NEW SOUTH WALES GOVERNMENT

RESPONSE TO

THE

PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY

September 2005

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1. Executive Summary

This paper outlines the key impediments to the capacity of New South Wales (NSW) to recruit and retain the health workforce needed by its community. Such issues are reflected nationwide.

The situation is now critical and major reform is required to address the issues of health workforce shortage in Australia. A range of reforms and strategies has been implemented over the years to enhance workforce numbers and distribution with limited sustainable success.

The paper was developed with input from across NSW Government agencies including the Department of Health; Department of Education and Training (DET); Department of Ageing Disability and Home Care (DADHC) and NSW Treasury with contribution from both clinical and administrative areas across the NSW Health system.

The paper looks at national and international trends that impact on health services and, in particular, the health workforce and identifies strategies implemented in NSW to address whole of health workforce issues across the human services sector.

The major challenges impacting on the health workforce fit broadly into the categories of structural disconnection, workforce productivity and workforce flexibility which support the direction outlined in the recent COAG communiqué.

A range of issues impact on the supply, flexibility and responsiveness of the health workforce. Each of these issues will be explored with recommendations identified. The review by the Productivity Commission is a critical step to reinvigorating our health workforce and this paper highlights issues and suggests recommendations across areas of focus including:-

- Failure of traditional approaches in education where health professional students being are in a single discipline, therefore making it more difficult to create health teams
- Poor connections between service needs and workforce education due to disincentives for collaboration between health and education sectors
- Demand that is both supplier and consumer induced
- Lack of formal planning mechanisms for funding and allocation of student places
- The ad hoc nature of many clinical placement arrangements
- Effects of training systems on workforce distribution
- Low numbers of Aboriginal people in the health workforce at the same time as Aboriginal health needs are increasing
- Lack of coordination of different roles and responsibilities of Australian and State/Territory governments
- Reinforcement of professional silos impacting on quality of patient care
- An ageing workforce that matches our ageing population
- The impact of superspecialisation and a health care system structured around specialty areas of disease and illness rather than health and wellness
- The imposition of highly specialised models of service delivery and training on rural areas

- The need to balance self-sufficiency in Australian supply with the reality of changing worker needs and global workforce shortages.
- System and professional support for rigid workforce role definitions

Currently the Australian health care sector is characterised by a series of serious role conflicts where professional groups determine education, training, regulation and supervision requirements as well as levels of quality. These role conflicts necessarily influence workforce supply and distribution and coupled with government disconnects can result in serious shortages. Unlike other industries, health care is an emotive industry where there are high levels of tragic risk for consumers with very different motivations and rewards driving health workers and health professionals.

The role of the clinical colleges in determining training numbers, length and content of training and location of training places has led to restrictions in available numbers of medical specialists in certain fields. The recent determination by the Australian Competition and Consumer Commission that required the Royal Australasian College of Surgeons to work with jurisdictions on trainee numbers highlights the continued need for reform in this area.

Existing regulatory practices have created a health workforce that is overly rigid and has limited capacity to adapt to what is a complex, changing environment with ever evolving service delivery needs. A key question is: what changes would enable the systems that produce and regulate the health workforce to become self-adjusting, flexible and responsive to external influences, while providing a workforce that operates as a team in delivering the quality care expected by the community?

A number of recommendations are made in this submission that seek to address current and future workforce challenges. The recommendations fit broadly into the categories of structural disconnection, productivity/workforce flexibility and workforce distribution.

It is critical that recommendations are agreed and actioned collaboratively by the state, territory and Australian governments to ensure that the community has continued access to a safe and quality health service.

2. Recommendations

WORKFORCE DISCONNECTS

Education and Training of the Health Workforce

1 Review the current *funding arrangements* for education and clinical training of the health workforce and establish a funding model that better reflects work based learning components of education for all categories of health worker.

2 Establish a process that enables *cooperative decision-making* regarding education and training for the health workforce. This process would incorporate:

- 2.1 an increase in the number of undergraduate places across the health professions including nursing, medicine, allied health and dental
- 2.2 jurisdictional service planning that determines the types of health training programs and numbers of placements available
- 2.3 better coordination between the vocational and higher education systems with broader scope for articulation that supports job flexibility
- 2.4 review of the eligibility criteria for incentives such as new apprenticeship schemes
- 2.5 transparent and collaborative approaches to the development of curricula that are designed to better reflect beginning practitioner competencies required by the community
- 2.6 expansion of targeted programs to ensure equitable workforce representation that meets community needs (eg programs targeted to increasing the Aboriginal workforce)

3 Increase *rural undergraduate and post graduate training opportunities* to address health workforce shortages and skill development by:

- 3.1 increasing the number of undergraduate places for rural participants
- 3.2 establishing a co-ordinated undergraduate scholarship program across all health workforce groups with greater support for scholarship students
- 3.3 expanding bonded rural medical scholarships to all workforce groups
- 3.4 targeting cadetships in identified areas of skill shortage for school leavers and students in the second or third year of university
- 3.5 expanding the ‘training in place’ programs that offer career paths for local residents from positions needing vocational training to those requiring tertiary qualifications
- 3.6 ensuring training and education infrastructure is equally accessible by all workforce groups regardless of location
- 3.7 establishing best practice in the use of communication technology for Continuing Professional Development (CPD)
- 3.8 establishing a more consistent approach across professional groups to support post-graduate training (eg scholarships and support continuing professional development)
- 3.9 creating training networks for all health specialties that include inner/outer metropolitan and rural centres
- 3.10 continuation/expansion of “generalist” medical speciality training eg general physician, general surgeon

4 Deliver clear and *transparent mechanisms* of allocation and funding of clinical placements by reviewing the current infrastructure, formula and management processes to ensure equity and accountability including:

- 4.1 continue to provide access to clinical placements where they directly relate to service planning priorities identified by States/Territories including new programs that support skill mix and redesign
- 4.2 establish an incremental fee structure for clinical placements where by education program priority areas (as developed by States/Territories) attract the lowest fee and full fee paying students in non priority education programs attracting a higher fee
- 4.3 the real costs of clinical placements must recognise the capital investment in training
- 4.4 review the capacity of the current clinical workforce to provide the level of clinical training required to ensure new graduates have core skills necessary to join the workforce
- 4.5 specify minimum standards for learning support
- 4.6 ensure that clinical placements provide opportunity for training 24hr/7 across the spectrum of public health services

5 Increase *access to clinical learning* through use of simulation centres by formalising a coordinated national approach.

WORKFORCE DISTRIBUTION AND FLEXIBILITY

6 Implement action to change the organisation of work to address recruitment, retention and maldistribution issues including:

- 6.1 introduce geographically based Medicare provider numbers as a mechanism to manage maldistribution of the health workforce
- 6.2 address the anti-competitive trade practice factors that inhibit the implementation of new models of care and skill sets.
- 6.3 explore current barriers to job re-design programs and implement changes in programs and policy including:
  - 6.3.1 professional, legislative and industrial issues, such as the provision of MBS and PBS to improve patient access to primary health care
  - 6.3.2 expand integrated primary care initiatives to increase access for communities to general practitioners after hours.
  - 6.3.3 the role of higher education and vocational systems in supporting job-redesign through recognition of prior learning, establishment of accessible career paths, the development of generalist training programs, Aboriginal recruitment i.e. prior learning/school support etc
- 6.4 review of taxation and superannuation policies by the Australian Government with changes introduced particularly to fringe benefits and superannuation tax to address the recruitment and retention of the health workforce
- 6.5 create an Australian Health Registration Board

7 Explore and implement models of service delivery to better meet the *needs of rural and remote* Australia, including:

7.1 further development of specialist services in regional centres with appropriate medical, nursing, allied and oral health programs
7.2 Australian Government funding for the teaching and research role of rural referral hospitals
7.3 development of new models of locum service provision.
7.4 enhanced use of information technology and introduction of electronic health record systems to support patient care and the health workforce particularly where access to health care professionals is limited

8 Review and *revise scope of health practice* in rural and remote Australia including:

8.1 the roles of health service staff and potential for expanded role of primary health workers including Aboriginal Health Workers
8.2 improved use of vocationally trained health workforce
8.3 expansion of role in provision of acute care for rural general practitioners with appropriate remuneration
8.4 Explore new models of service delivery that maximise skills of ambulance officers in rural and remote settings

9 Address *workforce shortages in rural and remote Australia* through introduction of policy changes, including:

9.1 implementing taxation based incentive systems for rural and remote practice
9.2 using debt instruments to encourage and reward people who work in rural and remote areas after completing their training (eg payment/exemption of HECS to work in geographic or subject area, scholarships for living expenses). This would be administered through the taxation system
9.3 structuring cadetships that enable students to exit with a lower qualification without penalty
9.4 creation of career pathways where people are needed, such as through preferential career advancement based on time spent in areas of need
9.5 developing whole of government strategies for national support of the overseas trained workforce

3. Background

3.1 The NSW health workforce

The NSW public health system is the largest health care employer in Australia, with almost 90,000 full-time equivalent staff (June 2004).[1] The doctors, dentists, nurses, allied health professionals, uniform ambulance and other health professionals involved in the provision of clinical services make up 64% of the health workforce, with remaining staff providing support functions.

In 2001 the NSW health workforce supply fell well below national supply levels[2]. The significant shortages that already exist and the current supply of the health workforce will not meet future demands.

A demographic shift has occurred from inland to coastal areas and to the Sydney basin[3] resulting in a declining workforce population in rural and regional NSW [4].

In addition to shortages, the distribution of the health workforce in Australia inhibits the ability to respond to needs with maximum effectiveness. The most obvious reason for this in NSW is the State's size and geography, covering regional centres, large towns, small towns and remote localities.

Rural NSW had an estimated population at June 1999 of 1,447,164 and a projected population for 2011 of 1,561,240. These population changes vary by geographical location with coastal areas experiencing significant population increases while decreases are anticipated in the far west of the State[5].

The projected increase and redistribution in population is not matched by a similar increase and redistribution of health professionals, as there are multiple structural and funding disincentives to moving away from the inner metropolitan areas.

Workforce distribution varies in NSW between inner and outer metropolitan areas; between metropolitan areas and rural areas and even between rural areas. Coastal sites (particularly the NSW North Coast) report less difficulty in recruiting and retaining health professionals than inland and remote sites. This variation in distribution necessarily results in differential levels of access to services for rural residents as outlined in Table 1.

Table 1 Oral Health Workforce: Number of Dentists per 100,000 population

Health Service	Number in 2002	NSW Population in 2000	Dentists/ 100,000 pop
Total Metropolitan	2395	5,015,268	47.75
Total Rural	399	1,447,231	27.57
Total NSW	**2794**	**6,462,499**	**43.23**

Source: Dentist Labour Force in NSW – 2002, Chief Health Officers Report 2002 NSW Health Department

[1] *03/04 Annual Report – excludes third schedule hospitals*
[2] *Australian Institute Health and Welfare(2003) Health and Community Services Labour Force 2001 Series No:27.*
[3] *Ib id.*
[4] *The public hospital medical workforce in Australia AMWAC Report 2004.3*
[5] *NSW Health, Rural Health Report, 2002*

The NSW Department of Health contributes significantly to addressing workforce shortages in NSW through a range of programs and incentives.

The Area of Need Program enables the recruitment of suitably qualified overseas-trained doctors into declared Area of Need positions on a temporary basis, while efforts continue to attract medical practitioners with general registration on a permanent basis. The Program provides an effective short-term response but should not to be viewed as a long-term solution to addressing medical workforce shortages.

While the Area of Need Program addresses workforce shortages in NSW, especially in rural areas, there are a number of other programs that also involve the recruitment of overseas-trained doctors. These include the Targeted Inland Recruitment Scheme (TIRS), the NSW Rural Doctors Network Locum Program and the Approved Medical Deputising Service.

3.2 Aboriginal health and workforce issues

Due to the poor standard of health that Aboriginal people suffer in Australia, a workforce needs to be developed that will encourage an increase in access to services for Aboriginal people. Due to the limited numbers of Aboriginal people completing secondary education and entering into tertiary education, entry requirements for health courses need to be more flexible. This needs to be complemented by greater opportunity for professional and educational development once Aboriginal people are engaged in the workforce.

The health workforce must match community needs. The right service is needed in the right location, with trained staff who can provide appropriate and accessible services.

The growing size of the Aboriginal community and the increasing emergence of health issues signal the need for an increased Aboriginal workforce across all work professions and categories and across all services and locations. Aboriginal people must be welcomed into the health workforce and the intrinsic knowledge and experience that they bring must be valued. For this to occur stereotypes and myths regarding Aboriginal people still present within the current health workforce must be dispelled.

Aboriginal Health Workers (AWH) are a great example of how a patient-centred approach can work. The Aboriginal health professional maintains a community focus, bridging the gap between patient and service. The AHW liaises with and listens to the community, and has an acute knowledge of community needs. They will advocate, interpret, provide service and make referrals as required. The Aboriginal Health Worker does not discriminate due to ‘body parts’ or geography. They adopt a holistic approach to the client’s health and understand that social and emotional wellbeing links inextricably to physical health.

The new directions in Aboriginal Health Promotion have adopted a community consultation model, in which Services need to identify the emerging community health concerns and how they will work with the community to resolve/minimise these. This model ensures that the profile and understanding of health issues impacting on Aboriginal communities are raised and that the Services adopt a proactive and consultative response. Additional benefits to this model are improved relationships between Aboriginal and non-Aboriginal health professionals and an improved relationship between service provider and the Aboriginal community.

Rural and remote areas often have a higher percentage of Aboriginal population. Providing accessible and responsive health services in rural and remote areas is essential. Proactive recruitment and retention initiatives targeting Aboriginal people would be highly successful as Aboriginal people have a strong link with their communities and would respond positively to the opportunity to work and train within their local area.

While many government programs can be accessed to assist in the employment and training of Aboriginal people, health services need to adopt the view that an Aboriginal workforce is an integral and essential part of the whole health workforce and that positions need to be targeted for Aboriginal people to ensure equitable workforce representation, culturally appropriate service provision and improved health outcomes for a growing sector of the community.

3.3 The national and international workforce picture

Current workforce shortages and future pressures have become a topic of concern in the global environment of health service provision. It has captured not only the attention of the health system but politicians, funding gatekeepers, media, bureaucrats and the public.

While the Australian health system is one of the best in the world it has been acknowledged that the system is under increasing pressure as a result of demographic changes, labour market shortages, technological advances and changing consumer expectations.

In this section the issues that NSW believes to have a major impact on the health workforce are outlined, international trends are considered and initiatives implemented by NSW are described.

3.3.1 Trends in the Australian population

The ageing of the Australian population has been well documented. The Productivity Commission, in its recent report, *Economic Implications of an Ageing Australia*, noted that over the next forty years one quarter of Australians would be aged 65 years or more[6]. It is expected that the rise in numbers of older Australians will become increasingly apparent over the next twenty years.

The rise in the number of older Australians is the result of both increased life expectancy and reduced fertility. The increased life expectancy has also been found to be associated with a decrease in the disability-free life expectancy[7]. The disabilities associated with the ageing population are, on the whole, an increase in the incidence of chronic illnesses and disease. Chronic disease is expected to account for 80% of the overall disease burden, Australia wide, by 2020 [8].

The ageing population poses significant fiscal pressures at both the Australian Government and State levels particularly in the area of aged care and hospital costs[9].

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[6] *Productivity Commission 2005, Economic Implications of an Ageing Australia, Research Report, Canberra.*

[7] *Duckett, SJ, 2005, 'Health workforce design for the 21st century', Australian Health Review, Vol 29, No 2, pp201 – 210*

[8] *Mathers, C. Vos, T. & Stevenson, C.* The burden of disease and injury in Australia. *AIHW, 1999. Canberra.*

[9] *Occasional Paper No. 1. "Impact of the Ageing population" Sep 2003*

The Aboriginal population does not share the same demographic profile as the non-Aboriginal population. Aboriginal people die approximately 20 years earlier than non-Aboriginal people and there is a rapid increase in the number of youth within Aboriginal population. Aboriginal people have a disproportionate prevalence of chronic disease with presentations occurring at much younger ages than non-Aboriginal people.

Associated with the population changes we have seen an increase in the demand for health services and an increased health workforce to meet that demand. Census data for 1961 identifies 72,598 health professionals. This figure had risen to 291,604 in the 2001 Census. The changes in health professional numbers per head of population showed an increase from 6.9 per 1000 population in 1961 to 15.4 per 1000 population in 2001[10].

3.3.2 Trends in the labour market

Australia has seen the development of an increasingly competitive national labour market, due to changes in workforce participation rates and reduced hours being worked.

Recent data from the Australian Bureau of Statistics shows that between March 1994 and March 2004, the labour force participation rate rose from 62.8% to 63.5% - an annual average growth of 0.1%. Over the ten-year period, participation rates for men and women moved in opposite directions. The participation rate for men fell while the participation rate for women rose[11].

However, the Productivity Commission identifies that there are significantly lower labour force participation rates for people aged over 55 years than younger people and that over the next 40 years labour participation rates will fall to 56.3%, a drop of 7%[12].

Australian Bureau of Statistics data also demonstrates that between March 1994 and March 2004, the average hours worked by employed people fell by 3% - an annual average fall of 0.4%. This decline in average hours worked arose due to the increasing incidence of part-time workers and was further exacerbated by the numbers of older people in the labour market who tend to undertake more part time work than other age groups.

3.3.3 Trends in the health care labour market

There is a worldwide shortage of health workers including doctors, nurses and allied health practitioners. In Australia the workforce shortages are particularly acute in outer metropolitan, regional and rural areas.

The current undersupply and maldistribution of the health workforce both in NSW and nationally is having a significant impact on the delivery of health services and these problems are expected to worsen in the future. The health system is experiencing severe shortages across a range of health professional groups and geographic locations. This situation will become more critical over the next 10 - 20 years in

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[10] ibid

[11] *Australian Bureau of Statistics, Australian Labour Market Statistics, July 2005, 'Population, participation and productivity: contributions to Australia's economic growth'*

12 Productivity Commission Report (2005), Op. Cit

Australia as the population ages, the national labour pool tightens and the workforce becomes increasingly global and mobile. This has resulted in the need for a strengthened national and state approach to obtaining, retaining and using the health workforce.

A key factor in the declining future supply of the health workforce is the ageing health workforce. The average age of the national nursing workforce was 44 years in 2003[13] and the average age of the medical workforce in 2002 was 46.6 years[14], while in 2002 the average age for the NSW Health workforce was 40.6.[15] The whole health workforce is ageing, has a tendency to work part time with a large percentage expected to retire in the next 20 years[16].

Jurisdictions across Australia all face the challenge of securing the workforce they need to deliver good quality equitable sustainable health care[17]. Providers of aged care facilities are also concerned that they will be unable to provide adequate numbers of trained staff, in both rural and urban areas, to meet the demands for care from the ageing population.[18]

The health workforce is currently under pressure to meet the demographic and social changes that have resulted from greater urbanisation, and a range of other factors including an ageing population, a population with increasing rates of chronic disease coupled with disability, new technologies and increased expectations for health care.

Over the next 20 years Australia will need to deal with an ageing population and an increasingly mobile workforce[19]. In Australia today, the national workforce grows at an annual rate of 170,000 per year. By 2020 this is predicted to be just 12,500 per year[20]. During the next 20 - 30 years the impact of these changes are expected to be highest in NSW and Victoria[21].

Table Two identifies ABS data relating to the top "ageing" worker categories Health care workers including general practitioners, nurses and dentists are ageing the fastest.

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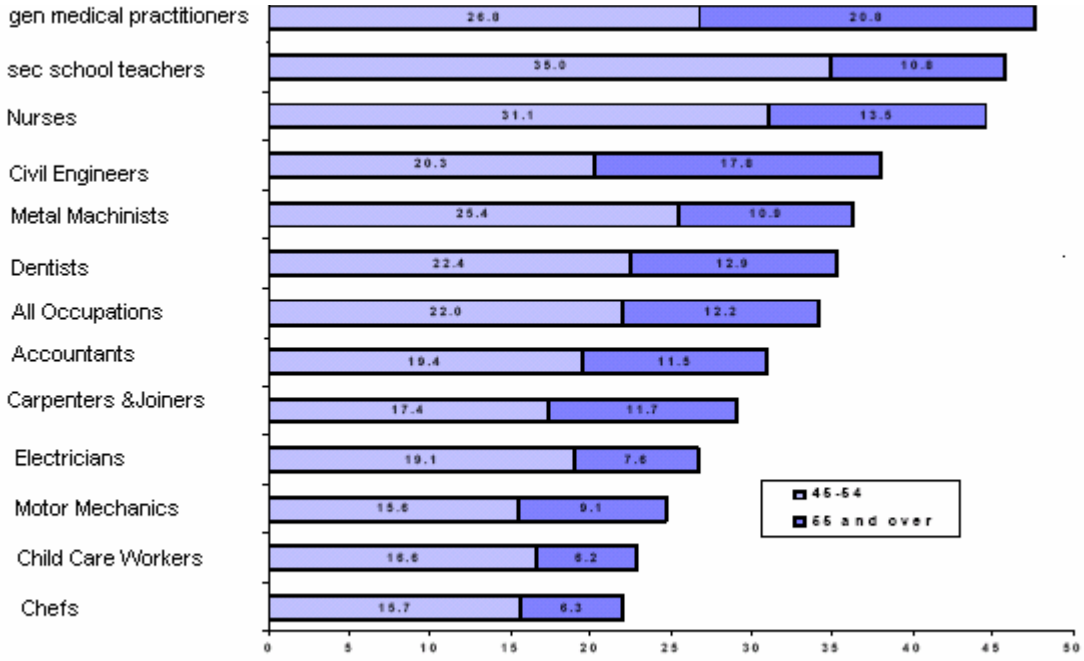
13 Australian Bureau of Statistics Labour force profile 2003 p13.
14 AMWAC2004 Op. Cit.
15 Occasional Paper No. 1
16 'Australia's health' 2004. Australian Institute of Health and Welfare,2005
17 Australian Health Ministers Conference (AHMC) National Health Workforce Strategic Framework, 2004
18 Richardson S., Martin B., 2004, The Care of Older Australians – A picture of the residential aged care workforce, The National Instistute for Labour Studies
19Australian Health Ministers' Conference (2004), Op. Cit.
20 ibid
21 ibid.

Table 2 Average % over 45 years, over 65 years by occupation, 2003



Source: ABS Labour Force Survey (average for 2003)

The other really important area that needs stressing is that because of the ageing population, we need a well adjusted healthy current generation of infants and toddlers because they are going to be the people who care for the next generation of the aged population. If we don't seriously invest in the mental health and physical health of young children in the first few years of life, then we won't have a sufficiently productive group of people who are well trained, employed, paying taxes, well adjusted and compassionate to be the ones who care for us when we become old.

3.4 International experiences

Most OECD countries report the same health workforce and health care delivery challenges. An OECD Report into nursing shortages found that workforce shortages appear to be driven by a broad set of economic, demographic and sociological factors[22]. Issues specific to nursing workforce shortages which were identified in the report included less young people entering the nursing workforce, in part due to an increased range of professional opportunities available to young people, the perceived low social value of nursing, negative perceptions of working conditions and an ageing nurse workforce.

Issues pertaining to the increased demand for health services in OECD countries are consistent with those issues identified for Australia: ageing populations, increased consumer expectations and rapid growth of medical technologies.

Strategies being implemented in NSW to address workforce shortages are consistent with those being implemented in most developed countries. The National Health Service (NHS) has initiated a range of reforms aimed at addressing health workforce

[22] *OECD, 2005, Tackling Nurse Shortages in OECD Countries, DELSA/ELSA/WD/HEA(2005)1*

shortages including:

- Strategies to increase numbers of people entering the health workforce
- Recruitment and retention strategies for the current workforce, including changes to taxation and superannuation policies[23]
- Redesigning and extending roles and developing efficient patient pathways
- Enhancing models of care and changing the way health professionals work
- Developing new workforce roles, such as in the Kingston Hospital Project, where the training of generalist Healthcare Practitioners (HCP) and Healthcare Practitioner Assistants (HCPA) is being undertaken[24].
- Developing new models of delivery, such as those outlined in a recent NHS publication[25], including emergency care practitioners, community paramedics and community practitioners.

Two national initiatives that have also been undertaken by the NHS of relevance to Australia are the development of a national workforce development approach and the development of a national registration body.

Information about these two specific initiatives is described below.

3.4.1 Planning workforce development in the NHS[26]

The National Workforce Development Board has responsibility for delivering the required numbers of training commissions. Its membership, balanced across the healthcare workforce and stakeholders, meets regularly to consider all the major workforce issues facing the NHS, and to accordingly advise Ministers. Other advisory bodies support the Board.

Twenty-four Workforce Development Confederations are developing leadership of local workforce planning. These are organisations of all NHS bodies, plus non-NHS health care employers including Higher Educational Institutes and Postgraduate Deans, who are responsible for developing innovative approaches to the delivery of integrated education and training, funded from the integrated Multi Professional Education and Training Budget.

The Workforce Numbers Advisory Board comprises experts on workforce planning on a multi-disciplinary basis to advise on numbers of future training places. In carrying out its work the Workforce Numbers Advisory Board will draw on Workforce Development Confederation plans and the recommendations from the Care Group Workforce Teams which are small, expert, action oriented advisory bodies, taking a national overview of the challenges of delivering services to a particular client group or condition and identifying innovative ways in which the skills and competencies needed in the workforce can be delivered.

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[23] *National Health Service, 2001, Investment and reform for NHS staff – taking forward the NHS Plan, http://www.pasa.nhs.uk/nationalpriorities/invandreformnhsstaff.pdf*

[24] http://www.kingstonhospital.nhs.uk/jobs/hcp.htm

[25] *Department of Health, 2005 Taking Health Care to the Patient, Transforming NHS Ambulance Services.*

[26] *Department of Health, 2000. A Health Service of all the Talents: Developing the NHS Workforce.*

3.4.2 Framework for regulation of health professions[27]

A number of recent reviews in the United Kingdom, including the Bristol Royal Infirmary inquiry identified the need for an overarching organisation to provide a common framework for regulation across the health professions.
As a result the NHS Reform and Health Care Professions Act 2002 established the Council For Healthcare Regulatory Excellence (CHRE).

The Council, which was established in 2003, promotes a consistent approach across all health professions. The CHRE enforces consistent standards of practice across the following professional regulation bodies:

- General Medical Council
- General Dental Council
- General Optical Council
- General Osteopathic Council
- General Chiropractic Council
- Health Professions Council
- Nursing and Midwifery Council
- Royal Pharmaceutical Society of Great Britain
- Pharmaceutical Society of Northern Ireland

The CHRE is independent of the UK Departments of Health and is answerable to the Westminster Parliament. It compares and reports annually on the performance of the Councils and advises Ministers on the issues in healthcare regulation.

3.5 State strategies to address health workforce challenges

NSW has invested significantly to enhance the education, training, recruitment, retention and distribution of the health workforce. While some of these initiatives have led to success, many require further reforms to ensure they are sustainable and integrated across the range of health delivery sites.

3.5.1 Workforce supply

As has been noted in this submission and the Productivity Commission Issues Paper, there are significant shortages of most health care professionals. Some of these shortages relate to numbers of training places available while others arise due to increasing demand and decreasing retention in the numbers of health professionals.

There has been an increase in health workforce related university places in 2003-4, with 2005 intakes increased by 1,494 in nursing, 1,237 in allied health and 227 in pharmacy. In spite of this, these increases will not affect the workplace until 2008 and **nursing and dentistry remain below recommended levels.**[28]

The estimated shortfall of nurses is 40,000 nationally by 2010 with decreasing workforce in allied health fields and public health dental professions[29] [30]. The average

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[27] *National Health Service, Op.Cit*
[28] *Australian Health Workforce Advisory Committee (2004), Annual Report 2003-04, AHWAC Report 2004.3,Sydney*
29 Data on Pharmacists, and Allied health professional shortages NSW Department of Employment and Workplace Relations Economics 2002
30 Projections of the Australian Dental Labour Force AIHW Cat. POH 1. Australian Research Centre for Population Oral Health ARCPOH 2005

hours worked across the professional groups is declining, with greatest reductions in nursing [31]. Between 1995 and 2001 the average hours per week worked by nurses fell by 1.9 hours from 32.4 to 30.5 hours.

Initiatives to attract nurses back to the NSW public health workforce and recruitment programs have resulted in an additional 5,085 nurses over January 2002 – July 2005; a 15% increase[32].

Despite this boost, a chronic shortage of undergraduate places is preventing an adequate supply of nurses, and other health professionals, to the community.

Shortfalls are occurring in other disciplines; the average hours worked by medical practitioners continues to decline to 44.4 hours per week in 2002[33]. A 2003 study of the demand and supply of pharmacists found an undersupply of community and hospital pharmacists in Australia in 1999, and projected that the shortfall would continue beyond 2010. [34]

National projections on oral health (Dentistry) highlight that Australia is experiencing significant shortages in the public dental workforce, particularly in rural and remote areas. It has been projected that 120 additional undergraduate places per annum are required to achieve self sufficiency by 2010[35].

From the 1980s to the 1990s there has been a substantial decrease in the number of patients seen by general practice dentists [36]. Dentists worked predominantly in the private sector (86%), whereas in the public sector, the predominant type of main practice was dental hospitals where 4% of all dentists work[37].

3.5.2 Recruitment and Retention Strategies

The NSW government has made recruitment and retention of the health workforce a priority. This includes re-entry of mature age workers, strengthening career path opportunities for clinical and support staff, improving workplace culture and providing differential packages to attract and retain health professionals in outer metropolitan, regional and rural areas. Some specific strategies are described below.

- **The NSW Health Workforce Action Plan**
  Health care is all about people. Workforce actions need to reflect the ageing population demands on health care and increasing consumer expectations. NSW Health is the largest health care employer in Australia; is part of a growing industry and provides fabulous career opportunities. What is needed is investment to support our current and future health workforce.

  The Plan highlights action required now, and in the future, to overcome health workforce shortages. Current supply and distribution issues are addressed and areas for longer term action to challenge traditional practices; explore new workforce models; develop different skill mix within and across professions and

31 Australian Health Workforce Advisory Committee (2003) Annual Report 2002-03 AHWAC Report 2003.1, Sydney
32 NSW Department of Health Annual Report 2003-04.
[33]Australian Medical Workforce Advisory Committee (2004) Annual Report 2004-05 AMWAC Report 2004.5, Sydney.
34 Health Care Intelligence for the National Pharmacy Workforce Reference Group2003
35 Australian Research Centre for Population Oral Health ARCPOH
36 Australian Institute of Health and Welfare (2005), Australia's Health2002,
37 ibid

enhance collaboration between health, education and training sectors are included.

It is about doing things differently with improved flexibility, to get the right skills in the right place at the right time. Collaborative action is needed. Isolated efforts will not solve the problem. Governments at all levels have recognised that a more strategic and patient focused approach to health workforce development is essential.

1. **Recognise** that the existing supply of the health workforce will not meet future demands. This calls for action by increasing the number of university places in health discipline courses.

2. **Highlight** the critical need to improve workforce distribution to match community need. The actions focus on the need to promote health careers to rural high school students, facilitate both undergraduate and postgraduate training in areas of undersupply and influence the distribution of placements using incentive packaging.

3. **Concentrate** on recruitment and retention of the health workforce. This includes strengthening career path opportunities for clinical and support staff, improving workplace culture and providing differential packages to attract and retain health professionals in outer metropolitan, regional and rural areas.

4. **Support** new models of care, flexible service delivery arrangements, different skill mixes, multidisciplinary education and training and development of new roles.

5. **Stress** the importance of employing best practice in workforce assessment and planning by linking workforce to service planning. This must be supported by timely and accurate health workforce data.

6. **Flexible** career pathways for entry into and between health care courses.

7. **Focus** on improving collaboration between and across health, education, training and regulatory sectors.

The Plan proposes a truly collaborative approach to providing a highly skilled workforce to meet the health needs of our community. Implementation of strategies will be done in partnership with national and state government agencies; clinical and clinical support staff of the health system; Area Health Services and other key stakeholders.

- **Eight Basic Physician Training Networks** have been created to enable the training of more specialists in rural and regional hospitals. The new networks group together metropolitan, outer metropolitan, regional and rural hospitals and ensure that rural and regional trainee vacancies are filled first. Trainees participate in training at all hospitals within each network.

  The creation of Basic Physician Training Networks has led to the appointment of 345 trainee physicians, 17 more than 2004 [38]. Networks in Surgery and Psychiatry will commence in 2006.

38 Medical Training and Education Council NSW 2005

- **The Dental Officer Rural Incentive Scheme (DORIS)** provides incentives for dentists. The Scheme has two components:

  - An enhanced remuneration package offering up to an additional $20,000 per annum over the award salary for the position being advertised which may be taken in a number of ways, such as payment of school fees or rental accommodation.
  - Limited rights of private practice.

- **Nursing Re-Connect** provides paid retraining for enrolled and registered nurses who have been out of the workforce. The key features of the program are that it offers:
  - 'Tailored, individualised and supported' re-entry to the workforce
  - Paid re-entry into an existing vacancy
  - Full-time and part-time positions
  - General and specialty areas.

- **Pharmacy Re-Connect** is planned for 2006.

- As part of its ongoing commitment to maintain and improve the health status of rural communities, the NSW Department of Health provides financial assistance to allied health students via the **NSW Rural Allied Health Scholarships** and NSW Rural Allied Health Clinical Placement Grants. The Program targets students from a rural background who demonstrate an interest in a rural career.

  The Rural Allied Health Scholarship offers $5750 in either of the final two years of undergraduate study. The scholarship is available to students from a rural background but there is no requirement on recipients to take up rural practice.

  The Clinical Placement Grants provide up to $500 (or up to $800 for placements in Broken Hill) to assist both rural and urban allied health students with expenses associated with clinical placements in rural areas.

  Eligible allied health disciplines include:

Aboriginal Health	Orthotics/ Prosthetics
Audiology	Pharmacy
Diagnostic Radiography	Physiotherapy
Dietetics	Podiatry
Hospital Laboratory Science	Psychiatry
Occupational Therapy	Social Work
Orthoptics	Speech Pathology

Nursing recruitment and retention initiatives are also generating good results.

- "Nursing Re-connect" which has been designed to attract nurses and midwives back to our hospitals who have been out of the nursing workforce for a number of years. As at July 2005, 1,254 nurses have returned to working in public hospitals since the program began operation in January 2002. Rural Area Health Services have employed 369 nurses through *"Nursing Re-Connect"*. Overall, there is a 75% retention rate for "Re-connect" nurses.

- An additional 300 enrolled nurses will be trained during 2005 in part to address the shortage of registered nurse undergraduate placements.
  A total of 1,040 trainee-enrolled nurses were employed during 2004/05 to complete the 12-month course. NSW Health allocates significant funds to the Trainee Enrolled Nurse strategy, with over $14M being allocated during 2004/05. Over 75% of the Trainee Enrolled Nurses are employed in public hospitals as Enrolled Nurses after they have completed their course.

- The Nursing Scholarship Program
  Nearly $2M is provided annually under this program. Undergraduate scholarships for the first year of a Bachelor of Nursing aim to attract rural people into nursing. Grants are available for all undergraduate students to undertake clinical placements in rural areas.
  In addition, $250,000 has been provided this year to support 28 Aboriginal and Torres Strait Islander students enrolled in a Bachelor of Nursing degree.

  Postgraduate nursing scholarships target shortages in clinical areas, especially those that have shortages. In 2005 387 nurses were awarded scholarships to the value of $882,000. Fifty percent (50%) of these went to nurses working in Intensive Care, Operating Theatres, Emergency Departments, and Mental Health and studying Midwifery. These are our "top five" shortage specialties. In addition, $250,000 has been provided in 2005 to support 28 Aboriginal and Torres Strait Islander students enrolled in a Bachelor of Nursing degree.

- Study Leave
  In 2003, $21M was allocated over 4 years for nurses study leave; this funding allows nurses to be "backfilled" while they are on study leave. Nurses value this opportunity.

- Skill Development Programs
  Significant funds are spent on a range of initiatives such as clinical skills development programs for registered nurses, midwives and enrolled nurses and support for newly graduated nurses entering the health workforce.
  These clinical development programs focus on identified areas of need such as emergency, intensive care, operating theatres and mental health. These programs are designed to enhance nurses' clinical skills and support their professional development. They encourage nurses to remain working in the public health system in NSW.

- Improvements in Nurses working conditions.
  NSW nurses and midwives receive the highest basic pay rate in Australia. In January 2005, nurse wages were bolstered by a further 3.0 % and another 3% from 1 July 2005. That is a cumulative increase of 36.2% since January 2000. There will be another increase of 4% on 1 July 2006 and a further 4% on 1 July 2007.

3.6 Health financing and its impact on health workforce

The link between health financing and health workforce is an important one. Two main issues emerge which need further discussion. These are the extent to which:

- current health system arrangements (funding and areas of government responsibility) preclude and/or constrain innovative and integrated approaches to

workforce management that support contemporary care models and access to services

- supplier and consumer induced demand supported by uncapped payments (the private health insurance rebate, MBS and PBS) and lack of a performance regime contributes to the distortion in the distribution of workforce, inequitable access and created perverse incentives

3.6.1 Health system arrangements – the need to integrate resources

The control of program budgets by different fund holders does not encourage horizontal integration of services across the primary, secondary and tertiary provision of care, or for specific care areas such as mental health and aged care. The arrangements therefore influence the ability of providers to deliver patient centred care or to implement innovative models of care.

The current Australian Health Care Agreement (AHCA) between the States and Territories and the Australian Government discourages, through its rigid funding and performance regime, the optimal and flexible use of the health care worker. States and Territories argued for a comprehensive AHCA that would enable Australia to address the full range of health needs for the population including both hospital, community based, population health and prevention through an overarching funding arrangement. This approach was rejected by the Australian Government in favour of a strictly hospital based agreement that focuses on inpatient care and does not recognise contemporary models of care or innovative approaches to patient management and treatment.

Governments have increasingly focused on ensuring that the health system is able to work across primary and secondary care boundaries to effectively manage demand and create a better focus on health promotion, disease prevention and management of chronic and complex conditions in the community. Recognition of the role of general practitioners as gatekeepers to the use of health services and creation of better incentives around this role is paramount in health system efforts to achieve more appropriate models of care and to sustain the systems capacity to continue to deliver services in the face of reduced numbers of healthcare workers.

Over the last few years NSW has developed many models of service that aim to provide integrated, comprehensive and coordinated care. This is a key priority as by 2020 approximately 80 per cent of the disease burden in the developed world will be attributable to chronic and complex conditions, with the ageing of the population a major contributor.

The NSW Department of Health is currently developing an Integrated Primary and Community Health Policy, which will create better links within the primary and community health sector, and between all sectors of the health care system. There will be a particular focus on improving integration with general practice.

People access the primary care services they need from a range of providers that are funded through different sources. Problems with this are:
- inequitable access to primary health care services (a mixture of geographical mal-distribution of primary health care services and affordability) and correspondingly greater use of emergency services.
- gaps and overlaps in service provision
- inappropriate use of hospital services for ambulatory care sensitive conditions resulting in a high proportion of avoidable and unnecessary admissions

- a lack of integration of primary medical services with other parts of the health system
- multiple separate interfaces with acute care that defies efficient management and lead to a bumpy and circuitous patient journey.
- a focus on acute episodes of care in isolation.

The benefits of integration have been demonstrated through service models trialled and evaluated across Australia and internationally. There is compelling international evidence that countries comparable to Australia, in particular Canada and New Zealand, that have a strong primary and community health care infrastructure have lower health care costs, less health inequality and generally healthier populations [39] [40] [41] [42].

A further barrier to the development of a strong, well-integrated primary and community health sector is the absence of a national primary health care policy. To date, the Australian Government has not shown interest in developing such a policy.

The NSW Department of Health is developing integrated primary care services. The services are being developed within current funding arrangements, however, over time these may evolve to create opportunities to efficiently and effectively provide comprehensive and continuing care to patients in the community.

Facilitating Multi-Disciplinary Care

The remuneration system can also constrain the ability of the system to use its human capital in an optimal manner – this can be demonstrated through the example of the MBS and the need for multidisciplinary cancer care.

At present, multidisciplinary meetings or case conferences are predominately funded for consultant, nurse and allied health attendance through the state and Territory governments for both private and public patients.

While there are also a range of MBS items that attract a Medicare benefit for case conferencing for GPs and consultant physicians, the MBS items do not cover specialists such as private surgeons, radiation oncologists or pathologists. The gaps in funding for private surgeons and pathologists has implications for facilitating multidisciplinary team meetings or case conferences in rural areas where the majority of clinicians have Visiting Medical Officer (VMO) status at rural health services. VMOs are usually only funded by fee for service through MBS items.

It is important to acknowledge that the MBS provides a rebate to the patient not the doctor. While it is possible for private surgeons or pathologists to bill for their time spent at the multidisciplinary meeting or case conference where their private patients are discussed, there is no MBS patient rebate associated with this for private

[39] *Macinko J, Starfield B, Shi L, The Contribution of Primary Care systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1998. Health Services Research, 2003. 38(3): p. 831-865.*

[40] *Shi L, Starfield B, Kennedy BP, Kawachi I,* Income inequality, primary care and health indicators. *Journal of Family Practice, 1999. 48(4): p. 275-284.*

[41] *Shi L, Macinko J, and Starfield B. The Relationship Between Primary Care, Income Inequality and Mortality in US States, 1980-1995. JABFP, 2003. 16(5).*

[42] *Starfield B,* Primary care: is it essential? *Lancet, 1994.* ***344****: p. 1129-1133.*

patients. This not only disadvantages the patient but also provides a disincentive for these clinicians to participate in multidisciplinary care.

There is potential to review the MBS to ensure that optimal patient care is delivered and that resources are used effectively and efficiently. For example, it may be the case that the introduction of a comprehensive multidisciplinary care item for the management of cancer (and indeed other chronic patients) may be more efficient. This would then free up workforce and monetary resources that could be directed to other priorities.

3.6.2 Funding arrangements can distort the supply and demand for health services

Increasing the supply of the workforce will only partially address the issues associated with a responsive and flexible workforce. A case can be made to ensure that the workforce is working in the most efficient manner and deployed in such a way that the health needs of the population are a primary motivator. A balance needs to be found between the need to maximise income with the health needs of the population including that of the provision of accessible and affordable services.

The major Australian Government outlays for health (the MBS, private health insurance rebate and the PBS) are uncapped and allocated without any associated performance requirements. Within this environment, private health service providers are responsive (as rational business people) to the price signals that this kind of regime encourages. The underside of this is the growing debate about whether this response to price signals is meeting the health needs of the population i.e. whether the workforce is deployed in the most efficient manner.

In addition, individuals significantly contribute to the cost of health care along with State and Territory governments. The main driver of growth (aids and appliances, dental services and pharmaceuticals) comes from areas for which benefits are paid out of ancillary tables offered by health funds. Policies to encourage people to take out private health insurance may have induced demand for health goods and services and an accompanying increase in out-of-pocket expenditures. Currently 10% of individual expenses are spent on medical services, 33% on pharmaceuticals (with 7% on PBS contributions), 21% on dental services and 15% on aids and appliances.

The Australian Government's insurance policies have not significantly reduced the burden on the public hospital system. Private hospitals are treating less complex and less sick patients then the public hospital system. Private hospitals are treating high volume, low cost, high profit patients. Public hospitals are treating sicker and more costly patients. The private sector is focussing on high volume, low cost procedures. Between 1999/00 and 2003/04 private sector activity for:

- Sleep apnoea increased by 84% compared to 12% in the public sector
- Same-day colonoscopy increased by 31.4% compared to a decline of 1.5% in the public sector
- Dental extractions increased by 41% compared to 2.4% in the public sector
- Caesarean deliveries (uncomplicated) by 57% compared to 20% in the public sector
- Renal dialysis increased by 114% compared to 33% growth in the public sector
- Chemotherapy increased by 58% compared to 8% growth in the public sector
- Follow up endoscopy increased by 26% compared to a decline of 7% in the public sector.

3.7 Vocational Education Training Sector

Better opportunities for vertically integrated career paths across the vocational education system, health and higher education are essential to increase the supply of educationally prepared health workforce for the future. NSW is exploring the possibility of improving health workforce supply through health related courses for VET in schools. These include courses (such as aged care) developed by the Department of Education and Training and the Health, Tourism and Hospitality Curriculum Centre and run in TAFE Institutes. They are endorsed by the Board of Studies and are available all over NSW.

There was interest in this approach as a potential area for ongoing collaboration at the joint AESOC/AHMAC meeting held in November 2004. Other VET health courses can be developed by any Registered Training Organisation to meet local need where TAFE is not in a position to deliver a course. They do not count towards a UAI and can only be delivered locally.

TAFE NSW is currently developing a proposal to the Board of Studies for consideration of two Higher School Certificate Industry Curriculum Framework Courses in Aged Care and Pathology Assistance. Industry Curriculum Framework Courses can contribute to students' University Admission Index. These courses will provide enhanced opportunities for articulation in a relevant university degree program. The course outcomes will also provide articulation into higher level Training Package qualifications at Certificate IV, Diploma or Advanced Diploma.

These initiatives will assist in creating integrated career paths across VET, health and higher education. However they rely on the Australian Government making available university places for articulating TAFE students. The former NSW Minister for Education Training indicated in a letter to the Australian Government Minister in 2004, that university places need to be targeted to improve pathways to university for TAFE graduates.

These initiatives are consistent with the national agenda for reform in credit transfer and articulation. The Joint Committee on Higher Education (JCHE) working party has developed principles of good practice for disseminating information on, and implementing, credit transfer and articulation. The JCHE has recommended that the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) adopt these principles. The JCHE is also recommending a national mapping exercise be conducted of current practices in credit transfer and articulation; and the establishment of a data working party to improve national performance in this area.

A successful model where structural arrangement has helped - The Public Health Education and Research Program (PHERP) funding provided by the Department of Health and Ageing has facilitated the development of infrastructure and collaboration between universities and State Health Departments to strengthen the public health workforce. This funding has resulted in building a pool of people with postgraduate public health qualifications to assist in the recruitment of a skilled workforce.

4. Reinvigorating the health workforce

The health workforce is our most precious resource. Given the size and impact of tragic risk in health care, failure to secure and support a sufficient and productive

workforce could result in health system dysfunction. This pressure is being felt and major reform is required to deliver a sustainable health system supported by adequate numbers of appropriately trained and skilled health workers. It is important to note that national action is required to deliver a future sustainable workforce. The following points highlight a way forward to reinvigorate the workforce.

Whole of government initiative required - One of the reasons for the lack of sustainable change in workforce numbers is that the human services sector does not have total responsibility for all aspects of the education, training, regulation, recruitment and retention of their workforce. Whole of government initiatives are required to address the structural disconnects that exist and reduce any disincentives to working in these sectors.

Health care is a service not a commodity - When considering reform areas, it is important to remember that health care is different from many other industries as health care is a service not a commodity. Market forces work differently in this industry and therefore different approaches to addressing health workforce issues are required than those which come from a purely market driven approach. [43]

Multiple sources of influence - Currently the Australian health care sector is characterised by a series of serious role conflicts where professional groups determine education, training, regulation and supervision requirements and levels of quality. These role conflicts necessarily influence workforce supply and distribution. Unlike other industries, health care is an emotive industry where there are high levels of tragic risk for consumers with very different motivations and rewards driving health workers and health professionals.

Many international reforms effective - The review of international experience in addressing health workforce shortages highlights differences within the Australian health care context. Many of the international reforms are effective as they are undertaken within a national framework for the delivery of health care. In Australia, the challenge is to bring about reform at a national level that supports the flexibility required at a local level to implement policy and practice within each jurisdiction.

COAG - At the Council of Australian Governments (CoAG) meeting held on 3 June 2005 governments agreed that the health system could be improved through reform in a number of areas. One of the CoAG reform goals is to improve the supply, flexibility and responsiveness of the health workforce. This paper primarily focuses on this goal. Specific discussion is provided around the workforce issues pertaining to the CoAG goal of improving the health of people living in rural and remote Australia.

It is also important to recognise that the configuration, operation and productivity of the health workforce impacts on the effectiveness and efficiency of the entire health system including the other priority CoAG areas.

A range of issues impact on the supply, flexibility and responsiveness of the health workforce. Each of these issues will be explored with recommendations identified.

[43] *Stanton P, 2002, 'Managing the health workforce: cost reduction or innovation', Australian Health Review, vol 25, no 4, pp 92 – 98*

4.1 Workforce Disconnects

4.1.1 Education and training of the health workforce

Key Problems

Traditional approach to education involves students being trained in a single discipline producing health workers that have specialist skills not used to working in interdisciplinary teams

Limited successful workforce planning due to lack of useful collaboration between health and education sectors

Lack of formal planning mechanism for funding and allocation of student places

Disconnect between metropolitan and rural needs

Disconnects, divided responsibilities and differing agendas between levels of government, the health and education and training sectors and other stakeholders present impediments to current service delivery and greater obstacles to system evolution or reform.

There is no 'seamless' mechanism in place to deliver necessary adjustments to health education and training numbers and better align health system priorities with education sector programs. As a minimum, formal mechanisms for engagement are needed to ensure that education and training programs align with health service planning.

While governments at all levels consider good health care a priority and a knowledgeable and skilled workforce is as critical to good health care, securing an adequate supply of suitably trained health practitioners through the education sector remains a constant struggle. Decisions about intakes and the allocation of funding seem to be skewed towards the education sector and action upon health workforce planning advice optional rather than mandatory.

The two major issues to ensure the adequate supply of health workers with appropriate skills and qualifications are the traditional approach to the education and training of the health workforce and the relationships between health and education sector.

4.1.1.1 Traditional Approach to Education

The traditional approach to the education and training of the health workforce has involved students being trained in a single discipline with little opportunity for shared learning with other groups of health workers. This approach continues to produce health workers who have specialist skills who have limited skills for working as part of an interdisciplinary team. There is a growing body of work that reports on successful small scale inter-professional training models in Australia and Internationally. However, further growth in new models of inter-professional training is largely unsupported unless it can be specifically funded through research grants.

Workforce planning is constrained, as there is little collaboration between the health and education sectors to ensure that adequate numbers of skilled health workers are trained and available in a timely manner to work where they are needed.

The key issue in relation to the governance of workforce planning in higher education is the lack of formal mechanisms. Coinciding with the Australian Government's reforms to higher education through the implementation of its *Backing Australia's Future* initiative, the Australian Government unilaterally abandoned the Joint Planning Committee process - the formal mechanism by which the States/Territories, in consultation with the Australian Government, could influence university educational profiles (the academic and educational course and program offerings of universities).

Given that universities operate as essentially autonomous institutions, their involvement in any State workforce planning solutions must be sought, particularly where there is a need for development of new courses and curriculum redesign. The Joint Planning Committee (JPC) process was the only mechanism that allowed the States some input to workforce supply planning.

Joint Planning Mechanisms

Having abandoned the JPC, the Australian Government now negotiates university profiles directly with institutions through the Institution Assessment Frameworks. The development of individual contracts (the funding agreements negotiated between the Australian Government and individual universities) excludes state input. This situation is anomalous given that the Australian Government, unlike the States, is not a health employer. In addition, individual agreements reached under the Institution Assessment Frameworks are more likely to align with national priorities rather than those of the state in which an institution is based.

University decision making around resource allocation continues to be largely driven by student demand and business realities, rather than workforce requirements. One outcome of this is continued competition between universities for market share in curriculum areas of higher demand and lower cost rather than areas that are relevant to state employers and therefore community need. Relatively resource intensive courses in this category are less likely to be offered or are likely to be rationalised leading to an artificial workforce shortage.

Under current university funding arrangements, Commonwealth Grant funding is allocated on the basis of the distribution of units of study delivered across twelve discipline clusters. Medicine, Dentistry and Veterinary Science form one cluster, with the highest level of available funding for health professions, $15,047 per equivalent full-time student load (EFTSL) in 2005. In addition, universities receive a loading for teaching hospital costs per medicine EFTSL. The value of this loading was $1,070 in 2005. Nursing is another cluster, funded at $9,511 per EFTSL including additional funding introduced in 2004 to support practicums. Other health courses (allied health) are clustered with Computing and Built Environment, funded at $7,212 per EFTSL (DEST 2005). Funding is indexed each year. Funding rates may also be increased by 5% in 2006 and 7.5 % in 2007, where providers comply with national governance protocols and workplace reform requirements.[44]

Students also contribute to the funding that higher education providers receive. The student contribution rates, for students commencing in 2005, were up to $8,018 for Medicine and Dentistry, up to $3,847 for nursing and up to $6,489 for health units.

[44] *Higher Education Support Act 2003*

Anecdotally, education and training providers assert that the cluster allocations do not meet the costs of course provision, even with the addition of the students' HECS contribution or fees. The funding gap is clearly greater for those health courses which are clustered at the lower levels.

It has also been suggested that the freezing of HECS costs for nursing courses to encourage higher enrolments may have created a disincentive to offer those courses due to an overall reduction in the funding provided.

It is important to ensure that incentives provided in one sector do not create disincentives in the other and it is essential for coherent policy outcomes to align objectives between sectors.

Professional bodies have claimed that funding levels for allied health should be similar to those of nursing, medicine, and dentistry, to better account for the clinical component of the courses (HPCA 2004).

4.1.1.2 Workforce planning needs

The current structural arrangements for the education, training and regulation of the health workforce create significant problems in providing flexibility and responsiveness to deliver adequate numbers of health workers with the appropriate skills to meet the changing health care needs of the community.

State and Territory workforce planning needs should determine education placements and drive negotiations with universities for the funding and allocation of student places, and development of universities' Institution Assessment Frameworks. The Joint Committee on Higher Education recently agreed on the need to reinstate formal discussions with the Australian Government along these lines. A formal mechanism should be developed to enable this to occur.

FACT ISSUE:	**NSW has a significant nursing shortage** *In 2004/05 NSW universities (Universities of Technology Sydney and Charles Sturt) turned away over three thousand potential nurses due to the lack of HECS funded places.* *Recent studies report significant nursing workforce shortages which are projected to worsen in the current decade. Studies for the National Review of Nursing Education projected an annual increase in demand for nurses of 2.5%, a shortfall of 40,000 nurses by 2010 and a need to increase nursing graduates by 120%.* *Preston's study on Australian Nurse Supply and Demand to 2006 for the Australian Council of Deans of Nursing indicated a nurse shortfall of 2.2% by 2006 and projected a 2006 requirement for nursing graduates of 10,182 with supply being projected at 6,131 – a shortfall of 4,051 graduates.*

An effective consultation process should also occur with the State whenever an education provider indicates that it is intending to reduce course provision in areas critical to the State's health workforce needs such as nursing or podiatry. Unilateral decisions should not be made in such important areas as they are not in the best

interest of the community. This issue appears contentious as universities would want to retain discretion to eliminate subjects that are not cost-effective.

A further illustration of the need for States and Territories to have a formal planning mechanism with the Australian Government, relates to the allocation of "new" Australian Government funded places to substitute previous marginally funded student places (over-enrolments). These represent significantly fewer fully funded places that what's required based on state and national workforce planning reports prepared by AMWAC.

The Australian Government Department of Education, Science and Training indicated at the joint AESOC/AHMAC meeting on 23 June 2005 that, although it expects to involve the States and Territories in the allocation of these places for 2007, this process will need to be put to Minister Nelson for his endorsement. As no methodology has been committed for consultation with the States, there is therefore no certainty that States' views will be considered.

The development of health practitioner initiatives in schools that provide a career pathway is a priority for the recruitment of the health workforce. As an example the school based training programs encourage the uptake of students into the nursing profession at various levels. There are currently a number of models providing school based training as the commencement of a nursing career. Some models are fully self-funded and provide a Certificate II as the outcome. Other models are delivered wholly utilising employer funding as this suits the employer.

These initiatives assist in creating integrated career paths across VET, health and higher education. However, as mentioned previously, they rely on the Australian Government making available university places for articulating TAFE students. The former NSW Minister for Education Training indicated in a letter to the Australian Government Minister in 2004, that university places need to be targeted to improve pathways to university for TAFE graduates.

Whatever the government's public policy and fiscal responses are, reforms will need to target training and education strategies to support new models of care that reflect population health needs. This will include consideration of medical and other clinical training places, and increased regulatory oversight and control of potential anti-competitive trade practices by professional colleges[45] as well as the need to be consumer focused and aligned with service planning.

To address the disconnect between the health sector and the education and training of health workers, NSW has implemented a number of strategies to assist it in meeting its workforce needs at a local level.

First, from a planning and coordination perspective there are three groups which meet to facilitate links between education and human services from a workforce perspective. These groups are described below.

1. *NSW Premier's Department/NSW Vice-Chancellors' Conference Strategic Initiatives Group* that discusses all aspects of higher education interaction with the NSW Government.

[45] *National Health Workforce Strategic Framework 2004 Op. Cit.*

2. *Human Services and Education Strategic Partnership Group* that will meet annually to determine opportunities for collaborative action on mutually agreed and interrelated priorities. The membership of this Group comprises the CEOs from the NSW Departments of Education, Health and Ageing, Disability and Home Care, along with the Vice Chancellors of the Universities based in NSW. The purpose of this Group is to formalise interaction between the NSW human services and education sectors to facilitate an effective human services workforce, covering hospitals, community, health and welfare agencies.

Advice on priority issues will be sought from existing forums across the human services and education sectors. (Group 3). Arising priorities and key issues will be raised at the NSW Premier's Department Vice Chancellors' Conference Strategic Initiatives Group.

At the most recent meeting of the Strategic Partnership Group members agreed that there is value in:

- working collaboratively regarding the need for additional places, distribution of the places, generating greater flexibility in courses and ensuring that funds cover cost of courses particularly clinical places;
- joint planning and mapping of future workforce requirements;
- Reviewing articulation pathways between the VET and Higher Education sector;
- Exploring economies of scale in offering particular courses - i.e. cohort size; and
- Reviewing restrictive trade practices that inhibit flexibility of training and education providers.

Many of these actions need to be coordinated jointly between the State and National governments to achieve these outcomes.

4.1.2 Clinical Placements

Key Problem

Clinical placements arrangements are currently ad hoc, personality and lobby group dependant and do not reflect the 24-hr/7 day week nature of health services

Clinical training placements have been identified as a key health workforce strategy to be addressed at a state and national level. As part of a strategy to allocate clinical placements for undergraduate health professional students in line with workforce needs and support across the state, the NSW Department of Health plans to:

- review undergraduate clinical placements to ensure appropriate supervision, supply, distribution and coordination across Area Health Services

- work with education providers to develop consistent governance structures for clinical placement management

An interdisciplinary stakeholder workshop was held in September 2004 that focused on:

- increased collaboration between the health and education sector
- improved alignment in education and supply training to achieve long term workforce self sufficiency.

It is recognised that there is a need to develop transparent and clear mechanisms for the coordination and management of clinical placements. Work is progressing on priority actions identified including mapping current clinical placement arrangements, defining the purpose of clinical placements across all disciplines and review outcomes, collecting data on expected future demand for clinical placements, simplifying the number of clinical placements, identifying best practice models of clinical placements and clarifying governance models.

A mechanism, by which the States/Territories agree fee structures for placements is required to assist with streamlining clinical placements and ensuring a match with current and future service needs.

As an adjunct to clinical learning and consistent with best practice, better use should be made of simulated learning opportunities. There appears to be no clear national approach to development and use of this learning model and the Australian government should take the lead on this important issue.

4.1.3 Summary

One of the reasons for the lack of sustainable change in workforce numbers is that the human services sector does not have total responsibility for all aspects of the education, training, regulation, recruitment and retention of their workforce. Whole of government initiatives are required to address the structural disconnects that exist as well as reducing the disincentives for working in these sectors. Enabling States/Territories to plan for a health workforce based on current and projected need is essential.

4.1.4 Rural Considerations

Key Problem

Training opportunities and distribution of the workforce

Education and training are crucial issues for the development of sustainable health care systems in rural and remote communities. To enhance the numbers of people training to become health workers and remaining in the workforce, issues surrounding location of, and access to, education programs needs to be addressed. This is particularly relevant for Aboriginal people in rural and remote locations and whether people from an Aboriginal background participate in training.

The nature of training programs for health professionals and their location impacts on workforce distribution. Strategies to cap specialists in areas of adequate supply and

to expand positions in outer metropolitan, rural, regional and remote areas are key priorities as is growing health professional numbers in local areas.

There is a mismatch between sites and content of postgraduate training in some areas of health care (paediatrics and child health is a good example) and where people will be practising in future. Nearly all of our training for paediatricians is hospital-based and runs on the back of junior doctors' service jobs, yet the growth area is in conditions that can usually be managed outside of hospital in locations close to where people live. 35% of the practice workload of general paediatricians in regional centres (and outer metropolitan) is developmental and behavioural paediatrics - ADD, autism, parenting issues - yet very few paediatricians have any out of hospital training in these areas because there are no funded training positions.

The NSW Government commissioned reviews of Basic Physician, Basic Surgical and Psychiatry speciality medical training programs by the Medical Training and Education Council (MTEC) to provide a consistent state-wide approach to the training and distribution of medical specialists. The improved network training system is envisaged to increase trainees going into medical specialities and provide more equitable distribution across inner and outer metropolitan and rural hospitals. Further expansion of the network training system is required to provide equitable access to training for the rural medical workforce and allow supply of medical speciality trainees for rural hospitals.

NSW Health is progressing the formation of the NSW Institute of Medical Education and Training through the convergence of the MTEC and the Postgraduate Medical Council (PMC), which is currently responsible for the allocation of junior medical staff in their first and second years of postgraduate employment. IMET will maximise the opportunity for education of medical staff for the NSW health system.

It is increasingly being recognised that rural practice requires a greater proportion of generalist medical skills than in metropolitan areas. The increasing specialisation of health education programs may result in a decline in health professionals with generalist skills. The inclusion of a generalist advanced specialist stream in medical Psychiatry training is one example of the recognition of the need to maintain strong generalist medical education programs.

A limited range of cadetships is currently available to medical students and environmental scientists. Greater use of the recruiting of cadets either from high school or once they have commenced university is influencing both the postgraduate supply and distribution of the workforce. Competition for high achieving school leavers is increasing with a wide number of enterprises and government departments providing cadetships prior to students completing the Higher School Certificate.

The health workforce must match the community needs; the right service in the right location, with trained staff who can provide appropriate and accessible services to the community.

4.1.5 Aboriginal workforce considerations

Key Problems

Increased Aboriginal health needs

Low numbers of Aboriginal people in the health workforce

The growing size of the Aboriginal community and the increasing emergence of health issues dictate the need for an increased Aboriginal workforce across all work professions and categories and across all services and locations. Aboriginal people must be welcomed into the health workforce and the intrinsic knowledge and experience that they bring must be valued. For this to occur stereotypes and myths regarding Aboriginal people, which are still present within the current health workforce, must be dispelled.

Involving Aboriginal people in the health workforce has been acknowledged as an important strategy for addressing the health needs of the community. During 2003/04, the NSW Department of Health provided scholarships of up to $10,000 to support 34 Aboriginal and Torres Strait Islander students enrolled in a Bachelor of Nursing degree, jointly funded 10 medical and allied health scholarships with Rotary valued at $2,500 each for indigenous people as well as providing a range of Aboriginal health career advice initiatives. The NSW Department of Health also secured additional funding to employ more Aboriginal mental health workers.

In 2004, the NSW Department of Health established the Aboriginal Health Awards to support and acknowledge excellence in the provision of Aboriginal health services and initiatives.

To effectively address the health needs of Aboriginal people, we need to:

- provide targeted programs for Aboriginal students to easily articulate from school through VET to higher education;
- identify the current skills, knowledge and experience of Aboriginal Health Workers as a basis for ongoing training and career development plans;
- establish ongoing training plans and support for Aboriginal Health Workers working in chronic conditions management; and
- develop prototypes for clinical protocols and health assessment tools for the early detection and management of chronic conditions in Aboriginal people and develop and implement appropriate training to support the implementation of the protocols across the wider “health” workforce.

4.1.6 Summary

Improving access to education and training for rural and remote residents and Aboriginal people is essential to address workforce shortages now and in the future.

4.2 Workforce Flexibility

4.2.1 The delivery of health care across Australia

Key problems

Different roles and responsibilities of Australian and state governments creates a lack of effective coordination

Professional silos

Ageing population

Current arrangements for the delivery of health care were established in the last century and do not adequately meet the health needs of the community or assist in addressing the current health workforce pressures. Nationally, the different roles and responsibilities of the Australian Government and the States and Territories create barriers to coordinated and integrated service provision. At the state level, government-run public health systems operate alongside private medical practitioners, pharmacists and for-profit hospitals.

Health service delivery also takes place outside the health services sector, for example, in supporting people with a disability. An increasing number of people with a disability have complex health care requirements and as a consequence require ongoing care and support by health care professionals including nurses and therapists. In addition, a significant number of clients have dual and multiple diagnoses, which means that staff need to be competent across a number of areas of support.

Job Re-design

Health care is characterised by an apprenticeship system with a series of professional silos. Rigid demarcation exists between professions that reflect neither workload requirements nor current practice. The focus has been on the development of specialised services supported by clinicians with specialist skills without consideration of a comprehensive service. In this context, flexible models of care that are patient rather than profession focussed have emerged as critical.

Rather than respond to profession-specific approaches to workforce shortages, there is increasing recognition that a realignment of existing workforce roles or new roles is required. Inter-professional and multi-functional approaches to health workforce planning are being taken up by a number of States in Australia. This is being driven by significant chronic illness patterns experienced by an ageing community that require complex care across disciplines when there are coexisting workforce shortages [46] [47].

[46] *Duckett S J, 2005, 'Interventions to facilitate health workforce restructure', Australia and New Zealand Health Policy, Vol 2, No. 14*

[47] *Australian Health Workforce Advisory Committee, Australian Medical Workforce Advisory Committee and Australian Health Workforce Officials Committee (2004), A Models of Care Approach to Workforce Planning – A discussion paper, Health Workforce Issues paper 1.*

The OECD reviewed the skills mix differences in nursing and medicine across member countries[48]. The OECD defined 'Skill mix' as a relatively broad term that can refer to the mix of staff in the workforce or the allocation of roles and activities among different categories of staff. Skill mix changes result from a range of different strategies including enhancing the skills of a particular group of staff, substituting tasks between different groups of staff, delegation up and down a professional discipline and development of new roles.

Increasingly Australian health care organisations are considering the issues of work re-design, including advocating workforce substitution. NSW Health does not support the terminology 'workforce substitution'. The focus needs to be on models of care, role re-alignment and definition of new categories of skills and occupation to match the models of care that need to be put in place.

There are a variety of options, for example, for the surgical workforce to use maximum skills at the minimum cost and create better opportunities across the professions. For example, anaesthetic technicians undertake some of the lower level tasks relating to provision of anaesthetics from anaesthetists, which free up the anaesthetists to undertake higher-level tasks. Duckett [49] states substitution will require:

- identification and clarification of the precise range of tasks to be substituted;
- protocols to identify the types of patients for who the substitute professional or assistant is relevant;
- clarification of the nature of the supervision, and reporting and regulatory requirements (if any);
- negotiation of payment/salary arrangements."

This approach to ensuring staff with the right skills perform tasks requires changes to the allocation and ownership of work. Critical medical skills need to be maximised with re-examination of the role of junior medical staff, particularly in the first two postgraduate years. Many tasks that have traditionally been undertaken by doctors may be performed by nurses or other non-medical clinicians with the appropriate training. Likewise, tasks performed by allied health professionals and registered nurses may be undertaken by trained assistants in nursing and allied health, such as medication management and mobility training [50].

There are a number of tasks that could fit within the substitution model, as shown by Duckett in the table reproduced below [51].

Table 1

Task*	**Traditional profession**	**Substitute professional/assistant**
Anaesthesia	Anaesthetist	Nurse anaesthetist
Clerking of new hospital patients	Hospital medical officer	Nurse
Closure of wound	Surgeon	Nurse
Foot care	Podiatrist	Foot care assistant
Foot surgery	Orthopaedic surgeon	Podiatric surgeon

48 Buchan J and Calman L, 2005, OECD Health Working Papers (17), Skill-mix and policy change in the health workforce: Nurses in advanced roles
49 Duckett, Op Cit
50 Duckett, Op. Cit
51 Duckett, ib id

Task*	Traditional profession	Substitute professional/assistant
Laryngoscopy/Naso-endoscopy	ENT surgeon	Speech pathologist/Nurse
Maternity care	Obstetrician	Midwife or GP
Mobilisation assistance	Physiotherapist	Physiotherapy assistant
Patient management	Medical practitioner	Nurse practitioner
Plain X-ray	Medical imaging technologist	X-ray assistant
Refraction	Optometrist	Orthoptist
Reporting pathology	Pathologist	Scientist
Reporting X-rays	Radiologist	Medical imaging technologist

** Performance of the substituted tasks will generally require additional training and clear protocols, and will also depend on the complexity of the condition and the comorbidities of the patient*

A further difficulty in achieving more flexible models of care is the organisation of health care delivery. There is little integration between primary and community health care, hospital services and aged care facilities and between private and public providers. Activities are coordinated within disciplines but are not collectively organised around the patient.

Capacity in the primary health system is required to address current and future health care needs. Workforce shortages are one of the limiting factors to enhancement of a multidisciplinary approach to care. Further, the funding for such a model is limited. Recent changes to Medicare Schedules do allow for some multidisciplinary approaches, but allied health services essential to such approaches generally do not attract MBS rebate.

In the next twenty years there will be increasing pressure on the future health workforce to care for the aged. In 2004 there were 5.4 people in the potential workforce for every person aged 65 or more. By 2050/51 this figure will have fallen by more than half to 2.2 persons. Over the next 40 years population ageing will increase government spending on health care by 25%.[52]

While the federal government has responded by announcing a $2.2 billion aged care package in the 2004-05 budget to boost residential care, [53] there is increasing debate about why people aged over 85 are placed in residential care rather than being cared for in their homes which is an increasing trend in European countries[54].

Strategies have been implemented at a national or state and Territory level to better meet the needs of people requiring services in the community. These include the Transition Aged Care Program, the coordinated care program, Extended Aged Care at Home (EACH) Package, Community Aged Care Programs (CACP) and ComPacks.

The success of many of these programs will require organisations and health professionals to utilise the skills of staff who may not have tertiary qualifications yet have the skills to adequately, and safely, perform the tasks required of them. This may include therapy assistants, enrolled nurses and carer support personnel.

52 Productivity Commission on Ageing Australia April 2005 Op. Cit.
53 Australian Government Budget 2004-05 Treasury Budget Paper 2
54 'Aged care policy needs a rethink: expert' John McCallum Victoria University Deputy Vice Chancellor Sydney Morning Herald March 11 2005.

4.2.2 Clinical re-design

Key Problem

Health care structured around specialty areas of disease and illness

Adequate and sustained staffing is integral to the delivery of health services, both in the short and longer term. In NSW, Area Clinical Workforce Plans incorporating the seven principles of the National Health Workforce Strategic Framework have been developed to facilitate the health workforce planning needs over the short to medium term (one to four years), and medium to longer term (five to ten years). The workforce planning guidelines assist with identification of health workforce requirements to meet future clinical demands, cognisant of the changing dynamics in health care delivery and future demands of clinical services.

As described earlier, health care is traditionally structured around specialty areas of disease and illness. Health workers have developed expertise in these specialist areas. Patients rarely present with one specific health problem and the specialist model can often inhibit the management of the patient.

Clinical re-design projects are being undertaken across NSW to address these challenges and establish new models of care and ways of working. These models put the patient journey at the centre of the care activity rather than the professional. This patient-centred approach requires a focus on staff having different skills and working in different ways.

Nurse practitioners have emerged, nationally and internationally, as a new level of the nursing profession and evolving with them are innovative models of nursing care that require specific educational and experiential preparation at an expert level. Extensive research has demonstrated that the Nurse/Midwife Practitioner role is safe and effective and highly acceptable to the patient population.

Achieving a critical mass of Nurse Practitioners across Australia in acute settings as well as primary and community settings will enable these new models of care to demonstrate their effectiveness. Certain sectors of the medical profession initially had some concerns regarding the concept of Nurse Practitioners. These initial concerns were particularly related to nurses being given the power to diagnose and prescribe. While many in the medical profession have since accepted NPs, others continue to oppose their introduction.

A major impediment to the impact of the Nurse Practitioner is the lack of access to the PBS. This precludes Nurse Practitioners from writing prescriptions that need to be filled at local chemists. Patients then need to be "double-handled" by travelling to a General Practitioner for prescriptions where another consultation may be required.

The NSW Framework for Maternity Services provides the platform for maternity services in NSW. This policy document supports a tiered model of care that is responsive to the different level of service needs for individual women during their pregnancy and birth. Midwifery models should be provided as part of a networked arrangement of primary, secondary and tertiary maternity services.

Midwifery models available in NSW range from the stand-alone midwifery-led unit such as the one located in Ryde, Northern Sydney to case load practice and midwifery teams operating through secondary and tertiary hospitals across the state.

Caseload models involve one midwife being the primary caregiver for each woman's antenatal, intrapartum and postnatal care. A second midwife is known to the woman and provides back up for the primary midwife and is present at the birth of the baby. Team midwifery models offer care to women by small teams of five to eight midwives who also provide care across the antenatal, birth and postnatal period.

In developing new models of care it is important to examine all support services. As an example, information technology is not maximised to assist health professionals in delivering care or the community in addressing their health care needs. There is much developmental work to be done in relation to technology for health care services, training and education. First, not all technology is available to all professional groups and in all locations. Many information technology systems are used for patient care, such as for ordering and checking pathology results, but are not available for education or research purposes. Some staff also report a reluctance to using technology to undertake their work or assist them with professional development.

Opportunities need to be explored which promote greater use of telemedicine for diagnosis, development of treatment plans, education of the workforce and ongoing supervision and support. The enhanced use of information technology to support patient care and the health workforce should be explored especially where access to health care professionals is limited. Telehealth programs are currently used to allow access to consultants or general practitioners in remote areas, to provide supervision and /or education of non tertiary trained health carers by specialist health professionals and to provide remote diagnostic services. However, currently factors such as limited access to computers, email and Internet limit the uptake and use of some forms of information technology.

A number of factors affect the flexibility of the health workforce such as training and education, legal and professional barriers and entrenched cultures and modes of operating.

New support roles will be necessary to assist all health professionals in the workplace and their timely and efficient operation. Teams need to work in different ways and develop mutual trust and collaboration. Shared care for obstetric patients is an existing example of the new models and ways of working.

Nurse Practitioners and Pharmacists could have restricted access to PBS systems. In the community and disabled services sector such initiatives would assist in the access by clients to timely and comprehensive medication review and monitoring of dosage for long term medications.

Appropriate training and education programs would be needed to up-skill staff to undertake new tasks. A further requirement would be the establishment of training programs of a more generalist nature, such as those being undertaken at Kingston University[55].

The introduction of innovative collaborative practice models where teams of generalist Medical Officers and Nurse Practitioners work together in acute care

[55] *http://www.kingstonhospital.nhs.uk/jobs/hcp.htm*

(including critical care) hospital settings inhours and afterhours is an example of role redesign.[56]

The formalisation of a nursing career pathway from school based traineeships, accessing Department of Education and Australian Government funding, to enrolled nurse education with increased recognition of prior learing in NSW undergraduate nursing and midwifery courses will provide flexibility within the nursing career pathway.

In 2004 Enrolled Nurses in NSW had their role extended and were approved to administer medications after endorsement by the Nurses and Midwives Board NSW . This extension of the EN role bought NSW in line with other States and Territories and met Recommendation 4 of the National Review of Nursing Education 2002 and Recommendation 26 of the Senate Inquiry into Nursing 2002.

Sustainable models for encouraging recruitment and retention of the health workforce are needed. Recognition of prior learning, accessible career paths, recognition of the many roles undertaken by the predominantly female health workforce and the impact of ageing and retirement plans all need to be considered.

4.2.3 Rural Considerations

Key Problems

Highly specialised models of service delivery and training should not be imposed on rural areas

Workforce shortages

The rural health workforce have traditionally taken a generalist approach to their work, particularly in light of the smaller numbers of health professionals and the need to be able to address the total health care needs of the community. Reforms that support the further development of this model in rural and remote areas are needed.

However, the specialist model in rural NSW differs from metropolitan centres with rural physicians and surgeons providing services that may be provided by sub-specialities in metropolitan areas. This requires a continuing commitment to "generalist" specialist training as well as sub-speciality training. It is only in larger regional centres that it is likely that sub-specialities will be available.

The generalist role should be recognised as a legitimate role and staff provided with the authority and skills necessary to undertake the broader range of practice and access to specialist advice and support when needed.

The experience in NSW has demonstrated that highly specialised models of service delivery and training should not be imposed on rural areas in particular models that

56 Numerous international examples e.g. Assessing New Models for the Delivery of Medical Services www.physicianhr.ca/reports/hollander-e.pdf; Vazirant, S2005, Effect of a Multidisciplinary Intervention on Communication and Collaboration among Physicians and Nurses, Am J Crit Care 14(1):71-7; Hoffman, LA, Tasota, FJ, Zullo, TG, Scharfenburg, C & Donahoe,MP, 2005, Outcomes of care managed by an Acute Care Nurse Practitioner/Attending Physician team in a subacute Medical Intensive Care Unit.

would limit the scope of work of rural practitioners and/or limit supply; eg through the reduction of generalist training courses such as general surgery or the establishment of specialist positions eg child speech pathology position rather than a generalist speech pathology position in a small community.

In view of workforce shortages, greater consideration is needed of the scope of practice of professional groups. This may include expanding the role of certain professional groups. For example:

- Procedural GPs provide surgical, anaesthetic, obstetric, emergency and mental health services. There is potential to consider an extended GP role in rural areas to take on duties that may be performed by specialists in metropolitan areas.

- to date there are 17 authorised Nurse Practitioners and a further 8 nurses working towards authorisation in rural and remote NSW. Nurse Practitioners are registered nurses working at an advanced practice level that may include ordering tests, prescribing and referral. In addition there are approximately 230 Clinical Nurse Consultants providing advanced nursing in a range of specialties including Mental Health and Critical Care across rural and remote NSW.

Another approach involves transferring some work to vocationally trained or new workforce groups. For example in Western Australia allied health assistants work under the supervision of allied health staff (receiving supervision via videoconference in some models) providing therapy to clients in remote areas.

Workforce shortages in rural areas are one of the major factors in inhibiting workforce productivity. Staff and managers consistently identify the lack of incentives for working in rural and remote areas as a contributing factor to recruitment difficulties. Additional payments for working in rural and remote areas are available for General Practitioners through both the NSW and Australian Governments. The Dental Officer Rural Incentive Scheme has been described earlier. While shortages are reported for all health professionals, there are limited incentive programs for nursing and allied health staff in rural and remote areas.

4.2.4 Summary

Inter-professional and multi-functional approaches to workforce planning, flexible models of care and team approaches and consideration of different needs in rural areas are required to improve the delivery of health care across Australia.

4.3 Workforce Productivity

The productivity of the current workforce is not maximised and, if this is not addressed, gains that could be achieved from enhancing supply and flexibility of the workforce will be limited.

4.3.1 Regulation of the health workforce

Key Problems

Health workforce is overly rigid

Professional silos

A large range of regulatory issues impact on the health workforce at both a state and national level. The health sector is characterised by traditional role delineations, which are reinforced by the professional regulatory framework that focuses on individual occupations, (for example, through professional boards), and tends not to reflect the team nature of most health care work. Workplace culture underpins this delineation of roles that impedes the development of interdisciplinary education, training and practice and the development of new models of care.

Regulation, including professional registration, plays an important role in ensuring health care professionals meet minimum standards to maximise patient safety. The registration process is costly, with limited consistency across the nation. In addition, processes for reform are usually driven by professional organisations. Registration boards influence education and training through course and individual accreditation as well as regulation of clinical supervision requirements. Some registration processes restrict health care workers ease of movement between different States and Territories.

Regulatory mechanisms can either enhance or reduce the capacity to engage in innovative job re-design. The role of the clinical colleges in determining training numbers, length and content of training and location of training places has resulted in restrictions in available numbers of medical specialists in certain fields. The recent determination by the Australian Competition and Consumer Commission that required the Royal Australasian College of Surgeons to work with jurisdictions on trainee numbers provides a useful example of both the current processes and the continued need for reform in this area.

Existing regulatory practices have created a health workforce that is overly rigid and has limited capacity to adapt to what is a complex, changing environment with ever-evolving service delivery needs.

In order to ensure patient safety and clinical quality, it is likely that a balance between existing regulatory processes and reform mechanisms to improve flexibility will need to be found that ensures accountable clinical governance can be supported by government health authorities.

Industrial relations issues will also need to be addressed to allow the development of a more flexible workforce. NSW believes that whatever changes are made at the national level to facilitate industrial relations reform or workplace reform need to work to breakdown the profession based silos and not create further disincentives to enhance workplace productivity. In this regard, NSW shares the federal government's desire for flexible, productive and less complex workplaces, but does not agree that the only means by which this can be achieved is the federal model currently proposed.

As described previously, health professionals tend to work in professional silos where they utilise their specialist skills. An opportunity exists to enhance the productivity of the workforce by moving away from professional practice to areas of practice that then allows for greater flexibility, productivity while encouraging multi-disciplinary learning.

The creation of a structure at a national level, responsible for the professional registration process, is worthy of review, especially as it would support mobility of the workforce across interstate boundaries. Many health professionals are very supportive of the concept, especially those living near borders who may work across States in addition to those who want the flexibility of being able to move easily between jurisdictions. The models implemented in the United Kingdom provide some useful insights into the development of national structures for the management of professional registration (see page 19).

Issues such as equitable funding arrangements for such a structure, the development of consistent standards for application across the nation, managing insurance and jurisdictional legislative issues are seen as inhibiting factors to such a structure working effectively.

Whatever the government's public policy and fiscal responses are, reforms will need to consider new models of care and training and education strategies to support them. This will include medical and other clinical training places, and increased regulatory oversight and control of anti-competitive trade practices by professional colleges[57] as well as be consumer focused and aligned with service planning.

4.3.2 Overseas trained staff

Key Problems

Heavy reliance on overseas trained staff

Complex bureaucratic process

Many of the NSW fully funded hospital resident doctors, specialists and GP positions remain unfilled[58]. A number of actions have begun to bring about more equitable supply of medical practitioners particularly in rural remote areas. Medical workforce intake is being boosted through a package of measures aimed at increasing the intake of overseas trained doctors and facilitating their entry into the Australian medical workforce. Initiatives include allowing overseas medical students to remain in Australia as interns and seek permanent residency, listing medical practitioners on

[57] *National Health Workforce Strategic Framework 2004 Op. Cit.*
[58] *Career decision making by doctors in vocational training- AMWAC Medical Careers Survey, 2002*

the Skilled Occupations List for the General Skilled Migration Program, streamlining the Australian Medical Council examination process and improving support programs. Overall, the Australian Government expects that by 2007 an additional 725 appropriately qualified overseas trained doctors will be working in Australia.

The NSW Area of Need Program enables the recruitment of suitably qualified overseas-trained doctors into declared Area of Need positions on a temporary basis, while efforts continue to attract medical practitioners with general registration on a permanent basis. The Program is not a complete solution for addressing medical workforce shortages. The Overseas Trained Doctor Scheme, developed in 2003, has recruited 250 doctors, 15.2% in NSW. Over 60% of doctors indicate an intention to stay in their current practice. 62.9% hold permanent residency in Australia [59].

NSW Health has a Labour Agreement in place with the Department of Immigration and Multicultural and Indigenous Affairs for the recruitment of nurses from overseas. This recognises that the domestic market cannot meet demands and there is a need to recruit these health professionals from overseas.

The public health system has actively recruited nurses and midwives from overseas during 2002, 2003 and 2005. Between January and July 2005 over 600 overseas nurses and midwives have either commenced employment or accepted the offer of employment in NSW public hospitals.

Overseas nurses and midwives recruited to work in NSW are required to hold registration with the Nurses and Midwives Board of NSW without the need for further assessment or education. The Nurses and Midwives Board of NSW undertake assessment of nursing and midwifery qualifications for registration in NSW. English language skills are also a requirement for registration.

Indeed, in 2003 – 2004, overseas qualified Registered and Enrolled Nurses exceeded the Australian educated by 28%. During this period, of all new registrations with the NSW Nurses and Midwifery Board, 58% were educated overseas.

Without training sufficient numbers of health professionals across Australia, we will continue to rely on overseas trained health professionals to assist in meeting health workforce needs.

However, there are many challenges identified with the process of recruiting and using overseas trained doctors including dealing with government departments and recruitment agencies, helping overseas trained doctors adapt and learn about the Australian health system and dealing with variations in skill levels and supervision requirements[60]. In order to better meet the needs of health services and individuals reliant on overseas trained staff, a number of enhancements need to be made. Withers and Powall have identified a number of strategies to enhance immigration programs[61]:

- A new two-stage (temporary to permanent) visa for independent skilled applicants for regional residence;

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[59] ibid.

60 AMWAC report 2004.5

61 Applied Economics Pty Ltd, Glenn Withers and Marion Powall 2003, Immigration and The Regions: Taking Regional Australia Seriously, Report prepared for the Chifley Research Centre - October 200[3]

- A new regional points bonus for past or existing temporary visa holders/applicants;
- Adopting real-cost parity for threshold standards for regional migration;
- Restricting performance conditions for two-stage visas to the residency requirement; and
- Enhancing regional provisions of other entry programs, including refugees and aged parents.

These strategies support recommendations from overseas trained staff to assist with whole of government approaches such as support for schooling, university fees, spouse employment and accommodation assistance, especially for those health workers who hold a temporary visas who find they are not able to access services, such as enrolments in government schools, without paying substantial fees.

4.3.3 Rural Considerations

Key Problems

Shortage of health professionals

Monetary incentives alone insufficient

The Need for tax reform

The shortage of adequate numbers of health professionals in rural and remote Australia is a major impediment to improving workforce productivity. A number of programs to attract health professional to rural practice have been implemented by all governments in recent years. A number of policy changes are needed to develop a sustainable health workforce in rural and remote Australia.

Providing flexibility in the exit and entry points in health qualifications and the related occupational roles enables people to match their work and study patterns with their life demands.

Development of employment packages for staff in rural and remote areas with workforce shortages may be a strategy to both retain existing staff and recruit new staff, particularly if any incentives offered are made available to both new and existing staff. Employment packages should include taxation and superannuation levers and other incentives such as retention payments, accommodation and relocation costs and funding for training, education and clinical supervision.

The Fringe Benefits Tax (FBT) legislative regime provides for a range of tax-exempt 'benefits' including:

- employment interviews and selection tests;
- removal and storage of household effects;
- sale and purchase of dwelling (as a result of relocation);
- connection and reconnection of utilities (as a result of relocation);
- relocation transport; Leasing of household goods while living away from home; and work related medical examinations.

These exemptions allow employers to source and relocate employees and potential employees, funding the relocation and associated employment processes without the

imposition of a taxation penalty in the form of FBT.

A range of benefits provided to Trainees engaged under the Australian Traineeship Scheme are also accommodated as exempt benefits to attract and retain entrants to the Scheme and ensure that there is no taxation impost on employers as a result of supporting trainees in certain ways during the Traineeship.

A range of exempt or concessional benefits is also provided for remote areas and a general exemption for superannuation.

There is no doubt that the above elements have had a positive impact on the capacity of employers to distribute workforce in cases where appropriate workforce can be attracted.

However, there are some anomalies in the FBT when applying it to employees in rural and remote areas. For example, in the metropolitan area, employees may package directly into the mortgage of their principal place of residence – this in turn results in an appreciating asset over time. In remote and many rural areas the option is often simply not available to employees, purchase cost is prohibitive or accommodation is poor or the family home has been tenanted whilst the employee is working in a rural or remote area.

It is likely that governments and employers will need to be flexible in exploring and implementing a range of creative solutions to distribution challenges. However, care should be taken to avoid unintended consequences and the risks of distorting wider health (and other) labour markets.

Monetary incentives alone don't attract specialists to rural and remote areas. Many rural doctors report problems with accommodation, employment and education opportunities for their spouse and children and problems with time-out relief [62]. Rural general practitioners continue to make up the majority of medical service providers in rural public hospitals and provide a wide range of procedural services[63].

The issue of clinical supervision is frequently identified as needing further development to assist with retention of staff in rural areas. Particular professional groups, such as allied health professionals, may be sole therapists working in a small community or working in a specialty field such as renal medicine. One model which operates in an attempt to address this issue involves dieticians working in renal medicine in rural areas participating in teleconference meetings with their colleagues in major metropolitan sites. This efficient and effective mechanism for provision of supervision and professional development is well received by dieticians in rural areas. Similar programs could be established for other professions and specialties.

[62] *AMWAC Report 2004.5 Op. Cit.*
[63] *ibid.*

4.3.4 Summary

Different strategies are required to address workforce productivity in rural and remote Australia. Attractive packages and innovative training opportunities are needed to attract and retain the workforce required in these areas.

4.3.5 Retaining the older workforce

Key Problem

Ageing workforce

One particular mechanism to enhance the supply of the health workforce is to focus on an increase in workforce participation in the older health workforce. Overall participation rates (the proportion of people looking for work or in a job) for the health workforce are expected to deplete at a greater rate than recruitment as the workforce ages. The aggregate participation rate in Australia is expected to fall over the next 40 years. This means that in the next 40 years the growth in labour supply will grow more slowly than the population so that hours worked per capita will decline by 10%[64].

The NSW Premier's Department has prepared a questionnaire on retirement intentions to be conducted by each of the government agencies in NSW. The survey was conducted in July 2005 and targets employees over 45 years of age. The purpose of the survey is to identify issues that affect employees' decisions about resigning or retiring so that future policy in this area can be strongly informed by a practical knowledge of employee needs.

The results of the survey will:

- inform workforce planning strategies within the NSW public sector, particularly those relating to the retention of older employees
- provide confirmation or otherwise of the importance of superannuation and phased retirement arrangements in the resignation and retirement decisions of public sector employees over the age of 45 years
- supplement information from workforce projections projects and the agency surveys in developing a picture of the future public sector workforce and in identifying labour supply issues
- inform estimates of the cost impacts of retiring employees
- highlight areas for further research and policy development.

Other strategies to increase participation rates of those over 55 years will involve changes to health management, workplace reform and changes to taxation and superannuation policies.

Some of the nurses recruited through *Nursing Re-connect* have come out of retirement and have been successfully re-connected. Approximately 15% of re-connected nurses have been out of the nursing workforce for over 15 years. These nurses bring a wealth of personal maturity and experience.

[64] *Economic Implications of an Ageing Australia,(2005) Productivity Commission*

4.4 Broader Reform

At the CoAG meeting held on 3 June 2005 a number of health reform areas were identified to improve integration across the health system to better meet the needs of the community. Further, it was agreed that improvements to the health system could be made through clarifying health professional roles and responsibilities.

The health workforce is crucial to the success of these health care reforms. Reorientation of current health services is needed to effectively address the projected burden of illness in future years. In order to achieve this, we need:

- Appropriately organised delivery systems linked with corresponding community resources and supported by appropriate infrastructure.

- The ability to work across the disease continuum from primary prevention through assessment, management and palliative care in a comprehensive way.

- To improve the integration of services across chronic diseases and across multiple service providers and settings and thereby also facilitating multidisciplinary care.

- An increased focus on community or home based services and the strengthening of partnerships between community, primary health care providers, including general practitioners, community care service providers (supporting people with a disability and older people to remain living at home), and the acute sector which would also facilitate multidisciplinary care and prevent unnecessary use of acute care resources.

- Models of care that support health service integration.

- Optimal utilisation of all resources both in the health and other systems (including the disability and community care sectors) and in the community to facilitate the provision of health services which are more effective and efficient and deliver services in the community as close as possible to where people live.

To reorient systems to enable effective health care delivery changes are required in roles of health service staff. This can include the roles of nurse practitioners, the role of allied health professions, the role of practice nurses, the roles of staff outside of the health system, such as exercise physiologists Home and Community Care workers, disability workers, and staff employed by local councils. It may involve incorporating “behavioural change” skills for community based health workers to assist patients with chronic disease adopt self-management approaches.

Summary
Changes are required to enable the systems that produce and regulate the health workforce to become self-adjusting, flexible and responsive to external influences, while providing a workforce that operates as a team in delivering the quality care expected by the community.

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6. Appendices

1. Examples of current rural workforce initiatives being undertaken by the NSW Department of Health

2. NSW Government Workforce Action Plans

Appendix 1

Examples of current Rural Workforce Initiatives being undertaken by the NSW Department of Health

Initiatives	Outputs	Future Directions
STATEWIDE INITIATIVES		
NSW Rural Clinician Locum Program The program provides additional funding for the provision of locum services to enable medical and nursing staff and allied health practitioners to undertake continuing and professional education and provides for reasonable leave provisions. $3 million is available each year in addition to that provided by AHSs	Funding in 2004/05 was allocated for the commencement of a two-year Obstetrics & Gynaecology Rural Relief Project administered by Royal Women's Hospital, Randwick, a Locum RN Replacement for Remote ED RNs managed by former Far West; Rural Dental Officers Locum Program managed by Justice Health and ongoing support for the Rural Paediatric Program managed by Sydney Children's Hospital. Residual funds of just over $2 million were allocated on an equal share basis between rural AHSs, with the rural sectors within Hunter and Illawarra receiving a share of the funds.	Additional models of locum service delivery which will improve sustainability of locum services are also being investigated. With the restructure of the new AHSs the rural Executive Officers have been encouraged to develop initiatives on a network basis.
NSW Institute of Rural Clinical Services and Teaching The Institute was formally established in 2004. Dr Hugh Burke was appointed as the Executive Director in 2005.	Increased recognition of, and support for, rural health professionals. The Institute aims to: • **Promote Excellence:** Identify and share good practice in rural health service delivery. • **Networking:** Assist the development of networks between rural health staff and service within and between AHSs. • **Information:** Act as a source of information for rural and remote stakeholders on rural health workforce and service issues. • **Fundholder/Facilitator:** Use its funds to create incentives for organisations to respond to perceived gaps in rural health service delivery. • **Advocacy:** Provide a voice for rural health services and the rural health workforce, the issues they face and strategies to address those issues and facilitate dialogue between professional groups involved in rural health.	Strategic plan currently being developed for the Institute
The Centre for Rural and Remote Mental Health (CRRMH) The centre is a major rural initiative of The University of Newcastle, Faculty of Health and NSW Health Department. CRRMH aims to bring quality education and research program to rural areas of NSW.	Education program on mental health issues including online forums, presentations via videoconferencing. Provided a refresher program for Rural Psychiatrists. Registrar training. Support existing mental health workforce.	Continue education and research programs.

Initiatives	Outputs	Future Directions
a) Aboriginal Health Workforce		
Aboriginal Workforce Development Strategic Plan The plan aims to address key workforce issues for Aboriginal employees.	Provision of professional and culturally appropriate health services to Aboriginal communities within NSW.	The Aboriginal Workforce Development Strategic Plan to be aligned with the Workforce Action Plan to streamline reporting required by AHSs.
Aboriginal representation across the health system NSW Health has set a target of 2% representation of Aboriginal people dispersed across all disciplines within NSW Health.	Areas Managers of Aboriginal Health established in each AHS and a generic position description developed.	Further work identifying positions in AHSs crucial to Aboriginal Health.
Zero Tolerance Policy NSW Health's Zero Tolerance Policy is a hard line campaign to tackle the number of assaults and episodes of threatened violence against staff, particularly nurses, working in the public health system. The NSW Government spent $7.5 million on physical improvements in hospitals with closed circuit TVs installed and duress alarms provided to staff, while lighting and car park security were improved. Another $5 million went towards increasing hospital security staff, particularly in emergency departments. Policies and training have been updated to make sure staff know how to handle difficult situations.	A program is underway to inform Aboriginal staff regarding workplace violence has commenced including A culturally appropriate Zero Tolerance brochure to be distributed to AHSs statewide. The brochure will provide, in a culturally appropriate manner, information to clarify the rights and responsibilities of Aboriginal health staff in relation to workplace bullying and harassment.	Develop culturally appropriate Zero Tolerance posters.
Professional development of Aboriginal employees in NSW Health system. Commencement of skills development plans in the former South Eastern Sydney Area.	Appropriate professional development and access to career opportunities for Aboriginal staff members including Aboriginal Employment Coordinators, which provide broad management skills and policy perspectives necessary to effectively perform their role.	Develop and implement an individualised, funded, skills development plan for each AEC and Aboriginal staff member (as per NSW Aboriginal Health Strategic Plan Supportive Strategy) including strategies for maintenance of professional skills (eg: nursing).
Aboriginal Health Worker (AHW) State Conference The State AHW Conference to be developed in partnership with AHW Forum and the community controlled sector.	Dissemination of information and professional development of AHW statewide and forum to discuss and provide responses to key recommendations for the National Conference. Currently negotiating funding allocations and identifying roles of key stakeholders.	Coordinate a State Conference every three years in line with the AHW National Conference.
Advanced Surgical Training Posts in Rural Areas Program Funding has been provided from the Department of Health and Ageing for training positions to posts at Albury, Coffs Harbour, Dubbo, Goulburn, Lismore, Maitland, Orange, Tamworth and Tweed Valley.	Improved recruitment and retention of rural specialists. Opportunities for increased exposure of advanced trainee specialists to rural practice.	

Initiatives	Outputs	Future Directions
b) Allied Health		
Chair in Rural Pharmacy at Charles Sturt University NSW Health is providing funding of $842,000 over five years for the position	Professorial position established which will provide support to pharmacists working for NSW Health and develop models of pharmacy service delivery for rural and remote Areas	Position established in February 2005 – reports on the position and outcomes achieved to be provided after three and five years.
Rural Allied Health Scholarships Undergraduate Scholarships Scholarships valued at $5,750 are available for students from a rural background undertaking allied health studies	Increased number of rural students undertaking allied health studies Thirty-one scholarships were awarded in 2004.	Revisions to the scholarship program including expansion of the eligible professions.
Rural Clinical Placement Grants Grants provide financial assistance for both rural and urban students undertaking their clinical placements in rural areas as part of the allied health course.	Exposure of undergraduates to rural clinical practice 144 grants were awarded in 2004	Continuation of the program.
Rural Postgraduate Scholarships Scholarships valued at $2,000 are available to rural allied health professionals undertaking further study	Six scholarships have been offered in 2004.	Continuation of the program
NSW Rural Allied Health Conference Biennial conference which provides opportunities for rural allied health staff to present about the work they are doing.	Promotion of rural based innovative models of service delivery.	The 2nd NSW Rural Allied Health Conference to held on 28 – 29 October 2005.
Rights Of Private Practice For Allied Health Professionals Some hospitals in rural communities do not have enough demand to employ fulltime allied health staff. The Plan announced that allied health professionals employed in the public sector would also be able to see patients privately.	Flexibility for rural allied health professionals to undertake additional work so that they have full-time employment. Circular issued regarding rights of private practice.	Further promotion of this opportunity.
Computers for Allied Health Funding allocated for the purchase of computers for allied health professionals in small communities.	Improved access to clinical resources	Allocation of further funding for computers.
Conference Sponsorship Program Funding is provided to AHSs to support staff to attend rural health conferences.	Aboriginal and allied health staff received additional funding to attend Conferences. 14 were sponsored to the Services for Australian Rural and Remote Allied Health Conference in 2004 and 18 sponsored to attend the National Rural Health Conference in 2005.	Continuation of program
c) Medical Practitioners		
Area of Need Program This strategy enables the recruitment of suitably qualified overseas trained doctors into declared Area of Need positions on a temporary basis whilst efforts continue to attract medical practitioners on a more permanent basis.	Recruitment of medical practitioners to rural NSW. As at March 2005 there were 213 medical practitioners working in Area of Need positions in rural and regional areas of NSW. Includes specialists, hospital non-specialists and GPs.	Program will continue to address medical workforce shortages in NSW.

Initiatives	Outputs	Future Directions
NSW Rural Medical Undergraduates Initiatives Program Provides financial and other support to medical students undertaking rural placements, including rural high school program activities where funding permits.	Exposure of rural undergraduates to rural practice. Scheme administered by the Rural Doctors' Network (RDN) on behalf of NSW Health	Continue program
NSW Rural Resident Medical Officer Cadetship Program Financial support to selected medical students in their final two years of study who commit to completing two of their first three postgraduate years in a NSW Rural Allocation Centre.	Recruitment of medical practitioners to rural NSW Scheme administered by NSW RDN on behalf of NSW Health.	Continue program
Scholarships for GPs Funding of $180,000 was given to NSW RDN by NSW Health in 2002/03 to co-ordinate a scholarship program for GPs to pursue an alternative pathway to Fellowship of the Royal Australian College of General Practitioners, offered through the National Consortium for Education in Primary Medical Care.	Five fully registered GP's working in RRMA 3-7 locations and five conditionally registered GP's working in rural general practice area of need positions in NSW were initially awarded scholarships. As at June 2004, three fully registered and three conditionally registered GP's remain in the program. All students have until mid 2005 to complete their study towards a Graduate Certificate in General Practice.	A final report is due from the NSW RDN in September 2005.
d) Nursing		
Aboriginal Nursing Initiatives A promotional video and an interactive CD ROM, "Nursing, A Way of Life" has been distributed to all high schools in NSW.	Increased number of Aboriginal people interested in perusing a nursing career.	Continuation of Aboriginal Nursing Initiatives.
Aboriginal Cadetship Program This three year program will support students, provide employment during semester breaks and guarantee a registered nurse position on successful completion of the Bachelor of Nursing course.	Increased number of Aboriginal people undertaking nursing studies. 34 applications have been received for the cadetship.	Continuation of Aboriginal Nursing Initiatives.
Aboriginal Enrolled Nurse Program A contract has been signed with the Department of Employment and Workplace Relations for 32 Aboriginal Trainee Enrolled Nurse positions.	Increased number of Aboriginal people undertaking Enrolled Nurse Training. AHS have submitted possible placements for these positions. Discussions are underway to develop a nursing specific career pathway with the Aboriginal Programs Unit TAFE NSW.	Continuation of Aboriginal Nursing Initiatives.
Aboriginal Undergraduate Scholarships Scholarships of up to $10,000 are available to Aboriginal and Torres Strait Islander students for each year of their Bachelor of Nursing Degree.	Increased number of Aboriginal people undertaking nursing studies. In 2005, 38 scholarships have been awarded at a cost of more than $365,000.	Continuation of Aboriginal Nursing Initiatives.
Rural Nursing Scholarships Scholarships of up $5,000 are available to first year students of a Bachelor of Nursing degree who are from rural NSW.	Increased number of students from a rural background undertaking nursing studies. In 2005, 105 Rural Undergraduate scholarships to the value of $407,500 have been awarded.	Continuation of the nursing scholarship program

Initiatives	Outputs	Future Directions
Nursing Clinical Placement grants Grants provide financial assistance to rural and urban undergraduate nursing students undertaking rural clinical placements. Grants are also available to nursing students at rural NSW universities who undertake clinical placements at metropolitan locations.	Metropolitan nursing students exposed to rural practice. In 2004 Rural placement grants were provided to 660 students at a cost of $236,350. In addition, metropolitan placement grants were provided to 131 rural students totalling $53,650,	
Postgraduate scholarships Scholarships are available to registered nurses employed in the NSW public health system who meet selected criteria. These scholarships provide financial assistance towards education/study costs directly associated with the nursing course being studied and aim to improve the recruitment and retention of nurses across NSW.	Over $173,600 was provided in 2004 to postgraduate scholarships to 97 rural applicants, which is an increase of $115,600 from the previous year.	Continuation of the nursing scholarship program
Nursing Re-Connect The program was launched in January 2002 for nurses who have been out of the workforce for some time. The scheme is clinically focused and individually tailored to meet the needs of the nurse. The nurses are supported in the clinical area and employed from day one while they refresh their clinical skills. It covers general and specialty areas and is available full time and part time.	Nursing Re-Connect has been successful in attracting nearly 355 nurses back to work in rural areas. A Mental Health Nursing Re-Connect was launched in April 2005. The mental health nurse recruitment strategy includes orientation programs; scholarships for further study; flexible rostering, mentoring, clinical skills updates and professional development. Nurses will be recruited to available positions from the following categories: *Mental Health Nurse ReConnect* - for registered and enrolled nurses who are either general or mental health trained and who wish to return to the workforce *Enrolled nurses* wishing to upgrade their qualifications to a registered nurse, linked to employment in mental health services; *Registered nurses* working in other clinical areas and seeking a career change; and *Existing mental health nurses* who wish to seek further career development.	Continuation of the Nursing Re-Connect scheme and target recruitment of specialist nurses.
ORAL HEALTH		
Rural clinical placements for final year dental students Students from the Faculty of Dentistry, University of Sydney and the University of Adelaide placed in public dental clinics in rural Areas.	• A better education for students by exposing them to the world outside the Dental School. • Opportunities for local clinicians to extend their role to mentoring. • Increase in number of dentist practising in rural communities. • Better use of rural educational facilities.	Extension of University of Sydney clinical placements from two to eight weeks to provide a richer experience of rural life and the possibility of completing a course of care for patients. Scheme to be piloted in Greater Western AHS

Initiatives	Outputs	Future Directions
Chair in Population Oral Health, Faculty of Dentistry, University of Sydney NSW Health will provide $250,000 a year for the position for a five year period initially.	Professorial position to be established to promote and enhance population health approaches to oral health. Remote and Rural Oral Health initiative to be developed.	Recruitment will take place in second half of 2005. Co-location with the Centre for Oral Health Strategy being explored to ensure better collaboration and the development of a related population oral health research strategy.
EXAMPLES OF LOCAL INIATIVES		
Outback Nursing Certificate The certificate is available to nurses in remote settings in far west NSW. The course is offered through Nth Qld Rural Health Training Unit. *Greater Western AHS*	Formal recognition of skills required for staff working in remote environment.	Collaboration with University Department of Rural Health (Broken Hill) for local training.
The Centre for Remote Health Research *Greater Western AHS*	AHS staff gaining experience in research and evaluation working alongside professional researchers	Opportunities for primary care staff to gain research and evaluation experience working in Centre on project-basis
'Adopt a Doc' program for social integration of medical staff *Greater Western AHS*	Increased support for medical staff moving to rural communities.	Strengthen partnerships with Universities
Vocational Education and Training (VET) program The program aims to ensure minimum quality work standards in all vocations and professions. *Greater Southern AHS*	Approximately 50 staff are currently enrolled in traineeships in fields such as hotel services, sterilising, health service support, medical administration and cleaning services.	This project has just commenced – the intention is to expand the initiative across the Area
Centralised student clinical placement process *Greater Southern AHS*	Student clinical placement policy and procedures developed, data on placement types collected and mapped, negotiations commencing with universities to improve partnership arrangements, staff receiving training in being a placement supervisor.	Currently expanding this program across the amalgamated health service.
Population Health Aboriginal Cadetship *South Eastern Illawarra*	Aboriginal Graduates skilled in better practice population health. Project proposal has been developed.	Finalise and implement project proposal
Aboriginal Workforce Development *Greater Western AHS*	Development of Aboriginal & Torres Strait Islander Health Worker course with TAFE.	Evaluate and expand education opportunities, to increase Aboriginal Workforce.
POPULATION HEALTH		
NSW Public Health Officer Training Program Rural placement	All trainees must complete a 6 month rural placement.	Problem-based learning exercise in remote public health practice developed with the University of Sydney Department of Rural Health, Broken Hill Campus.
Bug Breakfast Videoconferenced to rural sites	A 1 hour communicable disease training is videoconferenced through NSW Health Telehealth facilities to up to 16 sites across NSW each month.	Evaluated to improve quality of access. A website has been developed.

Appendix 2

NSW Government Workforce Action Plans

The paper reflects action required to implement the National and State Health Workforce Framework and Action Plan. The Plan highlights actions required now, and in the future, to overcome health workforce shortages. Longer term initiatives to address current supply and distribution include changes to traditional work practices, exploring new models of care, developing different skill mixes and enhancing collaboration between health, education and training sectors.

The *NSW Government Workforce Action Plan: Securing Our Health Workforce* (Appendix was released in March 2005, drawing on the seven National Health Workforce Strategic Framework principles adopted by State and Federal Health Ministers and the strategies agreed at the Premiers Workforce Roundtable.

The *NSW Health Workforce Action Plan* was developed in 2004, and announced by the Minister in April 2005. It provides a framework underpinning the *NSW Government Workforce Action Plan* and it also translates the National Health Workforce Strategic Framework principles into action at a State level.

1. Achieve self sufficiency in workforce **supply** in Australia
2. Ensure workforce **distribution** matches community need
3. Become the industry and **employer** of choice
4. Develop innovative approaches to health **education** and training
5. Develop flexible approaches to the way **care** is delivered
6. Employ best practice in workforce **assessment** and planning
7. Work **collaboratively** at state and national levels to make it happen

The Plan includes actions to address supply and distribution, recruitment and retention, new models of care, flexible service delivery, skill mixes, multidisciplinary education and training and development of new roles, employment of best practice in workforce assessment and planning, flexible career pathways and improvement of collaboration between and across health, education, training and regulatory sectors.

7. Case Studies

1. Ambulance Service of New South Wales – A proactive approach to reducing the structural disconnect between health and education

2. Indigenous Nursing - 'getting em n keeping em'

3. Using information technology to support rural health professionals

4. The NSW Institute of Rural Clinical Services and Teaching

5. Psychiatry Training in NSW

6. Linking service needs and workforce planning

7. Multidisciplinary Cancer Team Meetings

CASE STUDY ONE

Ambulance Service of New South Wales – A proactive approach to reducing the structural disconnect between health and education

Traditionally, ambulance officers have been trained by the NSW Ambulance Service. However, over the last ten years, there has been a move to tertiary education for pre-hospital ambulance training programs.

Charles Sturt University has been the provider of the Pre-Hospital Care undergraduate program in NSW. While there has been consultation and cooperation between the University and the Ambulance Service of NSW, two key issues have been raised which needed to be addressed:

- the formal recognition by the Service of academically qualified graduates to operate as competent base-level paramedics, and
- the incorporation of the Ambulance Service's medical and psychometric testing as a pre-requisite for course entry and clinical placements.

Cooperative decision making models which assist the University, its students and the Service were identified and a Memorandum of Understanding (MOU) has recently been agreed between the University and the Ambulance Service to address these issues.

The MOU's broad strategic initiatives include:

- Meeting the educational needs of industry and students
- Establishing joint research Initiatives
- The establishment of a Centre for Pre-hospital Care, Health Services Management and Emergency Management
- Mutual valuing of staff
- Assignment of key liaison staff, and
- Investigating Employer Reserved Places for course placements.

The signing of the MOU demonstrates a positive approach to bridging the disconnect between health and education.

CASE STUDY TWO

Indigenous Nursing - 'getting em n keeping em'

In September 2002 a report called 'getting em n keeping em' was developed by the NSW Indigenous Nursing Education Working Group to develop strategies to increase the number of Indigenous nurses and improve the competency of the Australian nursing workforce to deliver appropriate care to Indigenous people.

Some of the recommendations included:

1. Each university to allocate specific places for Aboriginal nursing students and provide HECS scholarships.
2. Increase the number of non-bonded scholarships to reach three fold increase above participation rates in 2002.
3. Universities to provide information sessions and residential workshops to introduce Aboriginal people into university life.
4. Provide Aboriginal Health Workers (AHW) articulation pathways into nursing.
5. At a local level develop partnerships between Aboriginal communities and schools of nursing.
6. Facilitate the availability of culturally safe housing for Aboriginal students away from home though partnerships need to be developed with Aboriginal Hostels Limited, employers and tertiary institutions.

CASE STUDY THREE

Using information technology to support rural health professionals

The NSW Telehealth Initiative is a state-wide network covering 240 facilities that supports 25 clinical services. Telehealth is the transmission of images, voice and data between two or more health units via telecommunications channels, to provide clinical advice, consultation, education and training services.

The Broken Hill Health Service utilises the NSW Telehealth program to assist in managing older people with complex needs. In the absence of specialist staff onsite, staff at the Health Service have access to a Geriatrician in Sydney to discuss any patients in need of a specific diagnosis and/or development of a specific management plan.

The Geriatrician consults with staff every fortnight for two hours using the Telehealth program. These consultations address the needs of the patients and also have an educative function for staff managing older, complex clients. Staff in Broken Hill report high satisfaction levels with the program and acknowledge an enhanced level of skill in their work through the education component of the Telehealth link.

CASE STUDY FOUR

The NSW Institute of Rural Clinical Services and Teaching

In February 2004 the NSW Department of Health established the NSW Institute of Rural Clinical Services and Teaching ("the Institute") to assist in attracting, retaining and supporting health staff in rural and remote NSW. The role of the Institute is to contribute to an effective and equitable rural health service by driving the agenda for attracting and sustaining a cohesive rural health workforce and supporting staff to improve rural health practice and service delivery.

The Institute has five key functions:

Promote Excellence
In undertaking this function, the Institute will play a key role in the identification and sharing of good practice.

Networking
In undertaking this function, the Institute will play a key role in the development of intra and inter Area networks between rural health staff and rural Area Health Services.

Information
The Institute should be a source of information for rural and remote stakeholders on health workforce issues.

Fundholder/ Facilitator
The Institute has been allocated a recurrent budget from the NSW Department of Health under the NSW Rural Health Plan.

Advocacy
In undertaking this function, the Institute will become a voice for rural health services and the rural health workforce, the issues they face and strategies to address those issues.

CASE STUDY FIVE

Psychiatry training in NSW[65]

During 2005, at the request of the NSW Minister for Health, the Medical Training and Education Council (MTEC) conducted a review into the delivery of psychiatry training. The review recommended establishing five training networks in NSW (to replace the eight training zones) to ensure that trainees are able to gain a full breadth of experience and fulfil all RANZCP training requirements within one network. Networks have been aligned with Area Health Service boundaries with the inclusion of rural areas.

Structures to support training

- Several structures have been recommended to support the delivery of basic, advanced and rural training. These include;
- Local committees to monitor and support the role of the Network Director of Training
- Funded Site Coordinators of Training
- State Directors of Advanced Training in each of the seven sub-specialties
- Innovation fund to support the development of network education programs
- Recognition of the importance of the NSW State Director of Rural Training (established as part of the Rural Psychiatry Project) Incentives developed to encourage training in rural areas.
- Trainee representation is included within all the new local and state structures

Enhanced Training Experience

The Principles also address the breadth of the training experience both at a local and state level. An important innovation will be the Psychotherapy Educators (psychiatrists or clinical psychologists) for each network to provide insight and education to trainees in relation to their general understanding of psychological issues across their caseload (in keeping with international practice in psychiatry training).

The recommendations also support the acquisition of psychotherapy case supervision where necessary as this has been a major problem for trainees. The local committees and Directors of Training will review and manage access to adequate resources to facilitate the delivery of training, for example by use of video-conferencing to support rural training.

Removal of Administrative Tasks

Two major issues identified by trainees, the removal of bed searching duties for trainees, particularly out of hours, and the revision of certain modules of the Mental Health Outcomes and Assessment Tool forms (MHOAT), will be addressed through implementation of these Principles.

[65] *Medical Training and Education Council of NSW, 2005, Psychiatry Training in NSW – Principles for the delivery of the Psychiatry Training Program in NSW, MTEC, viewed 2 August 2005, <http://www.mtec.nsw.gov.au/page/review_of_psychiatry_training.html>*

Better Education and Training Support

Another educational focus of the recommendations is the development of a training framework to ensure that all psychiatry trainees and other relevant health professionals receive orientation in their first year of training/employment and ongoing development relating to aspects of their role such as: risk assessment, working with the Mental Health Act, pharmacotherapy, NSW Mental Health administration structures and mental health assessment.

In liaison with the Centre for Mental Health a review of the cost, content and modes of delivery of the NSW Institute of Psychiatry formal education program and psychiatry fellowship programs in NSW will be undertaken.

The recommendations resulting from this review were endorsed by the Minister on 29 July 2005 for implementation for the 2006 clinical year.

CASE STUDY SIX

Linking service needs and workforce planning

Evidence suggests that at least 50% of patients diagnosed with cancer should have access to radiotherapy. One of the major reasons in NSW that this standard was not met was due to inadequate numbers of radiation therapists.

The Australian Government has funded a number of initiatives which have been implemented nationally to enhance radiation therapy workforce numbers and distribution. These initiatives include:

1. Radiation Therapist Distance Education Return to Work Program, as a means of getting those radiation therapists who have been out of the professional workforce for a number of years, back into the workforce.

2. Radiation Therapist Tutors: one in each NSW Radiation Oncology Treatment Centre (ROTC) to coordinate training & assessment of student radiation therapist placements, graduates radiation therapists undertaking their professional development year, liaising with Universities for clinical placement coordination and assist in ongoing education of ROTC staff.

3. Recruitment Program for Overseas and Australian Trained Radiation Therapists: to increase radiation therapists workforce numbers by providing financial assistance for appropriate overseas-trained and Australian trained radiation therapists returning home, who accept employment at NSW ROTC.

4. Funding more Professional Development Years at NSW ROTCs in 2005 – an increase of 24 positions over those funded by local resources.

While funding for these programs ceases by 2006-07, the ideal position is that sufficient radiation therapists continue to be available to meet service needs.

CASE STUDY SEVEN

Multidisciplinary Cancer Team Meetings

Multidisciplinary cancer teams typically include pathologists, radiologists, surgeons, medical oncologists, radiation oncologists, general practitioners and specialist nurses. Other allied health and palliative care team members may also participate. Clinicians may attend multidisciplinary meetings where several patients are discussed, only one of whom may be their patient.

Multidisciplinary meetings or case conferences typically discuss six to ten patients within an hour meeting. To access funding for their attendance, the physician is required to discuss, for at least 15 minutes, the patient for whom they will claim an MBS item. The time spent in discussion is dependent on several factors including the complexity of the patient and the stage in the treatment pathway and may range from five minutes for uncomplicated cases to 30 minutes for those that are more complex. While recognising the need for checks and balances, specifying of a minimum time limit is not consistent with the principles of outcome funding or flexible funding. (Historically the item descriptors that were developed with the relevant professional bodies states that the conference time to discuss the patient is in three time blocks:

1) At least 15 minutes but less than 30 minutes;
2) At least 30 minutes but less than 45 minutes;
3) At least 45 minutes.)

There is evidence that best practice care for patients is more likely to occur in multidisciplinary team meetings or case conferences than with the sequential model of care. It appears that decisions made in isolation may be based upon established practice and are likely to be different to those made among peers. Salaried staff in public hospitals participate in peer discussion and review for patients who have and have not been referred to them. General practitioners, consultant physicians and psychiatrists can only be funded, for peer discussion and review, through MBS and EPC items where the patients have been referred to them.

With regard to consultant physician case conference item, if more than one physician is in attendance, each physician can claim for the case conference item as long as they are from a different discipline (e.g. a benefit would be payable to a renal physician, geriatrician and a medical oncologist who attended to discuss a patient). However, two medical oncologists attending the same meeting cannot both claim a benefit.

CASE STUDY EIGHT

Royal Australasian College of Surgeons (RACS)

In June 2003, the Australian Competition and Consumer Commission granted the Royal Australasian College of Surgeons an Authorisation to continue as the sole provider of surgical training subject to certain conditions. One of these conditions, Condition 12, imposed an obligation on the College to seek and take account of the views of Health Ministers prior to determining numbers of first year trainee surgeons for Australia.

During 2004, NSW had 65 first year trainee surgeons in hospitals around the State. For 2005, NSW identified a requirement for 82 first year trainee surgeons. After prolonged negotiations and the injection by NSW of a significant grant to support the expansion of skills courses provided by the College, the College agreed to 79 first year trainee surgeons for NSW. At the same time the College determined a quota for Australia of 220 first year surgical trainees.

In 2005, states and territories undertook detailed modelling of the surgical workforce requirements. This work informed Health Chief Executives in agreeing that a minimum of 259 first year trainee surgeons was required in 2006 to meet the future need for surgeons in Australia.

Despite consultation during the modelling process and receiving formal advice from the Australian Health Workforce Officials Committee (AHWOC) of these requirements, the College has maintained its quota at 220 first year trainee surgeons for Australia – a shortfall of 39 potential surgeons from that needed by the States and Territories.

In August 2005, the College undertook selection of first year trainee surgeons. It is understood that from 272 Australian-resident applicants (80 from NSW) considered eligible to undertake surgical training, the College has determined that only 221 doctors, of whom 63 are NSW residents, can access its surgical training program in 2006.

The College has also determined at short notice that it will no longer allocate the 220 trainees to any particular State based on equity of distribution, leaving it to trainees to be recruited by individual hospitals.

The end result of this may be that NSW is only able to recruit its 63 residents with a further 17 NSW resident doctors unable to access training in their home or any other state and, doctors from other States choosing not to relocate.

Continuation of this system of determination of numbers and selection appears to create a serious disconnect between what communities need now and in the future and what professional Colleges allow.