Submission to the Productivity Commission Health Workforce Study

Department of Health Western Australia

Department of **Health**
Government of **Western Australia**

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Appendices

The Department of Health has developed this submission to the Productivity Commission's Health Workforce Study on behalf of the Western Australian Government.

Current health service reforms being progressed in Western Australia depend upon a sustainable, responsive and innovative workforce. Health workforce initiatives form a vital part in ensuring health system sustainability in Western Australia. The Productivity Commission's Health Workforce Study is therefore of key interest and importance.

This submission addresses the key health workforce issues of supply, distribution and skills in the context of health service delivery and reform in Western Australia. In each of these areas, the submission identifies the issues and barriers to improving outcomes and proposes actions that may warrant consideration. The submission identifies where levers for change exist at a State level and where such levers are outside the control of the Western Australian Government. The Health Department is prepared to respond further on any of the points raised within the submission.

Whilst it is clear that many potential initiatives exist at the State level, and throughout the current reform process in Western Australia these are being actively progressed, it is apparent that greater jurisdictional and federal coordination and collaboration is required to ensure system sustainability.

It is clearly of vital importance that all jurisdictions in Australia work together in an open and accountable way to understand and address the very real systemic barriers involved in the matters being considered by the Productivity Commission.

I look forward to the Productivity's Commission's final recommendations.

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Executive Summary

Consistent with trends throughout Australia, current and emerging workforce pressures pose a serious risk to sustainable health care delivery in Western Australia. As outlined in the Productivity Commission's Issues Paper, these pressures are multi-faceted, interrelated and systemic. Reconfiguration of the funding, policy, education/training and regulatory systems for, and of, health workforce is required. Health workforce sustainability must be the central driver. The challenges in doing this cannot be overestimated. The Western Australian Department of Health believes that the approach should encompass:

Sustainable Health Service delivery

- There needs to be a sustained effort by health policy makers at all levels of Australian Government to better manage the demand for health services into the future.

Stakeholder Collaboration

- The stakeholders in health care need to build consensus on the measures necessary for achieving both sustainable health services and a sustainable health workforce.
- On-going commitment to the development and utilisation of effective cross-sectoral collaborative mechanisms needs to be demonstrated with processes for regular evaluation to ensure system sustainability.

Education and Training

- The funding models applied to health workforce skill development require review.
- More effective interfaces between the education/training and health sectors need to be established, ensuring flexibility and responsiveness.
- The aims and objectives of key stakeholders in health workforce skill development need to be reconciled towards health workforce sustainability.
- Curricula development must reflect and respond to health care delivery requirements and be structured in such a way that 'job ready' additions to health workforce result.
- Health and education/training sectors should develop a stronger collaborative framework to support clinical placements.

- Strategies need to be developed to encourage private health professionals to contribute to the technical training of university graduates.
- The linkages of skill development pathways to the industrial relations platform and as a consequence, career pathways need to be acknowledged and addressed.
- Cross-sectoral linkages between schools, vocational education and training (VET) and higher education need to be improved.

Sustainable Rural and Remote Health Delivery

- The potential for integrating community doctor funding and services with hospital and health services needs to be explored by health jurisdictions. Appropriate streaming of funding for alternative health services tailored to meeting community health needs, based on levels expected if the community had adequate GP services, require development.
- More flexible arrangements to allow billing against the Medicare Benefits Schedule for GP-type services delivered by public hospitals are required.
- The introduction of blended payment arrangements under Medicare for rural areas rather than exclusive fee for service should be considered.
- Encouragement of the formation of group practices across solo doctor towns to reduce overheads and provide support for individuals is also required. This may include practice management and pharmacy services provided through Divisions of General Practice or through other organisations.
- New approaches to make private health insurance a more feasible option in rural and remote areas need to be explored by the Commonwealth Government.
- Greater collaboration and partnership between stakeholders in rural and remote health service delivery needs to be developed, including greater flexibility in commonwealth program approaches.
- Greater cooperation between jurisdictions is required to facilitate the increase use of technology to provide access to health services in rural and remote areas.
- Approaches to workforce attraction and retention in rural and remote areas need to be broadened including the exploration of the impact of taxation-based levers and remuneration structure on workforce distribution and community development.

Regulatory Structures

- The regulation and accreditation of professional standards needs to be simplified with particular attention given to new models of care and achieving national consistency.
- Regulatory models need to be sufficiently robust to respond effectively to workforce supply and distribution needs.

Workforce Planning

- Greater investment needs to be made in health workforce planning including the development of a better appreciation/measuring tool of the main drivers of health workforce demand.
- Health workforce planning at both a national and state level must be directly linked to health policy development and health care delivery.
- National workforce planning needs to be streamlined and better aligned to national and State health workforce strategic objectives.

Increasing Workforce Responsiveness to Health Care Delivery

- A national approach is required to address the current entrenched compartmentalisation of the health workforce into occupational groups which is reinforced by current regulatory, accreditation, training and industrial relations frameworks.

Health Delivery in Western Australia

Health Delivery Environment

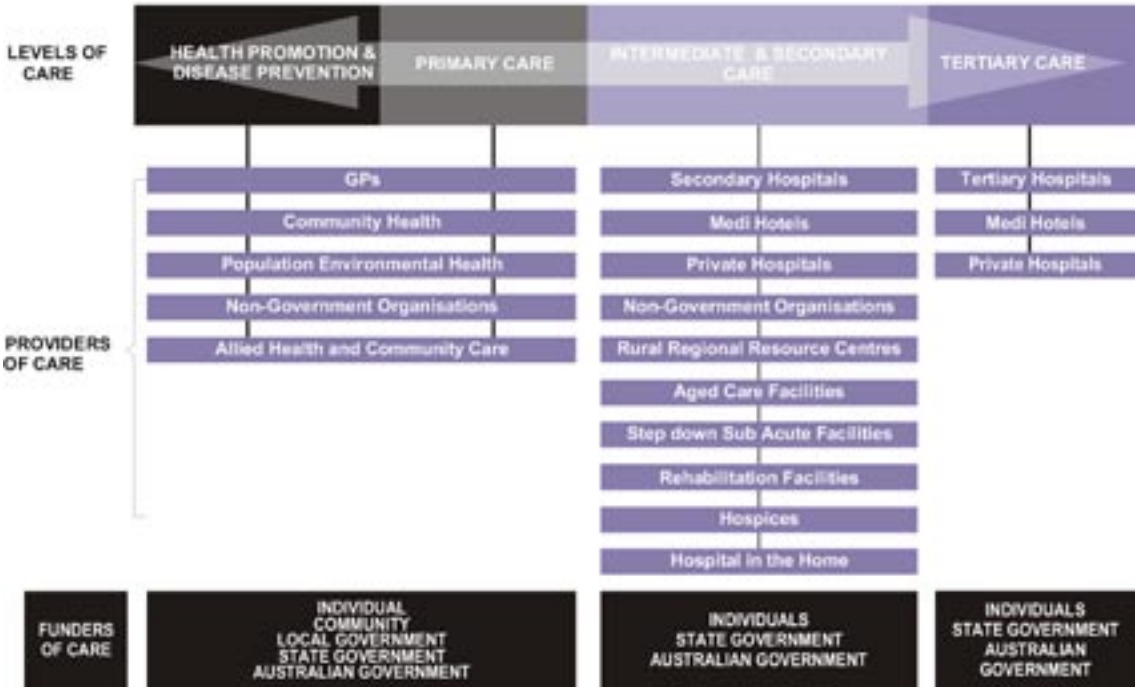
Western Australia covers an area of 2,538,943 square kilometres. In 2005, its total population is estimated to be 2,006,200[1]. The population distribution is heavily skewed to the Perth metropolitan area (estimated 2005 population 1,475,100[2]) and the population in regional and remote areas is highly dispersed. Approximately 500,000 people in Western Australia live in small isolated communities distributed across an area of 2.5 million square kilometres. The state population density is 0.8 people/square kilometre compared to 2.6 for Australia as a whole.

Aboriginal people make up 3.5%[3] of the total population in Western Australia. Of this population, 66%[4] live in rural, remote and isolated areas. The life expectancy of Aboriginal people in Western Australia is 16 years less than for non-Aboriginal people. The death rate for Aboriginal people is almost double that for non-Aboriginal people[5].

Western Australia's population is ageing. 11% of the population are aged 65 years and over. This is expected to double over the next fifty years[6].

The Health System in Western Australia

The following diagram portrays a typical service delivery configuration for health services in Western Australia.



The Western Australian Government provides health services to the Western Australian public through a dynamic system incorporating:

- Five tertiary health campuses.
- Eight public secondary campuses in the metropolitan area.
- Two privately operated hospitals that provide services to public patients under contract from the Department of Health.
- Six regional resource centres.
- Twenty district health services in rural and regional areas.
- Forty-five small health campuses of which a proportion are multi purpose services.
- More than 300 community-based and mental health facilities.
- More than 250 non-government organisations and statutory authorities.

The private sector plays a significant and complementary role in the provision of health services in Western Australia. There are 22 private hospitals in the metropolitan area and two outside. There are 120 private licensed nursing homes throughout Western Australia with more than 6000 beds.

Health System Reform in Western Australia

The health system in Western Australia is undergoing major reform in accordance with the recommendations of the Health Reform Committee (HRC) published in March 2004[7]. The reforms are based on the following underling principles:

Promoting and protecting health

- To give priority to promoting and protecting the health of the people of Western Australia.

Reducing inequities

- To reduce inequities in health status and inequities in access to health care with particular focus on Aboriginal people, people with mental illness and the poor.

Provision of safe, high quality, evidence-based health care

- To provide safe, high quality health care, underpinned by good evidence.
- To pursue a culture of continual improvement.
- To ensure appropriate care is provided in appropriate settings.

A patient centred continuum of care

- To ensure a patient focused, patient friendly health system.
- To enable a patient to move between the different levels of health care in a seamless and easy manner.

Value for money

- To ensure the use of health care resources is based on best value for money and allocated fairly.

Transparency and accountability

- To promote transparency and accountability to the community and to government.
- To promote a culture of "budgetary integrity" as the defining objective in resource use.
- To put in place clear and robust accountability mechanisms and ensure that these accountability mechanisms are adhered to.

Optimal public/private mix

- To ensure complementarity between the public sector and the non-government and private sectors.

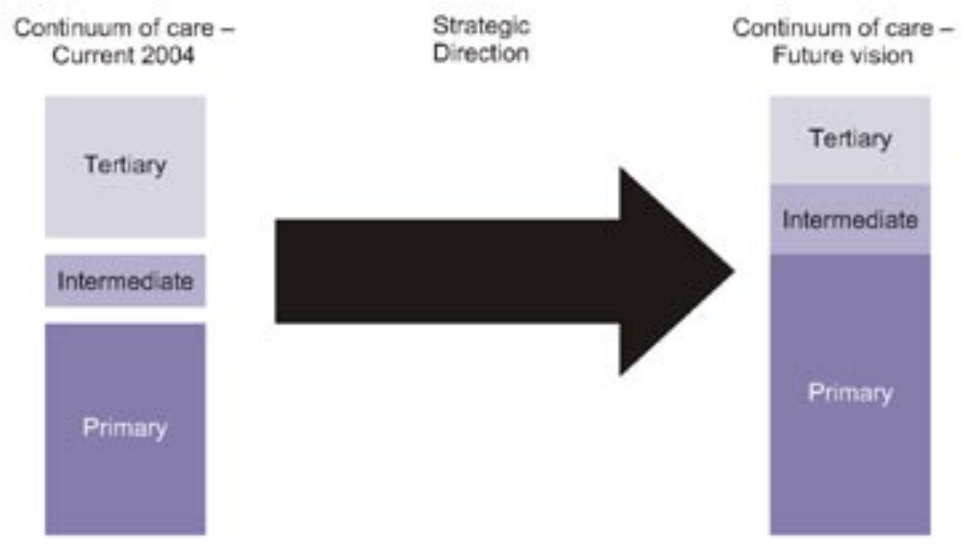
Sustainability

- To ensure that funding and workforce requirements for the Western Australian health system are sustainable into the future.

Overall, Western Australia is working towards a health system that:

- Appears to the patient as a single unified health system, rather than comprising discrete, disconnected entities;
- Increasingly emphasises the importance of health promotion, early intervention and prevention programs; and
- Provides care in the most appropriate setting, particularly through the development of both general and specialist secondary hospitals.

This is presented diagrammatically below.

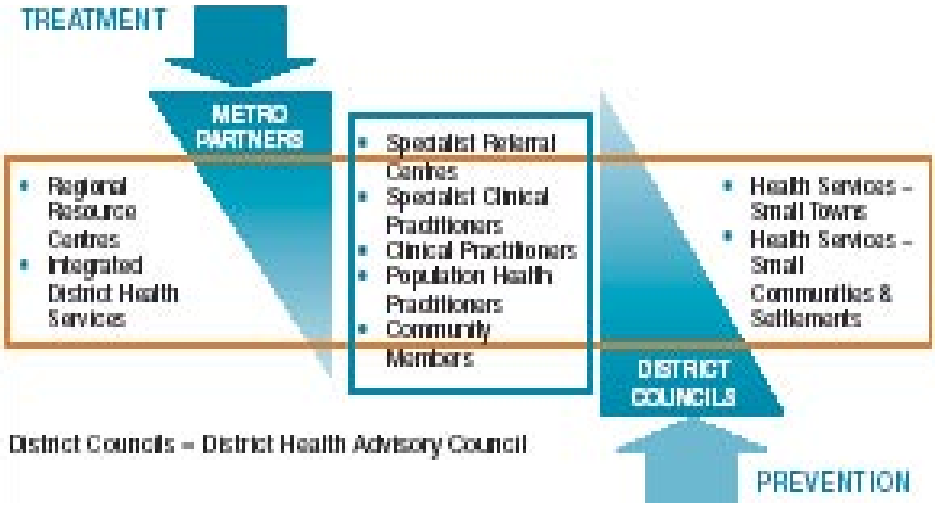


The WA health reform program followed a significant review of health services in Western Australia and this is drawn upon within this submission.

The reform program represents system wide changes in the way health services are delivered in Western Australia including the reconfiguration of the structure and operation of health services in the Perth metropolitan area.

A Clinical Services Plan for the reconfigured metropolitan system is currently near completion. This will describe the model of care needed to deliver quality care at the right time in the appropriate setting and delineate the level of clinical services to be provided at metropolitan hospitals over the next five, ten and fifteen years consistent with the HRC recommendations.

The HRC endorsed the following model for country health service delivery in Western Australia.



The Country Health Services Review, Department of Health, January 2003

All information relating to the Western Australian reform program is contained in “A Healthy Future for Western Australians – Report of the Health Reform Committee March 2004”. This can be accessed on-line at http://www.health.wa.gov.au/HRIT/home/ - Publications

Workforce Supply

Implementation of the health reform agenda to reduce inequities and ensure accessible, sustainable, timely, safe health care in Western Australia is dependent on an adequate and sustainable workforce supply. Western Australia faces the same challenges as other jurisdictions in Australia and most countries around the world in accessing required workforce resources.

Department of Health Workforce Profile

Current Workforce

The following Tables present workforce figures of the Department of Health as at July 2005.

Table 1: Persons Employed by Department of Health By Account Group, Month to Date July 2005

	Occupational Group	Jul-05
Metro	Admin & Clerical	5,360
	Hotel Services	3,220
	Medical	3,012
	Medical Support Services	5,133
	Nursing Services	11,122
	Site Services	362
	Metro Sub Total	**28,209**
Non Metro	Admin & Clerical	1,369
	Hotel Services	2,033
	Medical	198
	Medical Support Services	820
	Nursing Services	3,842
	Other Categories	103
	Site Services	213
	Non Metro Sub Total	**8,578**
	GRAND TOTAL	**36,787**

Note: Persons employed at multiple sites have multiple counts.

Table 2: Department of Health Full Time Equivalent (FTE) (Productive Hours) Workforce by Account Group, Month to Date July 2005

	Occupational Group	Jul-05
Metro	Admin & Clerical	3,742
	Agency Staff (Nursing)	287
	Hotel Services	1,983
	Medical	2,005
	Medical Support Services	3,238
	Nursing Services	6,285
	Site Services	285
	Metro Sub Total	**17,825**
Non Metro	Admin & Clerical	950
	Agency Staff	47
	Hotel Services	1,038
	Medical	126
	Medical Support Services	485
	Nursing Services	1,939
	Other Categories	52
	Site Services	151
	Non Metro Sub Total	**4,789**
	GRAND TOTAL	**22,615**

Note: Productive Hours is ordinary earnings plus overtime.

Key points

- The trend towards part-time employment is shown in the above tables with the number of full time equivalent staff significantly lower than the number of people employed. This is particularly true in the Non Metropolitan areas.
- The reliance on nurses in the Non Metropolitan areas is evidenced in the tables which show they make up the majority of clinical staff.

Future Workforce

Elements impacting on future workforce supply are well known.

Australia is undergoing demographic change by having a slowly growing but ageing population. The key workforce impact of this demographic change is that while the current national workforce grows at an annual rate of around 170,000 per year, by 2020 this is predicted to be just 12,500 per year posing a considerable threat to the future health workforce given other career options.

Currently, in WA the average age of the total health workforce is 44. The average age of nurses is 44, and doctors 45. However, when sessional doctors, who are generally the more senior practitioners, are included in the statistics, the average age rises to 50. As such, significant numbers of health workers will be exiting the system over the next 10 to 15 years.

Average hours worked by health professionals have also continued to fall resulting in the need for more people to deliver services. Health workforce participation rates are changing, most dramatically in the medical workforce, but also across all areas of the health workforce. These workforce participation trends are not simply due to increased female participation. There has been a significant and unexpected decline in the average hours worked per week by male doctors. Female doctors hours have also declined but not by as much and generally in line with expectations. Nursing hours worked has also declined. These changes have meant that in full time equivalent terms the size of the medical and nursing workforce has declined.

Between 1997 and 2002, average hours worked per week by male doctors have fallen by 3.0 hours, from 50.1 hours to 47.7[8]. Over the same period, female doctor average hours worked per week have declined by 2.4 hours, from 39.7 hours to 37.3 hours[9]. Given there are nearly 50,000 medical practitioners registered and working in Australia, if there is a decline by one hour per week, this represents a loss of 50,000 weekly working hours or the equivalent of roughly 1,000 full time doctors, from the Australian health system.

The average hours worked per week by nurses between 1995 and 2001 fell by 1.9 hours from 32.4 hours to 30.5 hours[10].

Importantly, the changing mind set and life style expectancy of the workforce, current and future, has changed significantly. In Western Australia, the Government has sought to address some of the changing expectations through a comprehensive examination of 'family friendly' initiatives in the workplace. Nationally, employers have sought to address the change through the use of 'satisfaction' surveys and the like which consistently indicate that the attractants to entice appropriate workforce capture so much more that money.

It is clear that a fundamental change in the mind set of potential and future workforce has occurred. Though, dealing with that change has – in the main – been left at the employer level. This submission, in part, advocates an examination of the structures and frameworks currently in place that hamper the capacity of employers – and the States – to address the current and emerging perceptions and requirements of the future and potential workforce in a global economy.

To achieve sustainability in workforce supply to enable Western Australia to confidently implement its health service reforms into the future, action needs to be taken in a number of areas. Some of these the Western Australian Department of Health can influence and some fall outside the Department's control.

Demand Management

Sustainable health services can only be achieved where the workforce is sustainable. Whilst outside the remit of the Productivity Commission's Study, the impact of increasing consumer expectations, in particularly as a result of the unprecedented access to information consumers have through the development of internet-technology, and the rapid advancement in the provision of medical services, including technological developments, needs to be acknowledged as a key component in health workforce considerations – and in the management of consumer demand.

The review of health services undertaken in Western Australia concluded that:

- Extraordinary pressures are being placed upon acute care services. Reductions in patient length of stay in hospital over the past decade have counterbalanced the increasing number of admissions, however, it is evident, not just in Western Australia but throughout Australia, that the potential for further major decreases in length of stay as a mechanism for hospital cost containment is limited.
- There will be significant increases in demand for hospital beds in most specialty areas and in demand on emergency departments into the future.
- To fund this growth in the demand for services, the WA Government would need to either significantly increase its revenue base and/or reduce expenditure on other essential services. These options are not sustainable in the long term.

There needs to be a sustained effort by health policy makers at all levels and tiers of Government to better manage the demand for health services into the future. This forms a significant part of the health reform program in Western Australia.

Workforce Policy and Planning

Health workforce policy at a Commonwealth level has a significant impact on health workforce supply and the ability at a State level to deliver health care objectives. This is best demonstrated by recent Commonwealth policy impacting on the supply of the medical workforce.

State governments are responsible for the registration of medical practitioners. In Western Australia, the Medical Board of Western Australia manages this responsibility. However, the Australian Government requires doctors to possess a Medicare provider number if services they provide are to be eligible for a rebate under the Medicare Benefits Schedule (MBS). Until 1996 new medical graduates were automatically able to obtain provider numbers and access the MBS.

In the 1996/97 Commonwealth Budget it was announced that new medical practitioners would need to have post-graduate qualifications in either specialist colleges or general practitioners colleges before being issued with a Medicare provider number. That would apply to doctors first registering on or after 1 November 1996.

The Budget also announced that from 1 November 1997 Temporary Resident Doctors (TRDs) would not be able to access MBS unless they have post-graduate qualifications. Further, arrangements allowing TRDs to practise would be phased out altogether by 1 January 2000. The Commonwealth later announced that (permanent resident) Overseas Trained Doctors (OTDs) would not be able to access MBS for 10 years after entry into Australia.

At the time of the Commonwealth announcements, the situation of rural and remote areas was of considerable concern to Western Australia and other geographically larger States. In those areas there were severe shortages of medical practitioners and a high reliance on OTDs.

The restrictions applied to doctors accessing the Medicare Scheme, along with deliberate policies of various Australian Governments in the early 1990s relating to restrictions on medical school intakes, have led inexorably to a shortage of medical practitioners. These initiatives, introduced with the rationale of curbing Federal Government outlays on medical services and despite objections by the States and Territories, led directly to the problems being experienced by all jurisdictions in Australia in providing adequate medical services to their constituents.

Effective health workforce planning at both a national and state level needs to be directly linked to health policy development and clinical services planning.

At a State level, the Department of Health is using workforce planning to support the delivery of health care in Western Australia. The processes for clinical services planning in the metropolitan area set out above include workforce supply projections. The Clinical Services Plan will ultimately be underpinned by a Health Workforce Plan. A health workforce strategic framework is currently being established to ensure health workforce measures and planning are fully integrated with health care delivery and that better collaboration occurs with the universities, the Vocational Education and Training (VET) sector and the Australian Government.

The Department of Health is also mapping the medical workforce and reviewing Western Australia's medical training capacity. This work will be undertaken in phases and has commenced with the surgical workforce.

Education and Training

The structural frameworks in place to govern the funding and delivery of health workforce skill development provide significant barriers to achieving health workforce sustainability.

Education and training plans which form the platform for college/university funding agreements are established on the basis of Commonwealth/State funding, institutional workforce profile, physical resources (eg location of buildings and equipment), previous delivery outputs and depending upon the sector (i.e. VET or higher education), labour market trends. As a result relatively low areas of employment demand are not adequately catered for in regard to skill development opportunities.

Many of the health occupations fall within what are categorised as "low areas of employment demand" when compared to national market trends (eg radiation therapy and podiatry).

Within WA there are 3.8 public podiatrists per 100,000 population - Victoria had 5.5 /100,000 PP and South Australia 4.4 PP[11] *(as these figures are headcount not FTE, the actual position in WA is far worse) However, Western Australia's only podiatry course at Curtin University of Technology will cease in December 2005. This will have significant impact on future supply within WA.*

A lack of growth funding for education and training, the implementation of "user pay" mechanisms and Competition Policy has impacted on the capacity of education and training providers to adjust their delivery profiles to reflect market trends. Colleges and universities are required to generate revenue through partnerships with industry and sponsorship arrangements in an endeavour to reduce government expenditure.

These constraints have a direct impact on health labour market supply and maintenance of skills. Courses which are expensive to deliver such as those required to support the health professions, are dropped to make way for more cost effective delivery options. Business rules are applied. The more expensive course options and in many cases, the same ones that have limited market potential due to supply and demand factors are retained on a "user pay" basis only. When applying these principles to the health workforce it simply means the cost of skill development is shifted from the education sector to the health sector. As a result government funds that were allocated for the provision of health care are used to subsidise the education and training budget.

Who should pay and who is cost shifting is the subject of debate between the health and education and training sectors. While the health sector considers paying for education and training services, particularly those programs that are aimed at preparing individuals for entry into employment, as not achieving maximum return from government

investment in health care, a completely different view is held by the education and training sectors. These sectors argue that as the health sector receives government funding to cover some training costs (eg the training of medical students), courses which have limited application in terms of national labour market trends (eg bio-medical engineering and radiation therapy), or have not been previously included within college/university profiles, should be paid for out of these funds. As a result any effort on the health sector's part to have these needs met by the education and training sectors is interpreted as "cost shifting".

The submission by the Western Australian Department of Education Services re-enforces and expands on the issue of cost shifting:

"Finally, the issue of cost shifting needs to be clearly appreciated. If a HECS based health course can be moved to the post-graduate level this load (which attracts a high Commonwealth allocation) can be converted into low-cost courses and the funding 'saved' put into other activities, such as research. This is not supposed to happen but does because the Commonwealth's complicated load balancing occurs over the total university profile."

Commonwealth funding of State/Territory education and training institutions occurs under an umbrella of national priorities. The national priorities used to determine education/training provision reflect economic and community needs (eg growth in the minerals sector or increased employment opportunities for Aboriginal and Torres Strait Islanders). They are aimed at achieving the best possible outcome for Australia. From an economics perspective health is not ranked as highly as other industries that have earning capacity. Although there is a national shortage of nurses, other industry workforce needs (eg the traditional trades) may be considered more important in terms of labour market supply and the funding of additional student places.

The Australian Vice Chancellors' Committee (AVCC) identified in 2003 that 37% of eligible applicants for nursing courses did not receive an offer due to limitations in university placements[12] *despite the acknowledged shortage of nurses in Australia.*

While national priorities form the conditions under which the States/Territories will receive funding for education and training services, there is considerable flexibility in how these conditions are met. State Training Authorities and universities undertake their own market research to substantiate their delivery profiles. As a result the extent that national priorities are met varies depending upon evidence of demand and such factors as institutional workforce profile, physical resources and previous delivery outputs. The Commonwealth are attempting to address some of these issues through the introduction of new legislation (eg the Skilling Australia Workforce Bill introduced in Parliament on 11 May 2005).

Labour market needs are the driving force behind Health's efforts to improve the linkages between the delivery outputs of the higher education and VET sectors. There can, however, be resistance from the higher education sector to utilising labour market trends for degree course profiles. For example, in a consultation process carried out by the Commonwealth on the development of a suitable model to underpin the distribution of additional university places, universities showed minimal support for the idea that labour market trends were an indicator of demand, although some did see a place for utilising this information in the health sciences. This approach appears to be based on a lack of confidence in the accuracy of workforce demand projections for the prediction of demand for particular professions.

Again the Western Australia Department of Education Service's submission addresses this issue:

"For us the primary issue is that there is a *major discontinuity between the role universities believe they have, which is to provide a broad general education informed by a research ethos on the one hand, and the needs of a health service which generally requires highly skilled employment-ready graduates on the other hand.* Any attempt to improve the current situation needs to be prepared for this difference in perceived roles.

Twenty years ago most of the Allied Health courses resided in the Colleges of Advanced Education, which under the Dawkins changes metamorphosed into universities. The needs of the Health Sector have remained but the role of the institutions has changed dramatically.

The funding model developed by the Commonwealth in recent years has made it very difficult for universities to be more vocationally oriented. We also believe the problem has been exacerbated by the Commonwealth negotiating places and priorities with individual universities and very rarely with State government agencies. This strategy is seemingly based on the invalid principle that the State perspective is equal to the sum of views of each of its universities

There has been no consideration of the initial cost to students of converting undergraduate to postgraduate courses, increasing course length either at undergraduate or postgraduate levels."

The Western Australian Department of Education Services submitted the following recommendations:

- That DEST [Department of Education Science and Technology] should recognise that the current mechanisms for university accountability for student undergraduate load in health related areas inhibit the meeting of workforce needs. Consultations with Health providers and State agencies should precede the development of funding agreements with universities.
- That DEST should acknowledge that a situation that allows universities to move HECS-supported undergraduate load to fee-paying post graduate load is not fair on the students and, because it will increase the time and cost, will be passed on in the form of increased costs to Health providers. This activity also enables universities to convert high-income course load into low-cost load areas. This activity by universities should be regulated.
- That DEST should ascertain a mechanism so that, if a university desires to cease to offer a health related course that has importance to Health providers in the State, the resources so provided by the Commonwealth for that course should be made available to other universities willing to provide the course.
- That existing problems must be dealt with as part of the negotiations for the allocation of new places in 2006 and in subsequent funding agreements"

The full text of the submission is attached at Appendix 4.

The combined effort of Australian health jurisdictions at the national level to date to increase the distribution of Commonwealth funding of skill development programs in favour of health have had minimal effect.

To work towards alleviating these systemic barriers to workforce sustainability, the Department of Health proposes the following actions:

- The development of new interfaces between the education/training and health sectors at multiple levels within the system.
- A review of the funding models applied to health workforce skill development. This will need to take into account the increased costs associated with the increased training requirements to provide sufficient workforce numbers in shortage areas such as the medical workforce (see comments under curriculum and workplace competence in Section 5 of this submission).
- A reconciliation of the aims and objectives of the key stakeholders towards health workforce sustainability.
- The establishment of new collaborative frameworks, eg health/higher education planning models, given the heavy reliance of Health on the higher education sector in regard to supply of graduate health professionals.

Workforce Regulation

The Department of Health supports the concerns outlined by the Productivity Commission and others regarding the barriers to workforce supply presented by current health workforce regulatory structures.

The regulation and accreditation of health workforce professional standards needs to be simplified with particular attention given to new models of care and achieving national consistency. Regulatory models need to be sufficiently robust to respond effectively to workforce supply and distribution needs.

State Levers

The Western Australian health reform process encompasses levers for the development of a sustainable workforce.

These are based on a vision for the State's health workforce - that it is motivated, passionate about what it does, actively seeks opportunities for continuous improvement in service delivery, embraces teamwork and shares a common set of values and sense of direction – and focused on the following areas:

- Improving morale, through the development of a workplace culture that has: a system wide focus on promoting better health and good health care; an environment of transparency, value, trust and learning through value-based leadership and creativity; a collaborative, friendly and supportive environment based on mutual respect. Mechanisms are currently being developed to support and reward innovation and continuous improvement and all staff are being offered opportunities to contribute to the development of a State health strategic planning.
- Enhanced workforce planning, through linking this with service planning, considering work practices, work design, role development, attraction and retention and safe working practices and collaborating with universities, the VET sector, the State Education and Training Department and the Australian Government. Some of the measures being undertaken by the Department of Health are outlined under workforce policy and planning above.
- Improving attraction and retention, through focusing on other workforce as well as nursing such as the medical workforce, allied health and aboriginal health workers. Initiatives being undertaken include the development and implementation of new approaches to undergraduate and postgraduate medical training in Western Australia in discussion with private hospitals, clinicians, medical colleges and the universities and the appointment of a senior adviser on allied health, initially to assist with the development of a comprehensive strategy addressing allied health workforce issues.

- Promoting research to attract and retain good clinical staff, through measures such as creating more opportunities for medical staff to engage in research activities, providing better funding and establishing collaborative research mechanisms.
- Developing leadership, particularly in clinical fields, through the engagement of both clinicians and non-clinicians in leadership strategies, recognising the importance of clinical leadership to lead and support health reform and the use of cross-institutional clinical collaboratives to facilitate this leadership role.

Attraction and Retention

Attraction and retention measures to increase health workforce supply need to be broadened to address underlying job satisfaction issues such as job design, career pathways, flexible working arrangements, capacity for innovation, good management and leadership. Many of these issues need to be addressed at a state level but a large number of them are dependent on the creation, within the system, of greater flexibility in terms of health workforce roles. This encompasses education and training, the accreditation/regulation of professional standards, support for innovation in health delivery and industrial relations considerations. Improving attraction and retention of the health workforce therefore requires collaboration by all jurisdictions and other stakeholders within the system. Attraction and retention in the context of influencing the geographical distribution of the health workforce is addressed in Section 4 – Workforce Distribution - of this submission.

Workforce Distribution

The population in regional and remote areas in Western Australia is highly dispersed. Approximately 500,000 people live in small isolated communities distributed across an area of 2.5 million square kilometres. The state population density is 0.8 people/square kilometre compared to 2.6 for Australia as a whole.

WA and the Northern Territory are the only jurisdictions that have a Statistical Local Area in the Rural, Remote and Metropolitan Areas (RMMA) Classification 6 (remote centres and urban centres with populations greater than 5000) and none in RRMA 2 and 3 (other metropolitan centres and urban populations greater than 100 000 and large rural and urban centres with populations of 25 000 to 99 999).

Shortages in the supply of medical, nursing and allied health professionals in the rural and remote areas of Western Australia have presented an on-going and increasing challenge to health service delivery. Measures to improve the geographical distribution of the health workforce to rural and remote areas are therefore of considerable importance to the Western Australian Government.

The Country Health Services Review, undertaken by the Department of Health in 2003, provides the framework for health service delivery in country Western Australia. The service development priorities of WA Country Health Service are to:

- Implement a regional health service system based on strong and effective partnerships between three levels of government, other human service agencies, the non-government sector and private sector.
- Improve access to safe and sustainable primary and secondary treatment and prevention health services in regions, particularly for specialist and general practitioners, community and allied health services and lifestyle education programs.
- Develop a regional network of health infrastructure that supports delivery of safe and sustainable health services to regional communities.
- Increase access to support services for regional people with mental illness, their carers and families.
- Develop and strengthen whole of government/community partnerships and initiatives aimed at improving the health and health conditions of indigenous people.
- Attract and retain medical practitioners, nurses, specialist and other health professionals to country areas.

- Develop formal linkages with metropolitan health services to support regional services and enhance the coordination of patient care.

Country Health Services nationally and locally are faced with the challenges of attracting and retaining medical service providers, nursing and allied health staff. Workforce availability and the costs of supporting a workforce in the current environment of global skills shortages affect the sustainability of country health services. This is a constant and worsening problem, with Governments struggling to address this issue in a comprehensive manner.

Medical Services in Country Western Australia

It is likely that the sustainability of private medical business in small country towns will diminish in spite of substantial investments made by Local and Commonwealth Governments in incentives for attraction and retention[13] .

State funded public hospitals are providing many primary medical services in Western Australia. In 2002, 62% of general practitioners in the northwest of Western Australia were State hospital based general practitioners, with only a handful of private practitioners (17%), whilst 16% were provided by Aboriginal Medical Services and 5% by the Royal Flying Doctor Services[14].

Shortages in medical practitioners in Western Australia are reflected in comparatively low per capita expenditure by the Australian Government under the Medicare Benefits Schedule in Western Australia. In 2002-03, the Australian Government spent $364 per person in Western Australia under the Medicare Benefits Schedule[15]. This was $44 per person below the national average rate of $408[16] per person. Because the number of doctors per capita is significantly lower in rural and remote areas than in major population centres, often less than half, MBS per capita expenditure in many remote areas in Western Australia is less than $100 per person[17]. This means that the demand in rural and remote areas either goes unmet or falls wholly on public hospitals.

In Western Australia, the lack of private general practitioners in a number of towns has led emergency departments at public hospitals to commence operating “booking systems” similar to private general practices. People wanting to see a general practitioner book an appointment at the emergency department.

The use of public hospitals to provide GP-type services is a less than optimal use of resources, as hospital emergency departments are designed and equipped to deal with genuine medical emergencies. It also compromises the State’s capacity to fully invest in its core health responsibilities areas such as acute, population and mental health. Medicare statistics for 2001-02 indicate that Western Australia had a very low incidence of claims against Medicare (ie. 3.86%) of the total after hours and emergency consultations. Apart from these services being delivered in remote areas by salaried medical practitioners as described above, where local private medical practitioners are available in rural areas, they are usually contracted to provide these services in many of the local hospitals. This results in these claims being processed through the Department of Health fee for service system and not through Medicare

In working towards addressing the issues relating to the provision of medical services in rural and remote areas, the Department of Health proposes that the following options are considered:

- The potential for integrating community doctor funding and services with hospital and health services needs to be explored by health jurisdictions. Appropriate streaming of funding, based on levels expected if the community had adequate GP services, for alternative health services tailored to meeting community health needs need to be developed. This approach has already been trialled to an extent for Aboriginal communities with the Primary Health Care Access Program (PHCAP), although the number of communities where PHCAP has been trialled is small.
- The negotiation of more flexible arrangements to allow billing against the MBS for GP-type services delivered by public hospitals as allowed for under Section 40 of the AHCA, where eligible patients may obtain non-admitted patient services as a private patient where they request treatment by their own general practitioner.
- The introduction of blended payment arrangements under Medicare for rural areas rather than exclusive fee for service. This will be attractive to GPs to even out their income stream and allow practice emphasis to shift more to prevention and promotion efforts currently not rewarded under Medicare.
- Encouragement for the formation of group practices across solo doctor towns to reduce overheads and provide support for individuals. This may include practice management and pharmacy services to be provided through Divisions of General Practice or through other organisations.

Private Health

Private health provision is severely limited in rural and remote Western Australia. The lack of availability of private service providers, particularly private hospitals and ancillary health care providers (in WA there are only two private hospitals outside of the Perth Metropolitan area), means private health insurance generally does not represent good value for money for people living in rural and remote areas. However, people in these areas pay the same premiums as metropolitan residents.

There has been a scarcity of initiatives to make insurance more attractive for people in rural/remote areas. For example, insurers might offer assistance with travel and accommodation for people to access private hospital services. However, there have been no initiatives in this direction.

Recent Commonwealth measures designed to increase private health insurance participation do not address these issues, eg

- The Medicare Levy Surcharge requires people earning above a specified income to pay an additional 1% on their Medicare levy if they do not have health insurance. People in rural/remote areas are subject to the Surcharge despite the fact that they generally do not benefit from insurance.
- Under the Lifetime Community Rating policy people pay higher insurance premiums if they take up health insurance later in life (the premiums increase progressively after age 30 years). People living in rural/remote areas may choose not to purchase insurance because of the lack of benefit while they are living in those areas. They may then move to the city later in life. Once in the city they could potentially benefit from health insurance but, if they purchase insurance, they will have to pay an increased insurance premium.

New approaches to make private health insurance a more feasible option in rural and remote areas need to be explored by the Commonwealth Government.

Addressing Community Needs

Whilst it is acknowledged that the Commonwealth does offer directed funds to assist rural and remote health service delivery through a myriad of programs, these tend to be based on "buckets of money" for defined purposes that, on a systemic basis, are responding to the greatest need.

However, the needs in individual communities often differ from what are assessed as broad systemic needs. There is a greater need for tailoring solutions to respond to the needs of individual communities.

For example, in relation to substance abuse, based on the situation in major capitals, heroin might be assessed as being a critical priority. In remote communities, there may be no problem at all with heroin. In one community, the problem there may be a serious problem with petrol sniffing and in another the problem may be alcohol abuse.

Increased collaboration and partnership between stakeholders in rural and remote health service delivery needs to be developed, including through more flexible commonwealth program approaches. Options include:

- Allowing State Governments to access Commonwealth workforce initiatives in rural and remote areas directed at private providers where these do not exist or do not have sufficient business scale to economically access commonwealth programs, eg, "More Allied Health Services" program.
- Putting together the funding for the various Commonwealth rural and remote programs into a large pool that is then divided between the States on an equitable basis (eg, starting with rural/remote population shares and applying Commonwealth Grants Commission-type adjustments). The Commonwealth could negotiate with States individually on the best way to use the funds allocated for that State.
- The provision of Commonwealth funds to the States as compensation for accommodating nursing home type patients, which is a Commonwealth role.
- Recognition of rural shire financial contributions to attract rural general practitioners by supporting adjustments to Local Government Grants Commission formulae.

Telehealth

Greater cooperation between jurisdictions is also required to facilitate the increase use of technology to provide access to health services in rural and remote areas. Current Commonwealth approaches act as barriers to developing and utilising telehealth services, eg, in restrictions on the funding of telehealth GP consultations and remote PBS prescribing and dispensing.

Attraction and Retention

Commonwealth programs including MBS and PBS do not provide sufficient incentives for health professionals to provide services in rural and remote areas. Market forces encourage doctors and other health professionals to maximise their income and personal lifestyle choices, which are more likely to be realised in populous metropolitan areas. This results in a shortage in specialists, medical practitioners, nursing and allied health professionals and a range of related services including retail pharmacy and medical imaging in rural areas. Despite a range of Commonwealth rural incentive programs these appear to have had limited or no impact on the accessibility of health services in rural areas.

Within a constrained labour market, attraction and retention initiatives play an important role in workforce distribution. Increasingly, those aspects that act as true workforce 'attractants' extend beyond the 'traditional' approach of more

money. The focus of employees has undergone a considerable shift over the last ten years with greater focus being placed on “the package” on offer from employers, rather than just salaries of wages. This incorporates such issues as locale & lifestyle, accommodation, child and aged care, school access, transport, hours of work, equitable distribution of work and benefits, and working environment (whether characterised as ‘management approach’ ie: trust, respect; or the physical environment ie: amenities, good tools of trade etc).
Similarly, the nature of remuneration has changed. The ‘remuneration package’ is now considered to capture all from salaries and wages through to childcare, accommodation benefits, flexibility of hours, leave, vehicles, holiday benefits (inclusive of fares, destination choices) and so on.

With the focus of workforce increasingly on the non-cash elements of remuneration packages, jurisdictions face a significant challenge in achieving appropriate workforce distribution without the capacity to directly influence all elements of remuneration. Distribution levers exist which, potentially, could assist jurisdictions in finessing more appropriate distribution of health workforce. However, in the main, these distribution levers are within the framework of federal legislation.

Those elements of the taxation system which deal with the benefits component of remuneration have been structured (either deliberately, or as an unintended consequence) so as to assist employers with workforce distribution and to support Government initiatives. These are specifically dealt with under the fringe benefits tax (FBT) legislative regime. There is no doubt that these provisions have had a positive impact on the capacity of employers to distribute workforce. However, there need to be further steps taken within the tax regime to address some of the anomalies that currently exist in relation to rural and remote workforce benefits.

Awards and agreements now provide that employers cannot unreasonably refuse a request from an employee to enter a salary packaging arrangement. Such provisions made it difficult for jurisdictions to achieve a meaningful impact on workforce distribution through differential availability of benefits. The by-product of the inclusion of these provisions in awards and agreements is the staff perception that access to such arrangements is an entitlement and, as such, access to the benefit should be equitable. It is acknowledged that the perception is not correct – taxation arrangements and structures are often unique to the individual. However, to employees, awards and agreements provide entitlements.

Prior to the “A New Tax System” (ANTS) reforms and changes to the definition of a Public Benevolent Institution, employment benefits in many areas of health systems were provided on a FBT exempt basis. With the introduction of ANTS, employment benefits provided within health systems were ‘capped’. The introduction of capping of itself has had little impact on the distribution of health workforce. The uniformity of its application and lack of indexation means that, over time, that proportion of remuneration a health employee might access through a ‘salary packaging’ arrangement will become less important. However, the perhaps unintended consequence of the change has resulted in a significant differential emerging between metropolitan and rural areas in the nature of items available to employees (within salary packaging arrangements) to include within the cap. The inescapable nature of many award and agreement provisions compelling packaging arrangements on request skews the benefit toward metropolitan areas. Within Western Australia, 87% of salary packaged benefits (in the context of the award and agreement packaging provisions) are accessed within the metropolitan area.

Rural and remote areas do not have access to the range and types of benefits available in metropolitan areas in that they are simply unavailable in the community and, in the main, the types of benefits available under the benefits regime go mainly to subsistence and accommodation. In some jurisdictions, employees are unable to access benefits they consider important (of value to them) within the capping arrangement. The consideration of other benefits that may assist in workforce distribution to remote and rural areas is tempered by the reality that incentives that may have a significant impact attract FBT and, in turn, are captured as remuneration on employee group certificates.

As a result, benefits not contemplated by the employee (relating to remote and rural areas – particularly with respect to accommodation) result in the ‘entitlement’ being accessed through the general employment arrangements rather than in a form desired by the employee. In such cases, the benefits regime as currently structured would see the bulk of what employees perceive as ‘their’ packaging benefits utilised by the employer’s rental subsidy arrangements. Clearly, increasing existing ‘capping’ of exempt benefits for hospitals will do little to remedy the skew between rural and remote and metropolitan benefits. Similarly, any changed regime should not result in leakage of existing salary and wages based taxation revenue to the Commonwealth.

Debt forgiveness may also be attractive to some jurisdictions as a lever to assist in appropriate distribution. For example, the Higher Education Contribution Scheme (HECS) results in significant debt for much of the health workforce particularly among the cohort jurisdictions are seeking to attract. Recent discussions with medical students in Western Australia around ‘debt forgiveness’ and/or scholarships (in this case from Local Government) resulted in a significant number demonstrating an interest to go to rural areas for fixed periods of time. However, the current

structure of the HECS and FBT legislation does not provide an appropriate vehicle for this to occur without prohibitive cost to the employer.

Accommodation and other general amenities also present difficulties under the current taxation regime. In the metropolitan area, employees may package directly into the mortgage of their principle 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.

Improving benefits provision along the lines set out above can also assist in the building or maintaining of rural and remote communities which is a key workforce "attractant" in itself. The challenges faced in attracting and retained the health workforce in rural/remote areas can not be addressed in isolation of the benefits of a coordinated systemic approach to build and support rural and remote communities.

Businesses, government offices and local industries have been withdrawing from many rural and remote centres and there has been a move away from the concept that a community can support facilities such as hospitals, schools and local business. In many cases, the reverse scenario is now in place; hospitals, health services, schools and remaining government offices are often principal employers and vital to the survival of community economies providing services to rural and remote areas. The reduction of opportunities for young people and the resultant accelerated aging of remote and rural communities have a profound impact on the capacity of jurisdictions to provide appropriate – and relevant – incentives for optimum workforce distribution in these areas.

Appropriate distribution should contemplate assisting and supporting workforce becoming a part of the local community as opposed to schemes designed to 'place' persons or provide services for finite time frames.

If it is accepted that taxation (specifically the general fringe benefits regime, debt forgiveness and scholarships) is and/or can be a significant lever in workforce distribution then it is an area that warrants further collaborative examination by jurisdictions, the Commonwealth and the Australian Taxation Office.

A benefit framework aligned to the Rural, Remote and Metropolitan Areas (RRMA) Classification Criteria may be more relevant than the current ad hoc arrangements. Such an approach contemplates that certain benefits might be provided by employers where service planning and required workforce configuration meet specific criteria agreed between the jurisdictions and the Commonwealth, within an application framework aligned to the RRMA or agreed alternative/s.

Such arrangements need not offend Section 99 of the Australian Constitution. Taxation revenue 'leakage' from such an approach – or indeed any benefits related approach – which results in effective distribution is nil. The reality in the context of such an examination is that there is no revenue to be harvested if there is no workforce in place – but importantly – where the provision of benefits aids in strengthening communities and services, the overall benefit to the health system and local economies could be considerable.

In working towards addressing the issues of workforce attraction and retention in rural and remote communities a broader approach as contemplated above needs to be explored.

Aged Care

The Western Australian Government, unlike other state governments, is not a major stakeholder in the provision of discrete institutional residential aged care services with only two state government nursing homes now operated by the state. However, it is a substantial provider of health and community care services for the aged and is situated at the interface between the community, acute care and residential care sector.

The overall funding formula that applies to the allocation of subsidies to residential aged care providers is not considered to be adequate in terms of sensitivity to the major variable cost of labour. This issue has been long documented and has been subject to three major reviews since 1999 (1999 Review of Nursing Home Subsidies carried out by the Productivity Commission (PC) followed by The Two Year Review conducted by Professor Len Gray in 2001 and then the 2004 Hogan Review). Overall, this long history of reviews has not resulted in any substantial adjustment to the methodology used to determine subsidy levels and consequently difficulties remain in attracting and retaining suitably skilled nursing and nursing support staff. This has had a significant impact on the attraction and retention of suitably skilled and experienced nursing and enrolled nurse support staff and therefore the ability to deliver quality residential care services to residents in Western Australia.

Adequate training, appropriate skilling and adequate levels of staff will be required to cater for the increasing numbers of elderly people with dementia as they pass through the public health system to the aged care sector.

State Workforce Distribution Levers

In line with Western Australian Country Health Service strategic directions, the following initiatives are being undertaken in Western Australia to improve access to health services in rural/remote areas:

- The establishment of scholarships for undergraduate and postgraduate allied health students who are willing to commit to rural practice. In 2002, four physiotherapy students were awarded a scholarship, and have since secured employment in rural WA. Scholarships have also been offered to physiotherapists currently working in country health services to undertake postgraduate studies.
- Contributions are being made to the Combined University Rural Student Placement Scheme, which provides funding to support travel costs for allied health students completing rural placements;
- The development of a Specialist Services Plan that will guide the development of (a) sustainable resident specialist services and (b) integrated visiting specialist services to rural communities.
- Improving research functionality within senior positions, to improve career paths.
- The development and delivery of a coordinated schedule of Therapy Assistant training models delivered by video conferencing and distance learning

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Outer Metropolitan Areas

There is now a widespread and significant shortage of medical practitioners in Western Australia. The workforce distribution issues in Western Australia are not restricted to rural and remote areas. Significant shortages are now being experienced in urban areas, particularly in the outer metropolitan areas.

The General Practice Workforce in Australia, 2000 published by AMWAC identified “Western Australia [is] noticeably below the national average” with regard to the GP workforce. In fact WA has 98.7 GPs per 100,000 which is over 10 GPs per 100,000 population below the national average of 110.6 GPs per 100,000[18].

In Western Australia it is estimated that the metropolitan region has 107.2 GPs per 100,000 population and 75.6 GPs per 100,000 within rural and remote regions. Both statistics remain below the national average.

WA is currently experiencing considerable population growth in outer metropolitan suburbs of Perth placing increasing pressure upon consumers’ access to primary health services.

Close collaboration between the Australian Government, State and Local government is critical when addressing short, medium and long term workforce shortages in outer metropolitan areas as well as rural and remote areas of Western Australia.

Workforce Skills

Health workforce skill sets need to be based on service delivery requirements. Competencies delivered by education/ training within the VET and higher education sectors are integral to health workforce career path structures and linked to the industrial relations platform. Collaboration between education and training institutions and health providers is required to establish a better alignment of education and training courses to health delivery needs. In particular there needs to be a re focusing of higher education course curricula development, accreditation and education models to address the health workforce supply, skills and distribution issues raised in the Productivity Commission's Issues Paper and this submission.

Skill development processes must address the current restrictive professional silos within health where career paths are restricted to one vocational stream, management is the only means of promotion and multi-skilling is virtually impossible.

Cross-sectoral linkages between schools, the VET and higher education sectors need to be improved. Career path structures that are supported by skill development programs that enable the smooth transition from non-degree qualified vocations to the professions have significant potential to alleviate some of the labour market supply problems that plague Health. They also tend to be more supportive of people wishing to re-enter the workforce and provide an avenue to deal with the problems experienced by many young people in not knowing what they want to do when they leave school.

An example of cross-sectoral linkages that do not support the above is the current pathways between enrolled and registered nurse careers. While it is acknowledged that some credits are awarded to individuals who have completed the VET qualification for enrolled nursing when entering into the under-graduate degree programs for registered nurses, it is not the most effective pathway to progress a career in nursing. The individual who is pursuing this career path option has completed an eighteen months course to practice as an enrolled nurse and irrespective of workforce experience, has to undertake in the vicinity of a further two years training depending upon which university they attend, to become a registered nurse (i.e. a total of three and a half years). However, the school leaver who enters directly into the under-graduate degree course for nurses with no experience whatsoever can expect to graduate as a registered nurse after three years of study. The experienced worker tends to be penalised.

Curriculum and Workplace Competence

As set out above, skill development options, whether available through the VET or higher education sector, form the basis of employment. They become the platform to support entry into the workplace and career progression. Curriculum must be aligned to work practice.

Under current structures the programs that are provided within the VET sector are aligned to workplace competence. The capacity for the VET sector to provide and support health workforce skill development is outlined in comments made by the Western Australian Department of Education and Training (WADET) attached at Appendix 3 of this submission. WADET comments also address current and emerging apprenticeship and traineeship issues impacting on health skill development and VET sector issues with clinical placements.

The Department of Health supports the greater use of apprenticeship and traineeship opportunities within the health sector. However, this will need the support of the Department of Education Science and Technology and industrial barriers will need to be addressed.

Undergraduate and post graduate skill development options through the higher education sector do not always adequately prepare people for employment within the health sector. New graduates are often not job ready and as a result, need to undertake further supervised training on the job to be fully productive. For example, nurse graduates on entering employment within Health undertake a further twelve months of supervised practice.

New graduates often enter into employment with no real idea of what the job is all about. They have a good theoretical knowledge of their field of employment but lack understanding of the tasks that form the job role and in some instances, the impact of their conditions of employment (eg shift work on social life). As a result some leave and seek alternative employment. Government funds invested in the education and training of these people are lost.

While it is acknowledged that higher education programs are developed in consultation with industry (i.e. professional bodies and employer groups), greater focus needs to be given to the actual job that the program is supporting and the technical skills that are required to function efficiently within the health system.

A number of issues for undergraduate and postgraduate training in nursing have been identified in a variety of published studies over the past 6-7 years. In 1998 “A Study of Graduate Nurse Programs in Western Australia to Determine the Attraction and Retention of Graduates to the Mental Health Area[19]” was undertaken by the School of Nursing, Curtin University of Technology, and was funded by the then Mental Health Division of the Department of Health. This study reviewed previous work undertaken, finding that teaching staff at both Edith Cowan University and Curtin University of Technology believed that it was “essential for university staff to work collaboratively with industry to produce a nurse who is able to work as a first level practitioner in the mental health setting”.

The UK has reintroduced the concept of Nursing Cadets as a means of providing potential student nurses with a comprehensive overview of what health care is all about and how a health service functions. Having the opportunity to undertake paid education and acquire practical experience in a supportive environment prior to commencing undergraduate nurse education courses may be a means of reducing the attrition rate from undergraduate programs. A cadet program enables trainees to work within a wide range of environments within the hospital to gain this understanding. Spending time in a clinical setting also enables them to see what the day-to-day care of clients is all about.

Clinical placements are a key means of developing technical skills However; work needs to be done on developing current arrangements to ensure that there is more balance between health service delivery needs and training requirements. For example, universities wish to see all clinical placements irrespective of student numbers to occur within the academic calendar year. However, this does not always take into consideration the working conditions and service commitments of the professionals that oversee these placements or what might be appropriate supervisor/ student ratios in terms of skill development. There is currently a growing reluctance within the health professions to continue to take on the burden of supervised clinical practice. A more equitable system of providing students with the opportunity to develop technical skills is required.

Historically the public health system has been a training ground for students enrolled in the health sciences irrespective of their intention to work within the public or private sectors. Given the demand for clinical placements and in many instances, the shortage of qualified professionals within the public health system to undertake the supervision of students, some consideration needs to be given to implementing strategies to encourage private health professionals to contribute to the technical training of university under-graduates.

Work is currently being undertaken by the Department of Health to develop and implement new approaches to undergraduate and postgraduate medical training in Western Australia in discussion with private hospitals, clinicians, medical colleges and the universities along these lines.

An assessment of current training regimes for the surgical workforce in Western Australia currently being undertaken by the Department of Health has identified the following issues:

- Traditionally all surgical training has been undertaken within the public health system which provided sufficient volumes of cases and exposure to a variety of procedures. However, in today's health system exclusive public sector training is no longer sufficient and training models that incorporate private sector rotations need to be explored and implemented in order to provide trainees with a holistic training experience.
- Of the total number of surgical procedures performed over 2001/02-2003/04 in the Perth metropolitan area, 58% were undertaken in the private sector with the remaining 42% (25% tertiary, 17% secondary) undertaken in the public sector. Yet there are very few posts/rotations that utilise the private sector. The need for greater private sector involvement in training surgeons is essential.
- There is a current mindset that the private health sector is not a training environment and consumers pay a premium for their choice of specialist and level of care. Changing this mindset and being able to see benefits of having trainee registrars and residents will occur over time and as a result of positive experiences from both consumers and specialists. Increased support needs to be provided to both the Registrar/Resident and specialist and private health facility is required throughout this period of change.
- Funding of registrar/resident posts is another deterrent from private sector training. Private sector training represents only part of a trainees training experience. Private health care facilities are reluctant to pay for what has traditionally been the responsibility of the public sector. However with the projected number of trainees required to utilise the private sector it is not sustainable for the State health system to fund these training posts. Access to Medicare rebates was restricted during the 1980's as an attempt to reduce medical expenditure (restrict supply) this policy/legislation must be reviewed as health systems across Australia require access to Medicare rebates in order to fund training posts within private settings.
- Private entities depend upon revenue. Trainees providing medical services to private patients within private entities must have access to Medicare rebates in order to generate revenue to fund/justify their posts. Whilst there is provision within current legislation to access Medicare rebates for trainees the process is cumbersome and ambiguous.
- Section 3GA of the *Health Insurance Act 1973* (the Act) provides for doctors enrolled in formal training programs to access Medicare rebates while undertaking training placements in private hospitals. The training program or course must be specified under 6E of the Health Insurance Regulations (1975). The Medical College must apply to the Department of Health and Ageing to be recognised as an approved course/placement, under 6E of the Health Insurance Regulations (1975). The hospital must also apply to the Medical College for its post/position to be approved by the College. The trainee in the approved post must then apply to the Health Insurance Commission for exemption under Section 3GA of the Health Insurance Act 1973 to be provided with a provider number for the specific location and for a specified time in order to access Medicare rebates. There is no retrospective provision for access to provider numbers.
- The application to the Health Insurance Commission states that Access to Medicare benefits as a Specialist Trainee enables access to "Other Non-Referred Attendances to which No Other Item Applies Medicare Benefits Schedule Items (Group A2)". Group A2 items are consultations; this is simply not sufficient to fund trainees within, for example, a surgical training program.
- Advice received from the Australian Government's Department of Health and Ageing states that other item numbers are accessible but at reduced rates – this may be sufficient, however details have not been provided to jurisdictions. Further, trainees at the time of accessing Medicare rebates must not be under the employment of a public institution nor providing services to public patients.

To successfully implement strategies to increase medical workforce numbers such as the surgical workforce, the Australian Government must make available sufficient funds through either Health Care Agreements or by removing the existing barriers to Medicare rebates in order to fund increased training requirements.

Health Education Partnerships

Health/education and training partnerships are seen as being a useful way forward on many of the issues raised in the section. An example of how these arrangements can be beneficial is demonstrated by the arrangements that exist between the University of Western Australia (UWA) and the Department of Health in regard to the delivery of the Graduate Diploma in Public Health Practice. A case study of this health/education training partnership is attached at Appendix 1.

To work towards alleviating the barriers to the delivery of health workforce skill requirements outlined above the Department of Health proposes:

- A new framework for clinical placements be negotiated between the health and higher education sectors. This should take into account the conditions of employment of health professionals as well as university academics.
- Private practitioners to be encouraged to contribute to the skilling of under-graduates through the provision of clinical placements. One way of achieving this would be to introduce an employer incentive scheme similar to

that that is available to employers of apprentices and trainees.
- Increasing the responsiveness of curricula development to health care delivery requirements.
- Improvement in the cross sectoral linkages between schools, vocational education and training (VET) and higher education.

Changing Workforce Roles

The health workforce needs to be responsive to new models of health care and changing skills requirements. Innovation in health service delivery needs to be underpinned by a flexible, innovative and responsive workforce. New technology has a significant impact on skill requirements for effective health service delivery and the current pressures on workforce supply are also impacting on evolving workforce roles.

The health workforce reforms being implemented in Western Australia recognise that:

- The rapid advances in technology has resulted in increasing specialisation at one end of the spectrum and, at the other end, some procedures becoming safer more routine and requiring less intensive hospitalisation. The challenge for the future is to: carefully assess the cost/benefit of any new technology before it is introduced; concentrate the use of high cost, highly specialised technology at particular health sites to maximise workforce availability and skills development and make the most efficient use of equipment; and change work practices, clinical pathways and settings once the use of any particular technology becomes more routine.

- There is a need to provide generalist health services, albeit at a higher level, in the suburban metropolitan areas of Perth while concentrating and rationalising the provision of more specialised services in a small number of highly specialised hospital settings.

In Western Australia, as nationally, nursing roles have changed. This has been recognised in WA by the Office of the Auditor General (WA)[20]. The rapid advances in technology (including for example, electronic transfusion and computerised monitoring machines) and the wider range of drugs available for patient care have required nurses to become more skilled. Moreover, a greater proportion of patients in hospital these days are seriously ill, requiring more intensive nursing care. In addition, while hospitals remain the main places of employment, nurses now work in a variety of other health settings. The largest growth in nursing Australia-wide was in community nursing with an increase of 36.3% from 1993 to 1999[21].

In response to these changes the Department of Health has undertaken considerable work on progressing the Nurse Practitioner Model within WA and most recently developed a Nursing Workload model which provides management with a tool to establish staffing profiles, focused on occupancy and patient mix rather than nursing ratios (see Appendix 2).

The United Kingdom NHS experience indicates nurse practitioners offer a complimentary source of care and are moving into most health care settings within the UK, including general practice, emergency departments, injury units and a range of acute and chronic care specialties and facilities. Further, the NHS has indicated that the intent is to train nurse practitioners to provide some of the health services that are traditionally the exclusive responsibility of doctors.

In allied health increasingly, the traditional profession specific roles are evolving, with a push amongst professional associations to simplify legislative constraints to enable allied health professions to adapt to community demand, following a competency-based approach. This approach would see the emergence of enhanced scope practitioners amongst allied health professions similar to that being occurring within the nursing workforce.

Academics are calling for a redefinition of the core business of physiotherapy and a total re-structuring of training programs and workplace competencies to reflect current research, attitudes and work practices, rather than the present array of technical and clinical skills[22].

Recognition of the increased capacity allied health professionals can provide within the public hospital setting has been recognised with allied health professionals dedicated to emergency care facilities to alleviate increasing pressure on emergency departments[23].

The current movement towards the greater specialisation of the workforce where what is required in the vast majority of health services is more generalist approach needs to be addressed.

An example of specialisation can be found in the large and evolving number of sub-specialties within Fellows of the Royal Australian College of Physicians, a situation identified by the College as an issue to be addressed. Internationally this issue is also recognised:

The United States has nearly 2 medical specialists for every generalist. This large proportion of specialists has been blamed by payers and others for overusing medical technology and escalating health care costs, without producing an observable improvement in patient outcomes. Powerful incentives continue to foster a generalist-specialist imbalance. For example, in 1997 the Health Professions Education Assistance Act provided nearly $200 million to encourage training of primary care physicians. This allotment was eclipsed that year by the more than $16 billion in direct graduate medical education (GME) support from Medicare and other third party payers that favour specialty training in the inpatient setting[24].

Currently there is much discussion about inter-professional co-operation, but in reality the professions tend to protect their scopes of practice, with each profession unwilling to relinquish some duties to the other profession. Nevertheless, there is a gradual repositioning of roles occurring.

Identifying those changes to workforce roles and skills sets that are beneficial while maintaining standards of health service delivery is the challenge ahead. It is a national challenge as the structure of the professions is largely set at the national level. Approaches will need to address the current entrenched compartmentalisation of the health workforce into occupational groups which is reinforced by current regulation, accreditation, training and industrial relations frameworks.

Indigenous Health

The Aboriginal and Torres Strait Islander population in Western Australia is approximately 60,000 or 3.5% of the population. 66% of Aboriginal Western Australians live in rural, remote and isolated areas.

Aboriginal people make up 23% of the approximately 100,000 residents in the north west of Western Australia. In 1999/2000 within the Kimberley and Pilbara Gascoyne Health Services, 11,000 Aboriginal people were hospitalised as opposed to 10,000 non-Aboriginal people[25] .

Aboriginal health outcomes in Western Australia are significantly below those of non-aboriginal people. The life expectancy of Aboriginal people in Western Australia is 16 years less than for non-Aboriginal people. The death rate for Aboriginal people is almost double that for non-Aboriginal people.

Initiatives to address the barriers to the provision of quality health care in rural and remote areas need to take into account the specific needs of the indigenous population.

Due to a mixture of geographic, social and cultural reasons, mainstream health services are not always accessible or appropriate for Aboriginal and Torres Strait Islander people. As a result, community-controlled Aboriginal Medical Services operate in urban, rural and remote locations offering a wide range of primary health care and other services.

National workforce modelling undertaken in conjunction with the development of the National Strategic Framework for the Aboriginal and Torres Strait Islander Workforce, has indicated that around 600 Aboriginal Health Workers should be employed across all sectors within WA – this would indicate a current WA shortfall of around 420.

The Department of Health endorses the comments of the Western Australian Department of Education and Training on the issues impacting on aboriginal health workers and the challenges faced (see Appendix 3).

A number of issues have been identified that impact on attraction and retention of Aboriginal Health Workers in WA. Role clarity and support are key concerns. Other important issues include mainstream cultural misunderstanding, a lack of appreciation of the capabilities of Aboriginal Health Workers, absence of legislation to support Aboriginal

Health Worker practice (e.g. remote area medications), divergent views regarding access to staff housing, vehicles and equipment, and limited opportunities for career development.

The need for accreditation or registration as a mechanism for regulating standards of training and practice for Aboriginal Health Workers has been given prominence in a number of key reports and the Australian Health Ministers Advisory Council has asked jurisdictions to examine this issue. The national project currently underway to develop a set of up to date national competencies for Aboriginal health work is expected to improve the likelihood of some form of national or common accreditation/registration process for Aboriginal Health Workers.

Western Australia has just undertaken a feasibility study in establishing an Aboriginal Health Workers Association in partnership with OATSIH. This will give further substance to the establishment of an accreditation/registration mechanism in Western Australia. In support of this a scoping paper is currently being developed.

WA Education Sector Submissions

Submissions regarding health workforce education and training relevant to the Productivity Commission's Study provided by the Western Australian Department of Education and Training and Department of Educations Services are attached at Appendix 3 and Appendix 4.

Appendix 1

Graduate Diploma in Public Health Practice

The Centre for Public Health (WACPH) is a joint initiative of the UWA School of Population Health (UWAPH) and the Curtin University of Technology School of Public Health (CUTPH), which is funded by the Australian Department of Health and Ageing under the Public Health Education and Research Program (PHERP) to provide postgraduate education and research training.

UWAPH and CUTPH propose to introduce a new postgraduate qualification, the GDPHP to provide a course of supervised Public Health (PH) Practice within an academic framework that is both distinct from and complementary to existing Diploma, MPH and PhD qualifications. The GDPHP will train PH practitioners to industry requirements using apprenticeship-style attachments similar to the well established approach taken in clinical medicine, dentistry and other health care professions.

There is an existing industry-based training program in public health conducted by the WA Department of Health - The WA Public Health Training Program (WAPHTP). It presently does not attract academic credit, but does satisfy the requirements for supervised professional experience mandated by the Australian Faculty of Public Health Medicine. The WAPHTP is open to both medical and non-medical trainees. It has grown to a significant size and is almost certain to grow further. The WACPH partners have adopted a collaborative model of engagement with the WATPHP moving in the direction of a three-partner consortium between UWAPH, CUTPH and the Department of Health, which will apply for funds from PHERP.

The GDPHP will meet an immediate need in so far as it will ensure high academic standards and provide accreditation for the WAPHTP. In contrast to the GradDipPH, MPH and other campus-based coursework qualifications, the GDPHP will be awarded on the basis of field competence gained in the course of a system of supervised rotational placements. It is anticipated that graduates will have gained significant employment market advantages, and that the GDPHP will be adopted as an industry standard for a basic applied qualification in PH.

The Department of Health has been closely involved in the design of the GDPHP with UWAPH and CUTPH. Their WAPHTP will become the first industry-based program to be accredited for the award of the GDPHP. However, the model is designed to be a generic one, which can be transferred into diverse settings with other health industry partners. Likely future partners include the Health Promotion Foundation; Department of Occupational Safety and Health; Disability Services Commission; the larger local government authorities; Australian Department of Health and Ageing; community health organisations including the Cancer Foundation of WA, National Heart Foundation, Diabetes Australia and others. Once a strong platform for the qualification has been established in WA, the academic partners intend to explore opportunities for offering the qualification to a regional market, initially through the World Health Organization.

The GDPHP will be administered and awarded by UWA and CUT as parallel and identical programs. Students will self-select to enrol solely at one or other institution. There will be no cross-institutional enrolments; rather the student groups will be combined as already occurs with the unit, Foundations of Public Health. Learning will occur in the health industry setting (rather than the academic classroom) in collaboration with the Department of Health, with supervision provided jointly by the industry partner and academic institutions. Each university will award separate graduate diplomas.

It is proposed that the Faculty may accept as a candidate for the GDPHP an applicant who satisfies all of three criteria: (I) Awe's or Cut's general requirements for admission to a graduate diploma or comparable standing as determined by the Dean; (ii) full-time or part-time employment in the health sector; and (iii) acceptance into the accredited training program of a recognised industry partner. The course will only be taken part-time due to a practical limitation of how many rotational placements can be achieved in one year (maximum of four per year). Thus the minimum duration of enrolment will be two years, and a maximum time limit of four years, excluding suspensions,

is recommended. The GDPHP shall consist of the following eight units to the total value of 48-points, and valued at 6 points per unit:

Proposed 6pt Unit	Competency Areas	Coordination
Professional portfolio	Professional Practice Policy and Leadership	CUT
Leading health services	Management Communication and Leadership	UWA
Applied epidemiology	Epidemiology & biostatistics	
Information management	UWA	
Evidence-based practice	Health care evaluation	UWA
Applied health promotion	Health promotion	CUT
Outbreak investigation	Infectious diseases	UWA
Managing health risks	Risk assessment/management	CUT
Applied health economics	Health economics	CUT

Candidates are required to 'demonstrate an understanding of the historical and social determinants of health in indigenous populations' in at least one of the units, and this is to be written up and assessed in the culminating unit entitled, Professional Portfolio. For candidates in Australia, 'indigenous populations' will mean Australian Aboriginal populations. For candidates located overseas, 'indigenous populations' shall be interpreted with a meaning more relevant to local circumstances.

Appendix 2

WA Nursing Workload Model

The development and application of nurses' workload models in Western Australia has seen significant advances in understanding and managing nurses' workload.

As a result of the industrial process, the Western Australian Department of Health introduced the Nursing Hours per Patient Day (NHpPD) model to manage nursing workload in February 2002. Since that time the model has continuously evolved and now covers all but a few areas within WA hospitals where nurses provide patient care. The model applies across all public hospitals in Western Australia and is centrally managed to ensure consistency in its application.

The Western Australian model has sought to identify and incorporate drivers of workload such as patient complexity, patient turnover and staff mix. It has evolved to incorporate models for emergency departments and critical care units. A model for theatre is currently close to completion.

The model has been applied in other settings in Australia. It has been implemented in Tasmania and is currently being trialled in the Northern Territory. The model is also being used for benchmarking purposes in South Australia.

The Western Australian model brings a number of benefits to Western Australia. It provides clinicians and managers with a practical tool to ascertain staffing requirements to ensure optimum patient care provision. It has improved the working life or nurses because it ensures workload is properly managed in a transparent process. This is important in managing stress in the workplace and is an important attraction and retention tool, especially in light of the ageing nursing workforce. It has been used as a strategic workforce planning tool in underpinning the nursing workforce component of the clinical services mapping process recently undertaken by Department of Health (see section 2 of this submission).

Western Australia aims to implement the NHpPD model in all areas of public hospital service delivery that involve the provision of patient care by nurses.

Appendix 3

Submission by Western Australian Department of Education and Training

Department of Education and Training

Comments on the Health Workforce Productivity Commission Issues Paper - Education and Training Issues

The Department of Education and Training provides the following comments on:

1. The capacity of the VET sector to provide and support courses for new roles as identified to substitute traditional roles, due to labor market shortages and changes in health delivery models.

These are:

1.1. The VET sector has a large capacity to provide and support new and emerging roles in the health industry.

1.2. The State and National VET sector stakeholders in collaboration with health industry do take an active and responsible role in developing skills frameworks and qualifications that strategically supports the following:

- entry level training and development target school leavers and the existing labour market
- gap training and advanced skilling of the existing health workforce
- vocational competency development for tertiary trained health professionals
- skills recognition for those workers with current competencies in the health sector workforce

1.3. The VET sector has developed national competency benchmarks and qualification frameworks to support the diverse and multi-faceted training and career pathways of the health workforce. These competency frameworks are reviewed and regularly updated to support the new and emerging skill requirements of industry. Because of the review process a wider range of technical roles have been identified including health support service roles and health service assistant roles for the general health service sector.

1.4. The national competency benchmarks have been packaged to enable industry and registered training providers to use the framework to support the skills development and assessment needs to meet their particular workforce planning needs. The Health Training Package provides nationally consistent standards and recognition of competence. These Training Packages are industry endorsed and have built in mechanisms and processes for customisation to meet the dynamic skills requirements of the industry.

1.5. Award negotiations have at times restricted the ability of the VET sector to gain accreditation for the appropriate skill and knowledge sets, particularly where the increased complexity of the skill has resulted in higher-level qualifications. An example of this type of constraint was the Division 2 nursing (enrolled nursing) qualification which was downgraded from an Associate Diploma to a Certificate IV in an environment where shortages of nurses existed and there was a demand from the health sector for more advanced skilled nurses.

2. Current and emerging apprenticeship and traineeship issues

These are:

2.1. Poor uptake from industry for employment based entry-level training opportunities such as apprenticeships and traineeships. National enrolment figures for apprentices and trainees enrolled under the Health Training Package in 2003 was just under 1,200. National enrolment figures for the Community Services Training Package were significantly higher reaching 13,000.

2.2. Sectors employing aged and disabled person carers had the greatest numbers of enrolments in traineeships at around 8,981. That sector has seen consist increases in enrolments from 1998 to 2003.

2.3. The health sector has demonstrated a poor uptake of the employment of trainees. The initial uptake has steadily declined since 1998.

2.4. Key stakeholders in the health sector, particularly nursing, have proven to be the most resistant to employment-based models of training.

2.5. Constraints upon employment based models of training in the paraprofessional health occupations is restricting access to occupational pathways for a large section of the labour market including existing health care assistants and other semi-skilled workers.
2.6. The qualification level of most traineeship enrolments is at the Certificate III level. Access to advanced qualifications in the health industry is constrained by the number of employment based training opportunities being offered in the sector.
2.7. Current and anticipated shortages of health educators in the VET sector will continue to limit the ability of the sector to provide increased opportunities for on the job training.
2.8. Employer training expenditure in the community services and health industries is less per employee, on average, than industry overall.

3. Clinical Placements – issues for the VET sector.

These are:
3.1. Ongoing constraints on the number of clinical placements available in health industry sectors, particularly in secondary and tertiary hospitals, mental health and paediatric health services.
3.2. Supervisory ratio's for students in the above sectors are higher for VET students than students in the higher education programs.
3.3. Time based clinical placement requirements for areas such as enrolled nursing versus competency based models of clinical placement is providing significant barriers for large sections of the community who would like to up-skill for entry into higher occupational levels.
3.4. Mature age workers, women, remote and regional based workers and Indigenous people are significantly limited in their ability to access higher educational skills and qualifications due to the rigid requirements of clinical placements.
3.5. Employment based training opportunities; particularly at Certificate IV, level would increase the access opportunities for large sections of the current health and community service workforce.

4. ANTA to DEST arrangements and the potential impact on this absorption on current VET sector health issues.

4.1. There are no known issues that are expected to impact on the shift of the VET sector arrangements from ANTA to DEST. To date the interface between the Department of Education and Training and DEST has been effective.

4.2. The national Industry Skills Councils and local Industry Training Advisory Bodies are establishing closer links in the development of community services and health industry training plans.

5. Indigenous health worker issues

In responding to the Health Workforce Productivity Commissions Issues paper, it needs to be stated that the Department of Education and Training acknowledges the Aboriginal view of Health Care and the principles of a Holistic approach to the individuals' health needs, of Body, Mind and Spirit. This acknowledgement goes further to include the role of Aboriginal Medical Services and the principle of Aboriginal Self Determination.

6. Aboriginal Health Workers

6.1. Aboriginal Health Workers (Haw's) represent the major employment category of Aboriginal employees in the Health industry with approximately 300 men and women working in the Government and Non-Government (Community Controlled Health Services) sectors throughout Western Australia. Essentially, there role is to dispense Primary Health Care to the Aboriginal Community and ensure that mainstream services are provided in a culturally appropriate manner. To be employed as an AHW one must first successfully complete a Certificate 3 in Aboriginal Health Work.
6.2. Aboriginal Health Worker training currently exists throughout Western Australia in the following independent Rot's:
- Marr Mooditj (Perth)
- Kimberley Aboriginal Medical Service (Broome)
- Bega Garnbirringu (Kalgoorlie)
- Ngaanyatjarra Health Service (via Alice Springs)

6.3. Future consultation with these RTO's will focus on course and curriculum development designed to meet the future demands of a changing health industry, by offering training that is relevant and appropriate while marinating a high standard of competencies in meeting the health needs of Aboriginal clients.

7. The Department of Education and Training is well placed to support Aboriginal workers and communities with a network of more than 50 campuses throughout the state. Apprenticeships and Traineeships may also provide for increased Aboriginal participation in the Health Industry.

8. The major challenge in the future will be to ensure that future health workforce planning is done in an inclusive negotiated manner with those agencies affecting Aboriginal employment. In a micro sense other challenges which present are:

8.1.1. Use of technology to improve access to courses in remote and regional areas.
8.1.2. Lack of facilities and resources to engage students in some remote areas.
8.1.3. Lack of adequate educational support for some workers /students in remote communities.
8.1.4. Use of mentoring / preceptors to assist with on the job training and clinical placements.
8.1.5. Need to develop better working / partnerships with key health stakeholders when discussing competency standards, wage parity and awards, regulations and legislation, career structures and pathways.
8.1.6. Use of Apprenticeships in hospitals Carpenters, Electricians, Mechanics, as well as blue-collar occupations, which have been a source of employment in country areas (orderlies, kitchen staff, gardeners etc).
8.1.7. Different health needs and population demographics than non-Aboriginal people.
8.1.8. Poor educational outcomes of Aboriginal students making University entrance in health professions less than acceptable.
8.1.9. Training opportunities to revolve around an Aboriginal perspective of holistic health, being an approach dealing with the individuals Body, Mind, and Spirit.
8.1.10. Increase numbers in the Nursing profession using training courses and programmes.
The Department of Education and Training has the capacity to support Aboriginal people currently employed in the health sector, as well as assist those considering a career in health. Through the Training Information Centre (TIC) information can provide Labour market trends, including information on how the economy, technology and global change can influence employment choices and changes. Further information can be provided on Job Qualifications, Career Choices, Re-entry Courses and Skills recognition. Attachment 1 outlines current full-time courses on offer in the field of health, as well courses relevant to professional development and community planning.

Key Recommendations for Aboriginal Health Workers

9. That the Department of Education and Training participate on the WA Working Party of the Community Services and Health Training Australia's (CSHTA) Aboriginal Health Worker and Torres Strait Islander National Competency Standards and Qualifications Project.
10. That the Department of Education and Training address the next meeting of the Aboriginal Health Council of WA.
11. That the Department of Education and Training develop strong links with the Community Services and Health Industry Skills Council with a view to ongoing consultation with addressing future training needs in the Community Services and Health Sectors.

Appendix 4

Submission by the Western Australian Department of Education Services

Our Ref: LJM:lr:

Ms Meryl Cruickshank
A/Manager
Workplace Policy and Standards
Workforce Directorate
Department of Health
PO Box 8172
Perth Business Centre
PERTH WA 6849

Dear Ms Cruickshank

RESPONSE TO THE PRODUCTIVITY COMMISSION'S "THE HEALTH WORKFORCE"

The Higher Education Office has an interest in those aspects of the report that refer to the role of universities and student demand issues. Our philosophy is that: *Western Australians should have access to tertiary education opportunities, including health programs, at the same rate and cost as people in other States.* Where we perceive that this principle is being breached we believe we should try to alleviate the situation.

There have been a number of cases during the last 7 to 8 years, which have been key concerns for the State. We have attached a paper (Attachment 1) which gives some substance to the positions we wish to submit.

The scope of our concern and expertise is limited to university and student issues and **within this we endorse all those points made under the heading "how are these tensions manifested" from page 27 to page 29 in the report.**

For us the primary issue is that there is a *major discontinuity between the role universities believe they have, which is to provide a broad general education informed by a research ethos on the one hand, and the needs of a health service which generally requires highly skilled employment-ready graduates on the other hand.* Any attempt to improve the current situation needs to be prepared for this difference in perceived roles.

Twenty years ago most of the Allied Health courses resided in the Colleges of Advanced Education, which under the Dawkins changes metamorphosed into universities. The needs of the Health Sector have remained but the role of the institutions has changed dramatically.

The funding model developed by the Commonwealth in recent years has made it very difficult for universities to be more vocationally oriented. We also believe the problem has been exacerbated by the Commonwealth negotiating places and priorities with individual universities and very rarely with State government agencies. This strategy is seemingly based on the invalid principle that the State perspective is equal to the sum of views of each of its universities.

There has been no consideration of the initial cost to students of converting undergraduate to postgraduate courses, increasing course length either at undergraduate or postgraduate levels[1].

1 **The significant extra costs in virtually all Allied Health areas will ultimately add to the cost of accessing those services. For example Podiatry was a 3 or 4 year HECS course in the early 1990s costing say 4*2400 =$9600. Now, as a postgraduate Masters it would cost 3*8000 UG =$24,000 plus 2 years PG @15000 = $30,000 – total cost $54,000. This is a 5-fold increase in just 10 years.**

Finally, the issue of cost shifting needs to be clearly appreciated. If a HECS based health course can be moved to the post-graduate level this load (which attracts a high Commonwealth allocation) can be converted into low-cost courses and the funding 'saved' put into other activities, such as research. This is not supposed to happen but does because the Commonwealth's complicated load balancing occurs over the total university profile.

We make the recommendations noted below as constructive mechanisms to correct a situation that, in our view, has been deteriorating for a number of years.
The recommendations are directed at action we believe the Department of Education Science and Technology (DEST) should undertake in order to address some of the key outstanding issues in the higher education aspects of the demand/supply equation.

Recommendations

That DEST should recognise that the current mechanisms for university accountability for student undergraduate load in health related areas inhibit the meeting of workforce needs. Consultations with Health providers and State agencies should precede the development of funding agreements with universities.
That DEST should acknowledge that a situation that allows universities to move HECS-supported undergraduate load to fee-paying post graduate load is not fair on the students and, because it will increase the time and cost, will be passed on in the form of increased costs to Health providers. This activity also enables universities to convert high-income course load into low-cost load areas. This activity by universities should be regulated.
That DEST should ascertain a mechanism so that, if a university desires to cease to offer a health related course that has importance to Health providers in the State, the resources so provided by the Commonwealth for that course should be made available to other universities willing to provide the course.
That existing problems must be dealt with as part of the negotiations for the allocation of new places in 2006 and in subsequent funding agreements.

Yours sincerely

TERRY WERNER
DIRECTOR
HIGHER EDUCATION & LEGISLATIVE REVIEW

15 July 2005

ATTACHMENT 1 BACKGROUND EXAMPLES AND CONTEXT

The State Higher Education Office has a long term involvement with the transfer of nursing from State to Commonwealth funding and the reviews of a number of allied health programs in the late 80s and early 90s but more recently in responding to a large number of ministerial letters received from students, parents and professional associations. Issues raised from the latter form the basis of comments we make on this report. A summary of major issues in health related areas from the past 7/8 years are noted below.

Audiology

It is recognised that there is a small but growing demand for audiological services caused by both population growth and ageing population. Information from several years ago suggested that there were a number of related programs in WA. There is the area of Speech and Hearing Science at Curtin University which considers the medical, clinical, pathological aspects of speech and language disorders; there was an ENT specialist program at UWA which was a research oriented medical science speciality and now has an audiology stream. Audiology was available at Curtin for the training of highly skilled technical staff who test hearing abilities, fitted hearing devices (often working with a surgeon) and undertake general 'ear' medicine; finally there were several programs for "teachers for the deaf".

The Curtin course was cancelled as it suffered a significant decline in students when the Commonwealth first moved Post-graduate Diplomas[2] to a self-funding basis.

While the numbers involved were not large the principles involved were significant. This policy move by the Commonwealth was made without consultation with the States or the areas affected, without considering the ramifications on the nature of the courses affected, the workforce requirements or the wider

2 Th
Graduate Diploma provided the opportunity for intensive skills training in a wide range of areas for students who had done generalist degrees – eg BA followed by a Grad Dip in Business provided considerably enhanced employment opportunities. The only area to escape the change was the Grad Diplomas in education.

community. Ironically it caused some universities to shift their courses to be 'research-based' in order to 'help' students – but detracted from what the workforce required.

Pharmacology

Most of the agitation over pharmacy came from students who were caught in the change from a three-year to a four-year degree. Students complained that the course was extended largely because the university had moved from a 15 week to 12/13 week semester and hence material needed to be covered over a longer period.

There were also a large number of concerns expressed about the influence of Pharmacists in the 'supervised practice' period and the overall goals and objectives of workplace learning experiences within an academic course.

Podiatry

We quote from a letter from Minister Carpenter to Minister Nelson in 2002:

> *It has recently been brought to my attention that .. university.. intends reorganising its Podiatry course so that instead of it being a four year undergraduate program it will be a post graduate course probably of two year's duration.*
>
> *This would effectively increase the cost of the course to students from about $20 000 to about $50-60 000 and delay entry into the workforce by a couple of years. It would also make it about twice the cost of a medical course.*
>
> *I understand that .... is probably not alone amongst Australian universities in contemplating this type of change. Unfortunately it is likely to extend to all the Allied Health areas within a short time.*
>
> *This change represents the first implementation of first time entry into a profession requiring post graduate qualification – a major issue of 'credentialism creep'. Apart from the cost inhibiting application by students from less advantaged backgrounds, a major outcome will be increased fees charged by therapists in order to recoup these additional costs - with flow on effects to health budgets.*
>
> *I appreciate that universities are self governing in terms of academic decisions but this type of development clearly impacts on the State's need to provide an effective, efficient health service.*
>
> *I would appreciate your advice on how we might work together to resolve some of the underlying issues.*

Optometry

We quote further from the previous letter:

> *As a State we have had ongoing problems with providing access to optometry courses. These are all important human resource issues in terms of servicing the need for Allied Health personnel in our large State and are important to me in the sense of providing courses in WA which are priced similarly to those in other States. It is clearly unfair to young West Australians to be required to undertake high fee postgraduate programs in this State whereas, if they were in Victoria, for example, they could do a HECS funded undergraduate program. The latter would be at a fraction of the cost of the former.*
>
> *I don't think either of us can stop this type of change happening but we might be able to present a view that the best interests of Western Australia should be served, and not just the best interest of individual universities.*

The response from the Commonwealth indicated that the new mechanisms being developed by the Commonwealth would address some of these matters. We don't believe the issues have been resolved to date.

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10 Australian Institute of Health and Welfare 2003. Nursing Labour Force (Health Labour Force Series No 29)
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14 Country Health Services Discussion Paper, North West Health Services, Department of Health, 2002.
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16 Medicare Statistics 1984/85 to September Quarter 2003, Department of Health and Ageing
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21 Australian Institute of Health and Welfare 2003. Nursing labour force 2001. AIHW cat. No. HWL 26. Canberra: AIHW (National Health Labour Force Series No. 26)
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