providing significant investment in workforce planning, States and Territories have little influence over the funding and allocation of education and training places due to divided responsibilities and roles between the health and education sectors as well as across the state and federal government levels (Diagram 3). In particular:

- The primary purchasing and funding relationship with universities is with the Commonwealth Department of Education, Science and Training (DEST). States and Territories minimal influence in decisions is reflected in the misalignment between the numbers and distribution of funded training places and forecast workforce demand.
- State and Territory health departments and the broader health sector have little capacity to influence course content or structure, despite persistent concerns that graduates are not 'job ready' and more innovative teaching and/or assessment models could achieve potential gains.
- Universities can alter the number of health training places within certain levels without needing to consult with State and Territories despite them being the principal employers.
- Health services are under increasing pressure to support larger numbers of undergraduate clinical placements, yet typically receive little or no remuneration from universities for doing so.

Diagram 3 Current health undergraduate / VET governance and funding arrangements



Current structural arrangements also prevent optimal use of available education and training resources and reduce capacity for innovation. In particular:

- Opportunities to improve articulation between the higher education and VET sectors can be impeded.
- There is little capacity for innovative educational models that cross traditional professional boundaries.
- The delivery and assessment of university education, particularly clinical components, continue to be based on 'time served' and/or number of patients seen rather than achievement of competence. This reduces the capacity to make best use of available training resources.
- The split in responsibilities for VET and higher education prevents a more strategic, systems-based approach to health education.

Although the health workforce has grown over recent years, the traditional dominance of manufacturing and other trades within the VET sector has continued largely unchallenged. While not without problems, the structures established under the Australian National Training Authority (ANTA) provided governments and industry the opportunity to develop a common approach whilst still recognising their individual needs. In the post-ANTA era, Victoria supports a governance approach that retains the benefits of the ANTA arrangements while offering greater clarity of responsibility for government, which in turn will benefit industry, students and training providers.

7.2.1 Resolving responsibilities for health education and training

As long as responsibility for allocation of health training places remains separate from the activities of jurisdictions and the broader health sector, the capacity to better align educational outcomes and service needs will be severely restricted. In Australia, funding of universities for health professional education contrasts with that in the United Kingdom where there is a direct contractual relationship between the health sector and universities. This ensures that universities are more accountable to the health sector to deliver relevant health professional education and adequate numbers of places. It also facilitates experimentation and responsiveness in terms of preparing new types of health workers.

Better links between the health sector and universities could improve university responsiveness to the sector's emerging needs. As major employers, it is essential that States be more involved in negotiating with universities over the number and distribution of places.

Streamlining Commonwealth government responsibility for health education, rather than the current split between DEST and DOHA, would also be beneficial. Victoria believes that this could be achieved through better interfaces between the two Departments.

To address the current Commonwealth-State disconnect, Victoria recommends that the funding and allocation model for health education and training (for both VET and Higher Education) be changed to allow State/Territories control over the purchase of health education places from universities and VET providers (Diagram 4). Under this model, the Commonwealth would retain control of the overall budget envelope while each State and Territory would become responsible for:

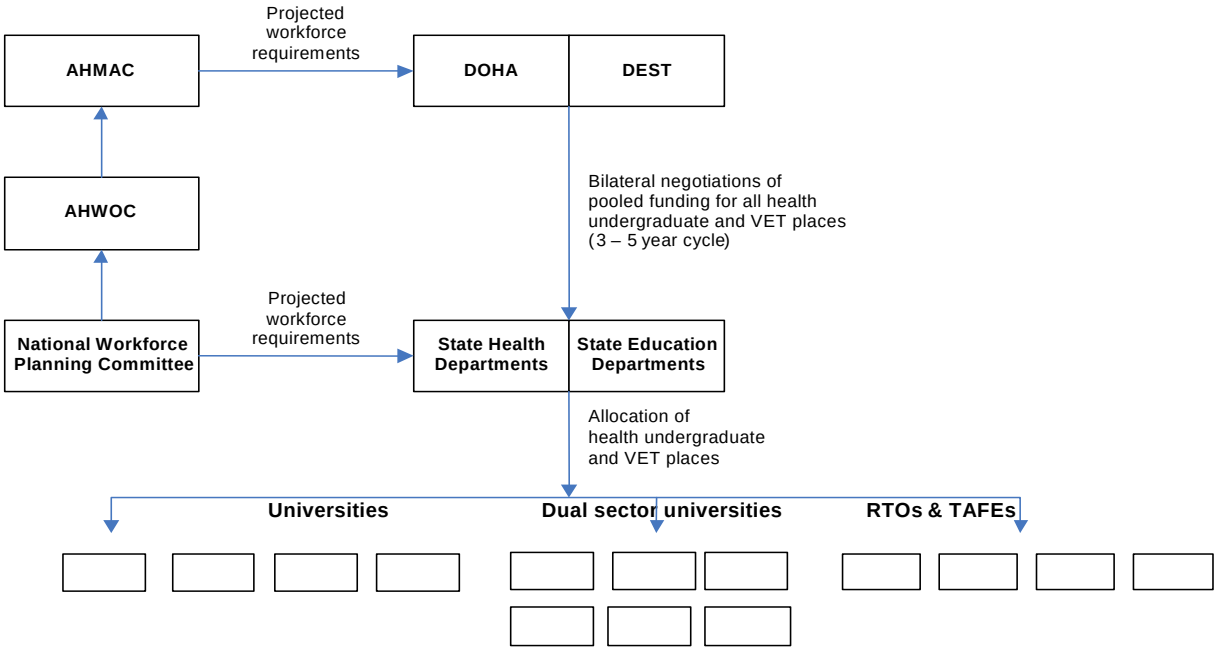
- Determining and clearly articulating their health workforce needs.
- Determining which health education places should be purchased from universities and VET providers.
- Allocating clinical placements to support delivery of these courses.

A potential model could see the quantum of funds based on identified jurisdictional education and training needs made available for States/Territories to determine the health education places to be purchased from universities and VET providers and allocate clinical placements to support delivery. This would be subject to periodic renegotiations on a three to five year cycle, taking into account broader service growth and relative growth against other sectors. Negotiations with education and training providers would similarly occur periodically to provide a level of funding certainty and in a manner enabling each State and Territory consistency with their broader education policies.

The agreement between the Commonwealth and each jurisdiction would clearly outline the purposes for which the funds were being utilised and the accountability and reporting requirements that jurisdictions and funded institutions would need to fulfil. It would provide a vehicle through which national training priorities could be preserved, State and Territory requirements be articulated, baseline training numbers could be negotiated and substitution between VET and higher education providers could be facilitated.

An alternative to this proposal would be to establish a national funding and allocation model for health education and training that involved the Commonwealth and all States and Territories. Purchase of places would still occur based on identified health workforce needs, however, this would be negotiated through a multilateral, rather than a bilateral process.

Diagram 4 Proposed health undergraduate/VET governance and funding arrangements



The abolition of ANTA and the transfer of functions back to DEST offers the opportunity to set new directions for the VET system that reflect the changing landscape of the Australian economy and workforce.

Victoria supports the Commonwealth and the States/Territories taking on full responsibility for discrete aspects of VET, including funding, purchasing and regulation. To this end, Victoria recommends the transfer of responsibility for funding and administration of traineeships and apprenticeships to the Commonwealth. Responsibility for all general publicly supported VET would transfer to States/Territories.

The perspectives of the health sector and particularly State and Territories, as the largest employers, should be represented in national VET decision making bodies to ensure that future investment and policies take into account the evolving needs and reflect the importance of the health sector. Thus, membership of the proposed National Industry Skills Committee (or any other similar body) should include health sector representatives including a government representative. The government nominee would ideally be someone who can represent the interests of public sector employers and health workforce issues more broadly. A nominee from AHMAC would be the preferred candidate.

Recommendations

19. ***That Commonwealth responsibility for health education be streamlined through better integration between DEST and DOHA.***
20. ***That the Commonwealth, States and Territories work together to explore options to reconfigure the funding and allocation model for health education and training (for both VET and Higher Education), with the objective of the Commonwealth providing State and Territory control over the allocation and purchase of health education places.***
21. ***That the Commonwealth seek a nominee from the Australian Health Ministers Advisory Council to sit on the National Industry Skills Committee.***

8 Enabling workforce flexibility and productivity

Despite some changes at the margins which for example, have seen, limited prescribing rights introduced for a small number of allied health providers and nurses, the current roles and responsibilities of professional groups within the health workforce have largely remained as traditionally defined rather than evolving to meet modern day client needs or emerging service models.

Within this context it is not surprising that, to date, responses to current and forecast workforce shortages have largely comprised initiatives that have increased the attractiveness of work for existing occupations, operating within traditional professional roles.

As discussed earlier, supply and demand forecasts for most health professions suggest that shortages will persist despite increasing effort at all levels of government. New approaches are required that challenge long held accepted norms and that explore:

- Reorganising work in priority service areas to minimise duplication of effort and make best use of available staff.
- Extend existing roles and scope of practice to provide greater workforce flexibility.
- Create new professional or assistant roles to meet current and evolving patient needs.
- Better employ technology to address training and workforce requirements.

AHMAC has noted that such an approach is not about reducing the quality of care, but rather recognising that a range of staff within the health system potentially do not utilise the full scope of their training, and that there is the potential to make better use of these skills.

Victoria has already established a range of initiatives to expand the role of health practitioners. These include establishing Nurse Practitioners, expanding scope of practice of Division 2 nurses to administer medications, establishing limited prescribing rights for registered optometrists, consideration of providing limited prescribing rights to podiatrists and preliminary work exploring opportunities for changes in skills mix within emergency departments, intensive care units and radiology. DHS has also established the 'Better Skills, Best Care' strategy, which aims to:

- Develop a plan for human services role design initiatives that integrate service and workforce development and guides work role realignment in Victoria.
- Raise awareness of current and projected human services workforce shortfalls with stakeholders and gain support for a systematic approach to role development and design, including culture change.
- Integrate role design workforce initiatives with innovative service planning strategies.
- Encourage locally responsive workforce review and redesign initiatives, both service-led and DHS-led.
- Develop and deliver the tools to support role review and redesign initiatives.
- Facilitate development of tailored, competency-based training for new and amended roles.
- Build an evidence base for role creation and redesign and qualitative and quantitative output measures.

Thirty-eight pilot projects have been funded (Appendix D) and more are planned for 2005-06. This work will provide evidence to support workforce redesign as well as identifying further opportunities for redesign in priority service areas.

Despite this state investment, a national approach is required to address some of the major structural problems inhibiting reform.

8.1 Changing funding and payment levers

In most industries, productivity improves through review and revision of the mix of factor inputs to achieve industry outputs. Since the price received by producers is related to outputs, producers have an incentive to develop the most efficient mix of inputs to produce the outputs. There is no equivalent set of incentives in many parts of the health sector. In particular, the current systems of remuneration for medical practitioners do not provide any incentives to review factor input mix.

There is substantial literature coming out of the United States that reviews the impact of different skill mix arrangements for both primary and specialist medical care. In general, this literature deals with the experience of providers, remunerated on a capitation basis. Under this circumstance, the purchaser or funder is agnostic as to the mix of professionals involved in providing care or preventive activities. Such arrangements encourage nurse substitution for medical practitioners in first contact care, as well as other substitution arrangements for specialty care without compromising health outcomes.

In contrast, as discussed in Section 5.1.3, Australia's system for remunerating medical practitioners provides for very few opportunities for substitution. The MBS is largely based on remunerating services actually delivered by a medical practitioner, irrespective of whether this service could equally have been provided by another professional. The MBS, as currently structured militates against productivity improvements as there is limited opportunity to substitute alternate appropriately qualified personnel for the medical practitioner.

As a result, improved access to health services can only be achieved by producing more of the same range and mix of health professionals, rather than developing new professional categories and provision models (for example, two medical practitioners and a nurse practitioner providing services in a country town, compared with current arrangements of three medical practitioners).

Expanding access to MBS and PBS benefits to non-medical professionals is thus important not only to improve workforce distribution, but to encourage optimal deployment of available workforce skills. It should be progressed as a priority area of reform, as recommended in section 5.1.3.

8.2 Opening up qualification accreditation and recognition

The power to recognise qualifications for purposes of registration and assessing overseas trained practitioners is a pivotal element of contemporary health practitioner regulatory systems and award and enterprise bargain structures. These functions effectively create significant barriers to entering the market for provision of health services in Australia.

State and territory health practitioner registration Acts empower state and territory based registration boards to determine the qualifications required for registration in their jurisdiction. In recent years, national bodies have been established to undertake the functions of accreditation of Australian courses and in some instances, assessment of international graduates. Appendix E provides information on these bodies.

Typically, these bodies have been established through agreement between jurisdictional registering authorities and, in some instances, as an initiative of, or in cooperation with, the respective peak professional associations. They are funded in certain circumstances through contributions made by the respective registering authorities, as well as by fees charged for examinations and course accreditations. Most are governed by boards comprising nominees that include state registering authorities, although in some instances, for example, in psychology and podiatry, the respective peak professional associations play a pivotal role and nominate most of the delegates.

In medicine, these bodies are referred to in state and territory legislation as carrying out statutory functions[31]. In others disciplines, the respective legislation provides registration boards with general or specific powers that enable them to delegate assessment of qualifications for the purpose of registration to national accrediting bodies.

Although these national accrediting bodies perform a crucial function, they are not subject to controls that ensure that the health system is best served and the public interest is protected. There are concerns that, as currently constituted and operate, these accreditation bodies:

- Reinforce traditional workforce roles, rather than focusing on evolving service and client needs. The single-discipline focus is opposed to current policy directions that encourage inter-disciplinary approaches, optimal use of workforce skills and workforce adaptability.
- Provide limited capacity for, or emphasis on innovation in learning and teaching models and in some instances, have the effect of 'homogenising' undergraduate education.
- Militate against best use of available resources by adopting assessment criteria that are time/setting-based rather than outcome/competency-based, thereby preventing students with previous experience seeking reductions in the duration of clinical training component.

Additionally, there is concern over the different accreditation standards and requirements for each occupational group. Research commissioned by Victoria examining the clinical placement requirements for meeting accreditation standards across a broad range of health and allied health professions found that:

> *'… there is limited evidence in the documentation from any of the professions that specified hours of clinical practice requirements have been set with any recourse to research. Nor were the consultations able to provide significant insight into how practice requirements were determined; rather the impression was gained that these are often historical artefacts determined through 'expert judgement' that had endured significant change in professional and educational practice. As such, the level of variation in requirements is difficult to support.'*[32]

[31] In all Australian jurisdictions (with the exception of SA), medical practitioner registration acts establish statutory powers for the Australian Medical Council to recognise qualifications for the purpose of registration.
[32] Human Capital Alliance, (2005), *Accreditation requirements for clinical placements,* Report to the Victorian government, May 2005, p 119.

In an era of growing workforce pressures and increasing globalisation of the health workforce, the systems governing entry to the health workforce need to be rigorous, transparent and accountable, whilst allowing sufficient workforce flexibility and, ultimately, ensuring adequate protection of the public.

Case studies

Medical physicists

Medical physicists have been identified as a specialty experiencing workforce shortage.

In response to the recommendations in the Baume Report, the Australian College of Physical Scientists and Engineers in Medicine (APSEM) developed and is implementing a national training program for medical physicists.

To be accredited as a medical physicist now requires a three-year undergraduate physics degree followed by a 5 year "Registrar" training program broadly comprising completion of a postgraduate qualification in Radiation Oncology Medical Physics (to at least the Masters level) and supervised clinical practice for three years.

Health Services are increasingly reluctant to employ medical physicist trainees because of the extended training period. Trainees are perceived as imposing a significant financial burden while contributing little to service delivery because of the length of time during which they are unable to undertake tasks without supervision. However, without the supervised clinical practice, graduates cannot be fully accredited as a Medical Physicist.

The current system places the ACPSEM at the heart of training, accreditation and registration, that is, it is:

- the sole provider of clinical training for Radiation Oncology Medical Physicists,
- the accrediting body for medical physics postgraduate courses,
- the examiner of professional competence and accrediting body for medical physicists, and
- the sole accrediting body for overseas trained Medical Physics graduates.

Victoria's preferred approach would be for training to be based on achievement of competence rather than time. This would reduce training time without affecting quality and safety of care, while reducing the burden on employers.

Mental health nurses

The Australian and New Zealand College of Mental Health Nurses is a non-statutory, professional body. The Health Insurance Commission requires mental health nurses to be credentialed by this college as a requirement for accessing payment under Medicare item number 10956 (services provided by a mental health worker) in addition to requiring the nurses to be registered with the Victorian Nurses Board, which already has a mechanism for recognising that they are qualified to practice as a mental health nurse. This double requirement, requiring nurses to meet the standards of both the nursing regulatory body and the professional body in order to access payment, is overly onerous. Few nurses are credentialed, with only an estimated eight nurses currently credentialed in Victoria.

Most accrediting bodies also assess overseas trained practitioners intending to apply for migration to Australia. This function is delegated by the Australian Education International - National Office for Overseas Skills Recognition (AEI-NOOSR).

Over recent years, jurisdictions have become increasingly reliant on internationally trained practitioners to cover shortfalls in local workforce supply. A number of bodies may be involved in assessment international practitioners:

- National accrediting bodies (such as the specialist medical colleges).
- Registering bodies.
- Professional associations or other professional bodies.
- Health services, who in Victoria conduct safe practice assessments.

This diversity creates a range of barriers to consistency and efficiency, similar to those identified previously for accrediting bodies, namely:

- Current schemes are difficult to navigate, with little consistency in processes or approach and duplication of effort across professions.
- Nationally agreed and enforced standards do not exist for all occupations (this is considered to be a particular issue in relation to international medical graduates, for whom there is not a mandated safe practice assessment requirement).
- The standards applied are usually developed and administered by the profession itself, often with little or no public input. This reinforces professional 'silos', and can result in decisions that are not sufficiently accountable or do not adequately take into account the broader public interest.

8.2.1 A national health accreditation and education model

In order to achieve a more flexible health workforce, it will be necessary to move away from traditional, profession-specific approaches to ones that are more multidisciplinary, competency/outcome based, that better align to forecast service demand and support educational and workforce innovation. Course accreditation is critical to this.

Victoria proposes that a multidisciplinary, nationally consistent approach to course accreditation and assessment of international practitioners be established through a national council. A National Health Accreditation and Education Council would:

- Identify competencies required for both entry level and more specialized practice across the health workforce, based on common core competencies.
- Assess and accredit courses for health practitioners seeking to enter (or re-enter) the health workforce.
- Maintain and publish a list of approved courses of study.
- Develop and publish standards and guidelines on the criteria and processes for course accreditation and assessment of international practitioners following consultation with key stakeholders such as educational institutions, professional bodies, consumers and government. This would include mandatory minimum requirements for safe practice assessments prior to entering the workforce.
- Assess courses and determine equivalence of overseas courses for accreditation purposes.
- Assess qualifications of international practitioners and determine additional requirements for purposes of registration in all categories.
- Provide leadership on national reforms and implement policy directions that allow the education and training system to respond to emerging health industry needs.

A representation of how such a Council may work is provided in Diagram 5. The Council would subsume those functions currently undertaken by profession specific bodies.

The National Health Accreditation and Education Council would be structured to allow for a more balanced representation from professions, universities and training providers, educational experts, government and consumers to ensure the public interest remains paramount. The Council would also be subject to the same public interest and accountability requirements as registration boards and other statutory bodies.

In order to retain sufficient professional expertise to the accreditation and assessment process, the Council could determine to allow other bodies to undertake accreditation and assessment processes. Those bodies would need to meet certain requirements including:

- Governing board membership allow for a sufficient balance of profession specific and public interest (non-profession specific) views.
- Processes for assessing individual qualifications are rigorous, open, transparent and fair, consistent with government policy, and include adequate arrangements for review and appeal.
- The criteria and processes for accrediting overseas courses of training are open, transparent and fair, and foster best practice in educating and assessing students.
- Mechanisms are adopted that foster collaboration and consistency of processes between the various profession specific accrediting bodies and promote cross-disciplinary approaches to accreditation.
- The organisation complies with legislative requirements in a range of areas including financial management, trade practices, privacy, health records etc.

Innovation in education and training

A critical role of the Council would be to ensure that proposed courses of training are necessary, timely and appropriate. Many health education courses have evolved over long periods of time and reflect professional and cultural norms. As the nature of service provision and client need evolves, it is important that the education and training delivered also evolves as necessary, and that there is a greater role for all health workforce stakeholders in contributing to such considerations. For example, any proposal to change the duration of courses would require the Council's approval, and consideration of any such application would be subject to consultation with a wide range of stakeholders.

Increasing clinical placement burden

More and more health courses now have the requirement for clinical placements. In Victoria, public sector service providers bear the greater burden of clinical practice supervision. There is little evidence to suggest that clinical schools/faculties using public sector facilities for clinical placements for their students are having regard to the service delivery pressures this is creating.

In Victoria, La Trobe University and the University of Melbourne are recognized by the Australian Council of Physiotherapy Regulating Authorities (ACOPRA) as delivering courses in physiotherapy. Both offer a 4 year Bachelor of Physiotherapy program. Considerable variation exists in the clinical placement requirements of the two institutions: La Trobe University requires 1056 hours, the University of Melbourne requires 1382 hours, a difference of 326 hours. ACOPRA does not specify the number of hours required as part of the clinical placement.

Increasing course duration

The length of Australian courses has been incrementally increasing, for example, podiatry at La Trobe University has gone from being a three year course to four years in the past five years. The University argues that this brings the La Trobe program into line with other universities.

The incremental increase is out of step with international trends and risks them becoming less compatible with comparable programs internationally. Under the Bologna process, European degrees are standardised at 3 years with Masters degrees at a further 2 years. Many health professional qualifications in the United Kingdom are of three years' duration.

Significant reforms to health education, particularly within the higher education sector, need to be progressed in order to ensure that course requirements are aligned with and proportionate to the educational outcomes required.

Future curriculum development and exploration of new or redefined roles in the health sector requires, as a staring point, a clear understanding of the competencies required for service delivery. A service stream approach, rather than a profession-specific approach to competency mapping is recommended. Priority areas are competencies required to care for older people and competencies required for delivery of primary maternity services. Ideally, this work would be undertaken nationally, in collaboration with jurisdictions and the relevant professional bodies.

Within this context, processes for recognition of prior learning should be reviewed and streamlined, so that candidates who demonstrate competence (including competence in an area of clinical practice) would not be required to complete a specified period of training in that area.

There is also a particular need to explore innovation in clinical training models, such as use of simulation centres, to ensure that best use is made of health service capacity and that the training is relevant, targeted and delivered as efficiently and effectively as possible. Victoria has already commenced work in this area, however, there is benefit in a national approach, given that most training courses are currently subject to national accreditation processes.

It would be difficult to progress such reforms unless they were aligned to funding and governance structures that created positive incentives for stakeholders to adopt them. Policy leadership for this should therefore rest with the National Accreditation and Assessment Council.

In the first instance, there may be merit in the Council undertaking a systematic review of health courses (VET, undergraduate, post graduate and specialist), focusing on areas of greatest forecast workforce shortage to explore opportunities for curriculum and teaching reform, taking into account issues such as:

- Does they take into account the forecast needs of the health system?
- Are graduates appropriately prepared?
- Are they optimum length?
- Are alternative technologies (eg skills simulators) used to the maximum effective outcome?
- Are there articulation arrangements for any related certificate courses?

Recommendation

22. That the Commonwealth, States and Territories work together to explore establishment of a multidisciplinary model for national course accreditation, curriculum leadership and the assessment of international practitioners. Such a national multidisciplinary model should provide an integrated system for the:

- ***Identification of service stream competencies required for both entry level and more specialised practice across the health workforce.***
- ***Review and streamlining of recognition of prior learning and structures introduced to increase utilisation of these processes.***
- ***Assessment and accreditation of courses for health practitioners seeking to enter (or re-enter) the health workforce.***
- ***Development of standards and guidelines about the criteria and processes for course accreditation and assessment of international practitioners following consultation with key stakeholders such as educational institutions, professional bodies, consumers and government.***
- ***Assessment of courses and determination of equivalence of overseas courses for accreditation purposes.***
- ***Assessment of qualifications of international practitioners and determination of additional requirements (if any) for purposes of registration in any category.***
- ***Progression of innovation in clinical training, to identify opportunities to maximise use of existing capacity and implement innovative training models to complement the existing, apprenticeship model.***
- ***Provision of leadership on national reforms and implement policy directions that allow the education and training system to respond to emerging health industry needs.***

8.3 Professional regulation

Statutory requirements for registration create barriers to entry to certain labour markets, including those for a range of health professions. Although regulation of health professions has been found to be broadly in the public interest, the structure and scope of such regulatory systems can reinforce existing professional boundaries and in some instances, militate against workforce innovation and flexibility.

In particular, regulatory schemes that have registration bodies dominated by professional interests and/or have defined scopes of practice, have the potential to compromise the broader public interest because of the resultant reinforcement of rigid professional boundaries.

In the Victorian experience, this occurs most commonly where new roles (such as support workers) have been proposed and/or introduced. However there are instances where the standards set for entry (and re-entry) to practice also appear to reflect professional interests, rather than those of the broader public.

In addition to the limitations of profession-specific registration schemes, the current state and territory based approach to health practitioner regulation also contributes to regulatory inefficiency and inconsistency. Each jurisdiction maintains its own regulatory scheme and associated administrations which creates:

- Significant duplication of administrative effort, both in maintaining the legislative framework and in supporting the boards themselves, the costs of which are ultimately borne by the consumer.
- Impediments to labour market flows that arise from requirements for practitioners to formally apply for registration and pay fees in each jurisdiction in which they practise.
- Variations in regulatory approaches create differing loci of power and functions for registration boards across jurisdictions.
- Achieving an appropriate, consistent balance between protection of the public and workforce flexibility is painfully slow and highly contested.

As noted earlier, in an era of growing workforce pressures and public accountability, systems governing entry to the health workforce need to promote greater workforce flexibility, be transparent and accountable, and ultimately ensure adequate protection of the public.

In recognition of its importance, Victoria has been reviewing its health practitioner registration Acts to ensure the regulatory scheme is sufficiently responsive and flexible to meet both consumer needs and future workforce requirements. This review has included extensive consultation with consumers, practitioners, registration boards, other government agencies (including the Health Services Commissioner and the Ombudsman) professional bodies and unions[33].

Based on this consultation, Victoria is considering a number of reform options. These include:

- Establishing an 'umbrella' health practitioners act to replace the 12 profession-specific legislative schemes currently in place.
- Changing the balance of membership on boards to increase the proportion of non-practitioners.
- Establishing mechanisms to ensure greater external scrutiny of board policy instruments that have the potential to further restrict entry to practice and/or scope of practice.
- Other structural reforms to achieve greater efficiency and consistency across the regulatory scheme.

8.3.1 A national health practitioners registration scheme

Whilst jurisdictional reforms can address some of the identified problems, the existence of eight separate, state-based registration schemes ultimately impedes labour market efficiency. Sectors such as law have addressed this by establishing a national scheme that retains separately constituted registration bodies in each jurisdiction, while providing for national portability of registration.

Since 2001, AHMAC has supported work to develop a nationally consistent approach to medical registration ('the NCMR project'). Although progress has been made, existing jurisdictional variations make such reforms complex and slow.

A new approach to the regulation of practitioners that balances the need for adequate protection of the public, streamlined entry and practice and, a more efficient, consistent approach across registered health professions and jurisdictions is required. Such an approach should also explore when and how statutory registration is applied to maximize the efficient use of resources and workforce flexibility.

In addition to progressing its own State-based reforms, Victoria proposes the establishment of a national scheme for health practitioner regulation (Diagram 5). This scheme would take the form of a National Health Practitioners Registration Council to:

- Establish and maintain a national register listing members of each regulated profession.

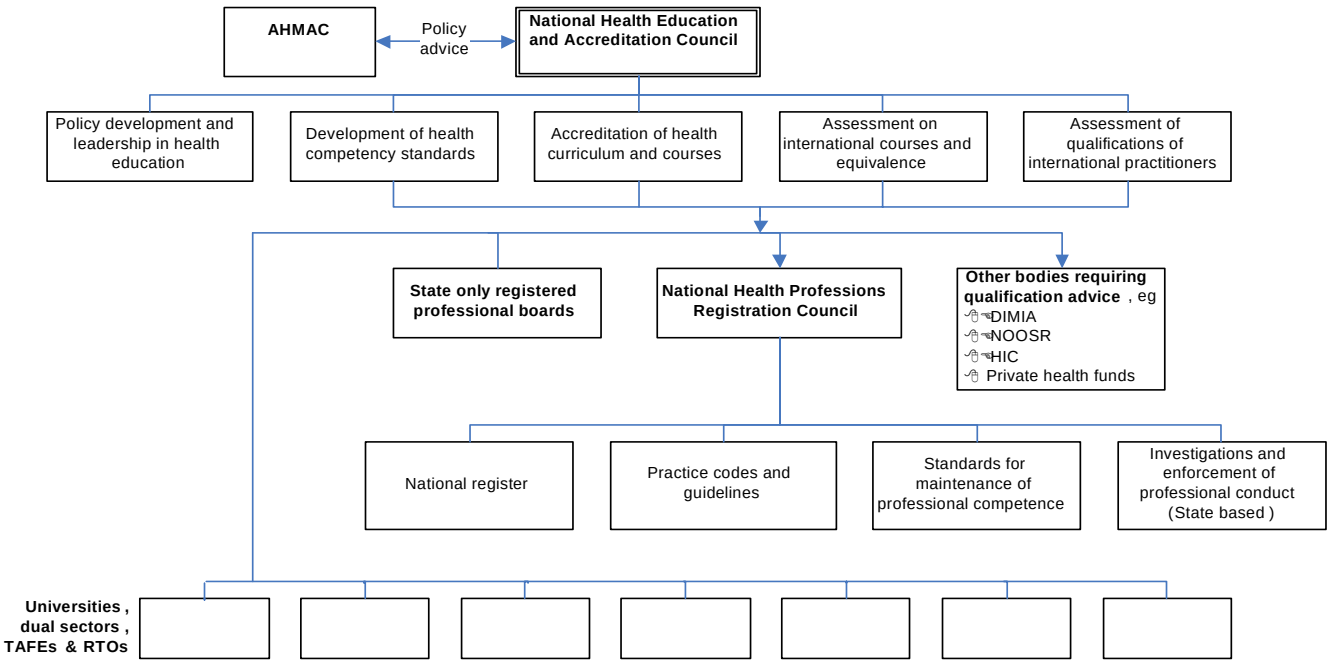
[33] Further information regarding this review, including discussion papers and commissioned research, can be accessed at http://www.dhs.vic.gov.au/pdpd/workforce/pracreg/sys_review.htm

- Determine the common categories of registration.
- Establish national codes of guidance governing the regulated health professions, including any mandatory requirements for assessment by health services prior to commencement of practice.
- Determine:
  - Qualification and training requirements for registration (or, should a National Health Professions Accreditation and Education Council be established, recognise those qualifications accredited by the Council)
  - Requirements for establishing that applicants are of good health and character and there is no matter that prevents them from safe and effective practice
  - Requirements regarding maintenance of professional competence.
- Receive notifications and delegate to locally-based processes, investigations into the performance/ competence, health and conduct of registered health practitioners. The Council would act on the findings from these locally based investigations, including removing practitioners from the register. This approach would complement reform proposals currently being considered by Victoria.
- Explore, in consultation with the National Health Accreditation and Education Council, alternative models of regulation for those occupations not subject to statutory registration.

In doing so, the Council would be able to align and make consistent those functions currently undertaken by jurisdiction-based registration boards across Australia. In instances where professions are not registered across all jurisdictions, this would be limited to those jurisdictions where they are currently registered.

Like the proposed National Health Accreditation and Education Council, the National Health Practitioners Registration Council would comprise a mix of professional, legal, government and consumer representation to ensure the public interest remains paramount. Ideally, it would include a nominee of the National Health Accreditation and Education Council to ensure appropriate linkages between the two bodies.

Diagram 5 National scheme for health education course accreditation and professional registration



An alternative model could be mirror the approach recently adopted for Professional Standards legislation across a range of jurisdictions.

Under this model, each jurisdiction's legislation would provide for the establishment of a state/territory board. However the same members would be appointed to boards in all jurisdictions and would be responsible for administering each piece of legislation and ensuring compliance with the relevant state/territory laws.

Each jurisdiction would have its own legislation and its own state board, all of who would be accountable to their relevant Minister. As such, existing controls could be retained at a jurisdictional level, subject to the terms and operation of an intergovernmental agreement to support this arrangement.

Recommendations

23. That the Commonwealth, States and Territories work together to explore the establishment of a national scheme for health practitioner regulation. This would provide:

- ***The establishment and maintenance of a national register listing members of each regulated profession***
- ***Common categories of registration across Australia.***
- ***National codes of guidance governing the regulated health professions, including any mandatory requirements for assessment by health services prior to commencement of practice.***
- ***Qualification and training requirements for registration.***
- ***Requirements for establishing that applicants are of good health and character and requirements regarding maintenance of professional competence.***
- ***Locally based processes for investigations into the performance/competence, health and conduct of registered health practitioners. The national scheme would act on the findings from these locally based investigations, including removing practitioners from the register.***

9 After hours GP clinics

In Victoria's experience, the major effect of the poor affordability and lack of availability of after hours GP care is the increased demand pressures being experienced by hospital Emergency Department (ED) presentations. In many areas, particularly in the outer metropolitan suburbs, there are large numbers of patients attending hospital emergency departments who could be managed by a GP. These hospitals lie within are recognised areas of GP shortage. Presentations are most noticeable in the out of hours periods and on week ends.

Table 18. Primary Care Type (PCT) presentations to Emergency Departments, Victoria

	2000-01	2001-02	2002-03	2003-04	2004-05 (est.)
Total number	316,909	340,480	363,445	364,693	375,782
Proportion of all presentations (%)	44	44	45	44	44

Preliminary estimates indicate that the rate of growth statewide in Primary Care Type ED presentations in 2004-05 continues. There is a 3 per cent increase in PCT presentations across the major metropolitan and regional hospitals in 2004-05 from 2003-04. This follows growth of 2 per cent, 7.2 per cent and 5.8 per cent in the previous three years.

In 2004-05, PCT presentations at the major metropolitan hospitals ranged from:

- 60 per cent of total presentations at the Angliss Hospital. The Angliss Hospital is located in an outer metropolitan area, and area of designated GP shortage.
- 18 per cent at Frankston Hospital. The Mornington Peninsula Division of General Practice has auspiced an after hours clinic (Medicentre) co-located with Frankston Hospital Emergency Department since 1986. This clinic is staffed on a roster system by local GPs and has historically been a bulk-billing clinic. Funding is entirely from MBS, with in kind support in the form of favourable facility lease arrangements from Peninsula Health. In mid 2002, Medicentre management introduced an up front payment of $40, retaining bulk-billing for health card holders only, in response to:
  - Doctors' perceptions that they were not generating enough income through bulk-billing to maintain a satisfactory income.
  - Demand increasing to a level where the heavy workload was a disincentive for staffing the clinic.

  Within 3 months of introducing the payment, attendances at the Medicentre reduced by around 30 per cent and within 6 months they had reduced by 50 per cent. Over the same period there was a significant rise in attendances at Frankston Hospital, equivalent to around one third of the fall in Medicentre attendances.

  The Medicentre has recently received funding from the Commonwealth through the 24 hour Medicare Program.

In the metropolitan area, several barriers have been identified that dissuade GPs from providing after-hours:

- Safety concerns.
- Lifestyle concerns about working out-of-hours and damaging family life.
- Extremely limited access to locums.
- Inadequate financial support for existing after-hours GP arrangements.
- Insufficient patient education about the availability and appropriateness of services.

Pegram[34] notes that the GP cooperative is an expanding option for an after-hours model of care. In a consumer preferences survey commissioned by the Commonwealth Department of Health and Ageing, most participants agreed that using existing medical infrastructure for the provision of after-hours medical services was sensible. In particular, hospitals, with the after-hours primary care service being a separate entity from the ED, were seen to:

- Offer a safe working environment.
- Enable patients to access other hospital facilities if needed.
- Reduce the need for after hours facility to have an auxiliary service.

[34] Pegram R, After Hours Primary Medical Care- An Analysis of Research, Current Data and Activity, Department of Health and Aged Care, Canberra, 2001.

Despite these findings, negotiating with the Commonwealth on the number and location of GP co-located clinics has been difficult. Victoria supports the provision of after hours GP services adjacent to public hospital emergency departments. However, expansion of such clinics to other public hospitals that are experiencing high PCT presentations has the potential to breach the terms of s19(2) of the Health Insurance Act 1973.

As part of the election commitments in 2004, the Commonwealth softened its approach and announced funding for 10 GP co-located clinics nationally. Victoria was allocated two clinics to be co-located at:

- Northern Hospital. The co-located after hours clinic has been operating for two months. Initial evidence is that there is some diversion of emergency activity although no formal analysis has yet been carried out. Prior to the clinic opening recruitment of GPs had been identified as a major risk; in practice GP workforce has not been an issue. There appears to be a cohort of GPs for whom evening sessional work, with little or no administrative burden and in a secure environment, is attractive.
- Sunshine Hospital. This is still not operational. Sunshine Hospital has been unable to attract GPs to the clinic. Sunshine Hospital had planned to recruit a GP through a tender process to operate the clinic as a private practice, however the tender process has not produced a suitable GP partner. Sunshine Hospital is currently working with the local Divisions of General Practice to develop a different model for operation of the clinic.

Earlier this year, the Commonwealth announced a further GP co-located clinic would be opened at the Royal Children's Hospital. However, there was no funding attached to this announcement and negotiations are continuing between Victoria and the Commonwealth on how this clinic will be funded.

With regard to the initiatives announced by the Commonwealth Government under the Twenty-four Hour Medicare program, the funding for specific clinics has not yet flowed into new service provision. The increase in the after hours MBS rebate effective January 1, 2005, has not had any apparent effect on ED attendances.

Victoria supports the expansion of the co-located clinic model to other hospitals experiencing high presentations of PCT patients and would welcome the opportunity to work with the Commonwealth to achieve an agreed outcome in this area.

Recommendations

24. That the Commonwealth work with States and Territories to identify successful models for attracting GPs to work in clinics co-located with public hospitals.

25. That the Commonwealth work with States and Territories to establish co-located GP clinics in those hospitals experiencing high primary care type patient demand.

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Appendix A Letter from the Minister for Education, Science and Training

MINISTER FOR EDUCATION, SCIENCE AND TRAINING
THE HON DR BRENDAN NELSON MP

The Hon Bronwyn Pike MLA
Minister for Health
GPO Box 4057
MELBOURNE VIC 3001

RECEIVED
21 JUL 2005
MINISTER FOR HEALTH

18 JUL 2005

Dear Bronwyn Minister

Thank you for your letter concerning a proposal for a joint State and Commonwealth review of undergraduate medical training requirements in Victoria. I apologise for the delay in responding.

Let me assure you the Australian Government is committed to ensuring that all Australians have access to high quality medical services. I consider the medical workforce pivotal to Australia's health care system and the Government continues to monitor and invest in the supply, education and training of tomorrow's doctors.

The Australian Government has provided increased training opportunities for Australian doctors. The number of publicly funded commencing medical school places in Australian universities has increased by more than 30 per cent since 2000. Victorian universities have received an additional 28 publicly funded medical school places each year since 2004 as a result of two Government initiatives, the Medical Rural Bonded Scholarship Scheme and the Bonded Medical Places Scheme.

The Government has also introduced new arrangements for 2005 to allow medical schools to provide full fee-paying places in medicine for Australian students. Universities may offer around 10 per cent of their commencing places in medicine as full fee-paying places from 2005.

The Council of Australian Governments has agreed to commission a wide-ranging report on health workforce issues. The Productivity Commission will present a final report by 28 February 2006.

The Productivity Commission inquiry will consider issues relating to demand for and supply of medical practitioners. In view of the inquiry, I do not believe that a further joint review of medical training requirements in Victoria is necessary at this time.

I understand that you have also raised your concerns with the Minister for Health and Ageing and I can assure you that they will be taken into consideration when the Government is next examining the scope for increasing the number of publicly funded medical places.

I have also replied direct to Minister Kosky.

Yours sincerely

Brendan Nelson

BRENDAN NELSON

Parliament House, Canberra ACT 2600. Tel: (02) 6277 7460 Fax (02) 6273 4116

Appendix B Assessment of international medical practitioners

Victoria has concerns with various aspects of these current assessment processes. It believes that the processes, as exemplified in the case outlined below for medical practitioners, may hamper jurisdiction's ability to recruit suitably qualified overseas trained practitioners.

Despite new Strengthening Medicare initiatives announced by the Commonwealth Government in 2004 to reduce red tape for overseas trained doctors seeking to practice in Australia, Victoria believes there remain issues with the assessment processes:

- The AMC administers the national assessment process to assess the medical knowledge and clinical skills of overseas trained doctors. To be eligible for general registration, candidates must be awarded the AMC Certificate and complete a period of supervised training approved by a State or Territory Medical Board.

  The standard of the AMC examinations is defined as 'the level of attainment of medical knowledge, clinical skills and attitudes required of newly qualified graduates of Australian medical schools who are about to commence intern training'. These overseas trained doctors are employed in hospitals as Hospital Medical Officers and residents, that is, they are being assessed for competency at a lower standard than the level at which they are being employed. This risks compromising patient care.

  In response, Victoria has developed a safe practice assessment process. Whilst initially intended to address this issue, employer concerns that its mandatory introduction might act as a disincentive resulted in it being implemented on a voluntary basis only. It is now being used to identify the skill development needs of international medical graduates.

- Assessment of most overseas trained specialists appears administratively cumbersome and inefficient. To date, only one specialist college, the Royal Australian College of General Practitioners (RACGP), has developed lists of qualifications that it believes are comparable to the Australian Fellowship level. Countries included on the RACGP list are the United Kingdom, New Zealand and Canada. Candidates with specified qualifications from these countries are eligible for the FRACGP without further training, examination or time requirements whilst working in Australian general practice.

  Other specialist colleges, however, have not followed the RACGP's lead. At a national conference on 20 March 2004, other specialist colleges agreed to a system that equates overseas qualifications as substantially, partially or not comparable to the Australian Fellowship. The colleges agreed that applicants with training deemed to be substantially comparable would be automatically registered as a specialist.

  However, the establishment of comparability by the specialist colleges is not based on clear criteria and is potentially open to different application. Victoria is aware of cases where candidates with similar qualifications and experience had different assessment outcomes resulting in one candidate qualifying for registration at the Fellowship level and the other not.

Appendix C Victorian nurse recruitment and retention campaign

A key factor in the success of recruitment and retention strategies in Victoria was the engagement and commitment of all key stakeholders, in particular Directors of Nursing and Health Service CEOs. Relevant industrial bodies were supportive and efforts were well coordinated across all stakeholder groups.

The major elements of the Victorian campaign to recruit and retain nurses include:

- **Advertising**

  This comprised a series of radio, television and print activities. Nurses were shown at work and spoke about their reasons for being in nursing. The campaign was supported by a call centre. A multicultural advertising campaign to recruit bilingual nurses was also run.

- **Re-entry and supervised practice programs and refresher courses**

  Since September 2000, funding has been made available to public health care facilities across the state to provide refresher/re-entry/supervised practice programs for former nurses returning to work. Those nurses, who are returning to work and who hold current registration are paid at the appropriate award rate during the period they attend the refresher course. Over 2300 individuals have benefited from this initiative. An evaluation found that, on average, participants had been out of the nursing workforce for 9.4 years prior to taking the refresher programs; 86 per cent are now working as registered nurses (76 per cent in public facilities). The majority are working part-time.

- **Overseas nurses pre-registration**

  More than 340 overseas trained nurses were supported to undertake bridging training to ensure they met Australian Nurses Council and Nurses Board of Victoria requirements for registration.

- **Promoting nursing as a career choice**

  The recommendations of the Victorian Nursing Recruitment and Retention Committee final report were implemented including:

  - Utilising the school nurse network as a method of raising the profile of nursing.
  - Working with Career Education Association of Victoria to ensure teachers have a better understanding of nursing as a career choice.
  - Developing a core set of materials to be made available for high school students describing the role and education pathways for nursing.
  - Principal Nurse Advisor motivational presentations to 1st and 3rd year undergraduate nursing students.
  - Developing a website to provide information on nursing as a career choice.

- **Victorian Nurse Back Injury Prevention Program**

  Funds were made available to 110 public health care facilities to implement programs to prevent back injury amongst nurses. This initiative resulted in savings of $6.4 million per annum through:

  - 48 per cent reduction in Work Cover claims for injuries sustained to nurses.
  - 74 per cent reduction in days lost due to injury.
  - 54 per cent reduction in the cost of claims at 12 months to those health services who have implemented the programs.
  - Feedback from the Aspirations project indicated that the program had been a significant factor in staff retention and had a positive impact on reducing sick leave.

- **Midwifery up skilling**

  Over 400 rural and remote mid wives in Victoria underwent upskilling to strengthen the opportunity for rural woman to deliver their babies as close to their families as possible.

- **Nurse agency strategy**

  In April 2002, DHS placed a cap on the price and volume of agency nurses used. The net effect has been that the proportion of casual staff who are agency staff has fallen from two-thirds to one-third.

  In its first year of operation there was a 17 per cent reduction in hours worked by agency nurses, saving $10 -$15M net. Since July 2003, Agency hours have average 2.7 per cent of productive hours in the productive hours (Nurse Bank 5.4 per cent)

- **Nurse Banks**

  Use of nurse bank has doubled since early 2002, with bank staff effectively substituting agency staff. Bank nurses are considered members of the employing facility's workforce with access to salary packaging and education and orientation programs available if a minimum threshold of hours are met.

Appendix D Better Skills, Best Care strategy

The provision of quality human services to any community requires an adequate supply of a suitably trained workforce –the right people in the right place at the right time with the right skills to deliver quality care to patients.

In some instances, increasing the number of health workers is achievable and can prevent shortages that restrict service capacity. However, this will not be enough to meet future demand or achieve sustainable services. It is necessary to examine how to make best use of available skills by exploring how:

- Work might be reorganised to minimise duplication of effort and make best use of available staff.
- New roles can be developed to meet current and evolving patient needs.
- Technology can be better employed to manage training and workforce requirements.

The Better Skills, Best Care strategy aims to progress these issues over the next two years by:

- Integrating role design workforce initiatives with current and planned departmental service strategies.
- Encouraging locally responsive workforce review and design initiatives.
- Facilitating tailored competency-based training for new and amended roles.
- Working with stakeholders to explore workforce issues and role design initiatives.
- Building an evidence base for role design and evaluation measures.

The strategy incorporates a series of projects to look afresh at the organisation of work for specific patient populations or services. These projects will develop, test and implement roles and role configurations that better align skills to patient needs.

Methodology

The approach to role review and redesign:

- Commences with consultation with a service or work area and interested parties.
- Maps a service stream or work area.
- Analyses the tasks required in delivering care.
- Analyses the skills and competencies required to perform those tasks.
- Clusters skills and abilities most effectively into work roles.

Changed and new roles can then be trialled and evaluated, and if successful, considered for broader application in the sector

Following a call for expressions of interest to services in April 2005, a mix of existing and proposed projects have received support. New projects will follow the methodology outlined above, tailored to the sector and the nature of the project. Tools for each stage (process mapping, job design, protocol development etc) have been provided, to assist the process and ensure a consistent approach. To this end, copyright licensing arrangements for skills mix analysis and redesign tools have been finalised with the UK NHS Modernisation Agency.

Existing new or redesigned roles will be evaluated and if successful, rolled out across the sector.

Work roles are being be reviewed and redesigned across or within traditional professions.

- *Vertical role differentiation*. Within a traditional profession, the focus will be on delegating more technical/less skilled tasks so that professional staff can focus on applying their high level skills more consistently and/or take on more challenging roles. This approach requires the development of competency-based training for new support roles, and may require advanced-level training for professional staff. Possible examples are allied health professionals taking on extended (historically medical) roles, with support staff taking on the more technical aspects of their current roles.
- *Lateral role differentiation.* The second approach to workforce change will be to develop composite roles tailored to service streams, combining competencies currently viewed as belonging to different professions. This involves an exploration of the possibility of new roles, often linked to the development of new models of care delivery. Possible examples are rehabilitation assistants and hospital-in-the-home workers.

The methodology is based on patients' needs and better matching staff skills with those needs. It commences with role development workshops – mapping one or more typical patient journeys at the pilot site, analysis of task required in delivering care and identifying who performs those tasks. These process maps are the basis for generating ideas about new ways of delivering care and possible amended roles, and the development of a new process that delivers better outcomes. Further steps include the identification of competencies required, education and training requirements, assessment of competence and implementation of the new way of working, considering supervision, indemnity and other issues.

Individual projects are commencing at differing points in the methodology, depending on their maturity at commencement. Evaluation pilots, where amended roles already exist, will perform a limited version of the role development workshops, to check whether additional tasks can be delegated and the impact on other roles in the service area.

Evaluation

An evaluation framework has been developed to enable assessment of the DHS workforce design strategy and its pilot projects, between now and end-June 2006. Impacts of role change on patients, staff and services will be assessed as well as the process and tools used in workforce design. Tools to collect evaluation data include:

- A patient survey of perceptions of care, compatible with the Victorian Patient Satisfaction Monitor.
- A staff satisfaction questionnaire, being developed with input from the quality managers of the pilot sites, and,
- Regular data collected by services of adverse incidents, length of stay and waiting periods.

In addition, each pilot will agree on one or two measures that best capture the expected impact of their particular role change.

Pilot Projects

Work role	Setting	Project description
Physiotherapists	Orthopaedic Outpatient	Evaluation of an existing amended physiotherapy role providing primary contact and management of patients with defined low back pain referred to an orthopaedic outpatient clinic
Speech Pathologists	Outpatients	Evaluation of the use of fiberoptic endoscopic evaluation of swallowing procedure by speech pathologists in an outpatient setting
Physiotherapists	Emergency Department	Evaluation of an existing amended role physiotherapist working in emergency to improve the quality of care for patients with soft tissue injuries
Physiotherapists	Orthopaedic outpatient	Evaluation of an existing amended role physiotherapist working in orthopaedic outpatients with patients most likely to receive conservative management
Amended Allied Health Assistants	Slow stream rehab residential	Evaluation of existing multiskilled allied health assistant in acquired brain injury rehabilitation in a residential care setting
Division 1 Nurse	Radiology	Development of an amended role for Division 1 nurses in radiology that involves insertion of PICC lines in defined patients (scope being finalised)
Physiotherapists	Emergency Department	Development of an amended role for clinical physiotherapists involving assessment and treatment of minor injuries in emergency
Speech Pathologists	Inpatients & Outpatients	Introduction of a clinical pharmacist into a disease management unit to provide medication reviews and recommend solutions for medication related issues
Pharmacists	Outpatient disease management unit	Implementation of the use of fiberoptic endoscopic evaluation of swallowing procedure by speech pathologists in inpatient and outpatient settings
Division 1 Nurse	Emergency Department	Development of amended roles for Division 1 nurses to enhance the quality and efficiency of care for patients in emergency
Speech Pathologists	Inpatients	Implementation of the use of fiberoptic endoscopic evaluation of swallowing procedure by speech pathologists in an inpatient setting
Physiotherapists	Orthopaedic Outpatient	Development of an amended physiotherapist role within orthopaedic/musculoskeletal service settings to provide primary care for suitably triaged patients
Radiation Therapists	Specialist acute	Development of an amended role for radiation therapists to include breast mark-up
Radiation Therapists	Specialist acute	Development of an amended role for radiation therapists to include breast mark-up
Radiation Therapists	Specialist acute	Development of an amended role for radiation therapists to include breast mark-up
Orthoptists	Glaucoma Outpatients	Development of an orthoptist-led glaucoma eye monitoring service to improve access and monitoring for stable glaucoma patients
Orthoptists	Diabetic Outpatients	Development of an orthoptist-led diabetic eye monitoring service to improve access, screening and monitoring for diabetic patients

Work role	Setting	Project description
Speech Pathologists	Inpatients & Outpatients	Implementation of the use of fiberoptic endoscopic evaluation of swallowing procedure by speech pathologists in inpatient and outpatient settings
Speech Pathologists	Outpatients	Implementation of the use of fiberoptic endoscopic evaluation of swallowing procedure by speech pathologists in an outpatient setting
Speech Pathologists	Inpatients	Implementation of the use of fiberoptic endoscopic evaluation of swallowing procedure by speech pathologists in an inpatient setting
Professional & Support	Elective surgery	Development of a range of new and amended roles that focus on the patient's journey through episodes of care to support enhanced delivery of elective surgery
Patient Care Assistants	Dialysis & oncology	Development of a range of new and amended roles to support the super clinic service delivery model focusing on primary injury/urgent care, dialysis and day oncology services
Intake/access staff	Acute ambulatory	Development of a range of new and amended roles to support the super clinic service delivery model focusing on primary injury/urgent care, dialysis and day oncology services
Amended professional	Acute outpatients	Development of a range of new and amended roles to support the super clinic service delivery model focusing on primary injury/urgent care, dialysis and day oncology services
Amended Allied Health Assistants (Physiotherapist support)	Acute	Development of an amended allied health assistant role providing a cardio respiratory and related physiotherapy support services in acute care
Amended Allied Health Assistants	Acute inpatients	Development of a combined stream amended allied health assistant role in acute care setting, focusing on support for physiotherapy and occupational therapy
Amended Allied Health Assistants	Community, at home	Development of a multiskilled community support worker role, providing health promotion, health screening and intervention support services in the home
Podiatry support worker	Community health	Development of a support role for podiatry services focusing on basic tasks in relation to foot care in a community health setting
Division 2 Nurse	Intensive Care Unit	Development of roles for Division 2 nurses in ICU (scope being finalised)
Amended Allied Health Assistants	Rehab	Development of a combined allied health assistant role to support allied health professionals in the provision of rehabilitation services
Psychiatric Services Officers	Community	Identify opportunities to amend the role of psychiatric services officers in a community mental health setting
Dietetic Assistant	Acute	Development of a dietetic support worker to improve dietary compliance and nutritional status in a hospital setting
Amended Allied Health Assistants	Acute & GEM/rehab	Development of a combined allied health assistant role to provide intensive therapy in an inpatient setting
Amended Allied Health Assistants	Community based paediatrics	Development and implementation of a combined stream allied health assistant role to support the provision of allied health services in community paediatric care
Amended Allied Health Assistants	Acute	Development and implementation of amended allied health assistant role (occupational therapy and physiotherapy) to support the provision of allied health services in the acute setting
Psychiatric Services Officers	Acute inpatient	Identify opportunities to amend the role of psychiatric services officers in an acute inpatient mental health setting
Psychiatric Services Officers	Specialist services	Identify opportunities to amend the role of psychiatric services officers in a specialist mental health setting
Pharmacy Technicians	Acute	Development of a clinical pharmacy support role in an acute inpatient setting

Appendix E Major national workforce accreditation bodies

Profession	National accrediting body	Legal structure & date established	Functions
Chinese Medicine	Nil	___	___
Chiropractic	Council on Chiropractic Education Australasia Inc	Incorporated	Assesses and accredits chiropractic undergraduate and postgraduate courses; Advises and makes recommendations on statutory accreditation, approval or prescription; Develops, advocates and maintains valid and reliable accreditation standards and processes to assess the suitability and quality of chiropractic courses and whether provider institutions develop, implement and evaluate those course goals and outcomes successfully; Develops and conducts competency assessments and advises on the suitability of chiropractors to practise in Australasia under sponsorship, on work visas or for migration; Advises and make recommendations on chiropractic education and standards of practice and regulation of chiropractors in Australasia; Establishes and maintains relationships with bodies and organisations in other countries having objects and functions, in whole or in part, similar to the objects and function of the Council; and Ensures that the Council achieves its purpose and objectives
Dental Practice	Australian Dental Council	A registered corporation limited by guarantee. ABN 70 072 269 900	Advises and make recommendations to State and Territory Dental Boards and Dental Practice Boards in relation to: - accreditation of education courses leading to a dental qualification, conducted by Australian dental schools, - assessment of the suitability for practice in Australia of persons with overseas dental qualifications, and - uniform criteria for recognition of qualifications for registration; Holds copies of the registers of each State and Territory Dental Board; Provides advice on matters concerning the occupational regulation, including general and specialist registration, of dentists and para-dental personnel; and Does all such other lawful things as are incidental or conducive to the attainment of any of the above objects.
Medical Practice	Australian Medical Council Inc (AMC)	Incorporated	Accredits Australian and New Zealand medical schools and courses; Accredits Australian/Australasian programs of specialist medical training; Assesses overseas trained medical doctors who wish to practise medicine in Australia; Advises state and territory medical boards on uniform approaches to the registration of medical practitioners and maintains a national network of State and Territory medical registers; and Advises AHMAC on the registration of doctors.
Nursing	Australian Nursing Council	Established as an unincorporated body on 1 July 1992 and became an incorporated body under the *Associations Incorporation Act 1991* of the ACT on 24 July 1992. A.R.B.N. 061 504 407 Limited Liability	The Council leads State and Territory nurse regulatory authorities in evolving standards for statutory nurse regulation. Objectives of the Council are to: - identify matters which impact on or are relevant to statutory nurse regulation; - maintain an Australia a national database of nurses; - assess overseas qualified nurses consistent with the registration and/or enrolment requirements of the Australian nurse regulatory authorities; - develop and be guided by a strategic view of statutory nurse regulation in the national and international contexts; - establish consultative mechanisms with key stakeholders to assist in the achievement of the purpose and objects of the Council; - foster co-operation, consult with and provide advice to government bodies, professional and other organisations, and international nurse regulatory authorities; - apply a continuous quality improvement approach to its activities.

Profession	National accrediting body	Legal structure & date established	Functions
Optometry	The Optometry Council Inc	Company limited by guarantee and not having share capital. Registered under the Corporations Law. ACN 074 875 111 Limited liability of members.	Assesses overseas optometry qualifications. It also assesses, for the purposes of accreditation, the Australian and New Zealand optometry courses. The objects for which the Council is established are: to grant accreditation to Australia and New Zealand optometry schools and the courses conducted by those schools leading to basic optometric qualifications; at the Council's discretion, to withdraw or suspend any accreditation previously granted by the Council in the event that the Council resolves that such accreditation should be withdrawn or suspended; to assess for admission to practice in Australia and New Zealand overseas trained optometrists; to advise and make recommendations to the Council of Optometry Registration Authorities (or its successor body) on matters concerning the registration of optometrists; to provide information to government and to government departments relating to law and policy concerning the registration of optometrists in Australia and New Zealand; and to provide information and advice to government and to government departments relating to law and policy concerning the adequacy or otherwise of a person's skills in the field of optometry for the purposes of migration to Australia or New Zealand.
Osteopathy	Nil	___	___
Pharmacy	Australian Pharmacy Examining Council Inc (APEC)	Incorporated.	Established to assist overseas trained pharmacists to obtain registration in Australia and thus enable them to practise their profession in Australia.
	Council of Pharmacy Registering Authorities (COPRA)	Incorporated in the ACT (ABN 455 681 533 54)	
Physiotherapy	Australian Council of Physiotherapy Regulating Authorities (ACOPRA) Inc.	Incorporated	Accredits new and existing physiotherapy programs in Australian universities; Assesses overseas trained physiotherapists who wish to practise in Australia; Advises Commonwealth Government agencies and Physiotherapists Registration Boards in Australia on legislative matters relevant to a consistent national approach to physiotherapy registration; and Responsible for the oversight of the Australian Physiotherapy Competency Standards.
Podiatry	Australasian Podiatry Council		The national professional body affiliated with the State Podiatry Associations and the New Zealand Society. The Council functions include assessing the qualifications of overseas podiatrists wishing to practise in Australia and establishing examination procedures as part of this process.
Psychology	Australian Psychological Society Ltd	Incorporated	The Australian Psychological Society (APS) is the main body in Australia that assesses psychology qualifications gained overseas or locally, as nominated by the Federal Government under the General Skilled Migration Categories.
	Australian Psychologists registration boards have recently formed the Council of Psychologists Registration Boards (Australasia) Inc	Incorporated in Tasmania under the Associations Incorporation Act 1964	According to the Rules of the Council, the Council is established for the consideration of matters of joint or common concern or interest to the various Psychologists Registration Boards in Australia and New Zealand.
Medical Radiation Technology	Nil	____	____