Tasmanian Government

Submission to the

PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY

for the

COUNCIL OF AUSTRALIAN GOVERNMENTS

September 2005

Published by the Tasmanian Government

Department of Health and Human Services

Hobart, Tasmania

Authorised by the State Government of Tasmania 15 Murray Street, Hobart.

Contents

The Tasmanian Government welcomes the Productivity Commission research study into the health workforce. While each State and Territory has its own specific demographic issues, the effectiveness of the health workforce is an issue for all levels of Government. Any national response needs to be sensitive to regional and jurisdictional differences.

This submission focuses on the particular impact of health workforce issues and opportunities on Tasmania as a small state. Tasmania has also made contribution to the Australian Health Ministers Advisory Council (AHMAC) submission, which represents issues of mutual concern to jurisdictions.

Issues and actions key for Tasmania

Tasmania's innate characteristics have strongly influenced its population and economy. In turn, these affect the requirements of healthcare services and the need for promotion of wellbeing within Tasmania, and the workforce as an input to the provision of those services.

Key health workforce effectiveness and efficiency issues for Tasmania:

- 'Service squeeze': rising demand and constraints on workforce supply
- Requirement to deliver appropriate services to a highly dispersed population
- Flexibility of workforce design and utilisation, including supply pathways
- Optimising training capacity and mix locally and from other jurisdictions
- Role clarity, balance and resourcing in service and education provision
- Supportive systems, cohesive data and service self-adjustment

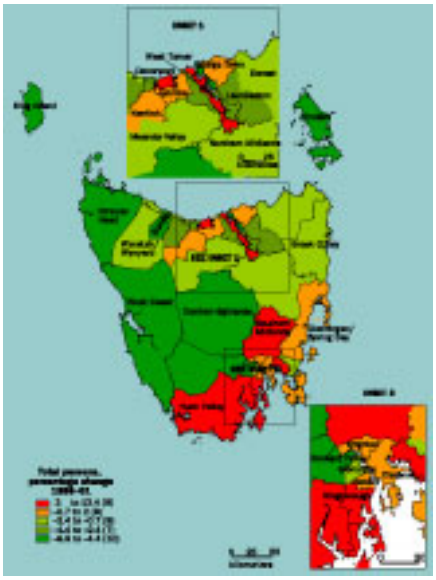
Key actions which would assist the Tasmanian health workforce:

- National regulation of health professionals
- National accreditation of courses
- Competency based courses aligned to workplace needs
- Modification of Medical and Pharmaceutical Benefits schemes to provide incentive for better distribution of health care workers

Demand for Health Services in Tasmania (TOR 3)

Population distribution *(TOR 3a)*

Tasmania has a small population (483,952 estimated at December 2004[1]) which is particularly dispersed.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"Tasmania has the highest percentage of [population of] any Australian state located outside its capital city."[2]

Where population growth or redistribution is occurring, it is mostly outside the urban centres (as defined by the ABS classification of population centres[3]). The largest percentage increases occurred at centres including Scamander, Lewisham, Otago, Sulphur Creek, Eaglehawk Neck, Howden, Cremorne, Leith, Woodbridge, Oatlands, Strahan, South-Arm and Richmond.[4]

Geographic prevalence and patterns of disease also influence the demand (and need) for health care services, and therefore demand for the health workforce. A clear understanding of the evolving epidemiology of the population to whom services are to be provided is necessary if good health outcomes are to be experienced with relative uniformity. In the North West region of Tasmania, for example, respiratory and cardiac conditions are currently found at a higher rate than for the State as a whole, requiring additional focus on services to address these complaints.

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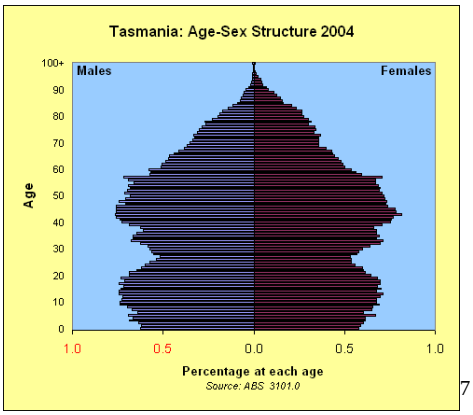
[1] Australian Bureau of Statistics, *Unpublished.*
Population Growth. Cat. No. 2016.6., Australian Bureau of Statistics, Canberra, Australia.
[2] Resource Planning Development Commission, 2003, *State of the Environment*
www.rpdc.tas.gov.au/soer/recommendation/120/index.php
[3] ABS classification of population centres : 'urban centre 1' (20,000 people or more), 'urban centre 2' (1,000 to 19,999) or 'locality' (200 to 999)
Australian Bureau of Statistics 2001, *Census of Population and Housing: Selected Characteristics for Urban Centres and Localities, Tasmania 2001. Cat. No. 2016.6.*, Australian Bureau of Statistics, Canberra, Australia.
[4] Resource Planning Development Commission, 2003, *State of the Environment*
http://www.rpdc.tas.gov.au/soer/set/5/issue/79/ataglance.php

Demographic trends *(TOR 3a)*

The Tasmanian population has seen both decline and growth in the last decade. It is currently growing very slowly through natural increase and migration, but is ageing rapidly. This is 'due in part to the conventional causes of population ageing (low birth rates and increased life expectancy), but which in Tasmania's case are exacerbated by the older median age of migrants to Tasmania compared with those who leave'[5].

The combination of these factors already means that the average age of Tasmanian males is higher than for any other State or Territory, and current projections indicate that the average age of all Tasmanians will soon exceed that of South Australians – currently the State with the oldest population.[6]



[7]

The dependency ratio (of those outside the traditional working age range to those within it) for the State is projected to increase substantially over the next 40 years due to the rising number of elderly. The number over 65 is anticipated to more than double and the number over 80 is set to more than treble over that time, while the numbers of Tasmanians in lower age groups are already in decline.[8]

There is debate about whether an ageing population necessarily foreshadows greater demands on the delivery of health services, or whether the benefits of higher standards of living experienced by those who will become our elderly may lead to reduced morbidity and hence lower overall cost. However, it is clear that the increase in the proportion of the population who are in older age cohorts is likely to impact on the need and demand for certain types of health care.

It is expected that demand for aged care services will increase at a significantly faster rate than the supply of aged care services allocated on the current benchmark of people aged 70 years and older. The anticipated increase in demand is based on the fact that the number of people aged 85 years and over is projected to increase at a faster rate than the population 70 years and over. As people age, their likelihood of using aged care services increases significantly. Typically, people now entering residential aged care services in

[5] Jackson, N.O., 2005, *Comment on latest ABS Release (Dec 2004) – Population Growth positive but slowing*, http://taspop.tasbis.com/webapps/site/588/widgets/1396/news/news-more.html?newsid=6273
[6] Jackson, N.O., 2005, *Comment on latest ABS Release (Dec 2004) –Median age one month behind South Australia* http://taspop.tasbis.com/webapps/site/588/widgets/1396/news/news-more.html?newsid=3020
[7] Jackson, N.O., 2005, *Comment on latest ABS Release (Dec 2004) –The "Bite" in Tasmania's Age Structure* http://taspop.tasbis.com/webapps/site/588/widgets/1396/news/news-more.html?newsid=3019
[8] Tasmanian Government, 2004, *Tasmanian Government Submission to the Productivity Commission Study into the Economic Impact of an Ageing Population.*

Tasmania are aged in their mid eighties or older. Failure in aged care service provision will push unmet need into the health sector at a substantially higher cost.'[9] ***(TOR 3b)***

Consultation with service delivery areas indicates that case complexity and co-morbidity are rising, although length of stay is generally decreasing, partly through the implementation of new technology and techniques. ***(TOR 3a)***

The Productivity Commission recently estimated that ageing would account for about half of the rise in health care expenditure in the coming decades.[10]

Socioeconomic status *(TOR 3a)*

Tasmania's population is characterised by relatively low socioeconomic status. On the Henderson half mean measure in 2000, Tasmania had the highest poverty rate of any State, and the highest proportion of low-income families (<$21,000 per annum) and people receiving income support.[11] Tasmania also had the second highest level of disadvantage according to the ABS Index of Relative Socioeconomic Disadvantage (now SEIFA)[12] and the highest proportion of households that went without meals or heating due to financial hardship.[13] This was also reported to have resulted in over 30 per cent of Tasmanians not seeking medical care, and 30 per cent not purchasing the prescribed medication.[14]

These results have clear implications for the way in which Tasmania's poorer socioeconomic status places higher demand on health and community service resources[15] resulting in later presentation, greater likelihood of hospitalisation and more complex treatment requirements.

Tasmanians have in recent history experienced poorer health and wellbeing outcomes on a range of indicators including mortality rates, leading causes of death, life expectancy, potential years of life lost, self-assessed health status, and prevalence rates for morbidities that have been identified as national priority areas.[16]

For those in employment, rising household incomes have enabled consideration of greater expenditure on health and wellbeing. While expenditure in this area must be weighed against other goods and services, given that health and wellbeing is commonly perceived to be a superior good, people are more likely to spend greater than proportionate amounts on it as their economic standing improves.[17] For Tasmania, economic progress and the

[9] Tasmanian Government, 2004, *Tasmanian Government Submission to the Productivity Commission Study into the Economic Impact of an Ageing Population.*
[10] Productivity Commission, 2005, *Economic Implications of Ageing*, p143.
[11] Australian Bureau of Statistics special data services, cited in *Social Health Atlas Australia*, 1999.
[12] Australian Bureau of Statistics, 1998, 1996 *Census of Population and Housing: Socio-Economic Indexes for Areas.* Catalogue No. 2039.0, Commonwealth of Australia: Canberra.

[13] Australian Bureau of Statistics, 2001. *Household Expenditure Survey 1998-99*
[14] Department of Health & Human Services, 2001. *Economic Wellbeing in Tasmania: Healthy Communities Survey 1998*. DHHS: Hobart.
[15] Tasmanian Government Submission to the Senate Community Affairs References Committee Inquiry into Poverty in Australia, 2003, p9.
[16] *Social Health Atlas of Australia*, 1999; Australian Bureau of Statistics, *National Health Survey 1995*; and Australian Bureau of Statistics, *Australian Social Trends 2001*.
[17] AHWAC/AMWAC 2005 (forthcoming) *Demand for Health Services and the Health Workforce*: Health Workforce Information Paper 3, p 10.

decline in unemployment rates may yield greater than proportional growth in demand for health care, and may realise some areas of latent demand or unmet need. ***(TOR 3b)***

Consumer Expectations *(TOR 3b)*

At the same time, the level of awareness of consumers in general has been rising, with increased coverage of health information by the media. Levels of access to information about health care and wellbeing have risen. Advances in technology, pharmacology and development of procedures in Australia and elsewhere have enabled better treatment of some conditions, and treatment of a wider range of conditions.[18]

Advances such as these, and demand for them, have been a major factor in the growth of health care expenditure over the last few decades.[19] However, not all advances lead to productivity in the sense of better meeting the originally recognised need with the same level of resource input. They may also extend provision of service beyond previously accepted outcome levels or widen scope of treatment, both driving demand, albeit toward better outcomes for consumers.[20]

Tasmania has found that it is not always possible within current service delivery structures, or on a per capita basis, to justify investment in some of these treatments and technologies. Should it be agreed that investment is to occur, location also needs to be carefully considered in conjunction with other factors, such as the critical mass of staff and co-located services required for sustainability, avoidance of duplication, collaborative arrangements for maximum utilisation, and implications for consumer access. ***(TOR 3b)***

Consumers in Tasmania have sought the treatment they perceive to be best. In some cases they have also identified and made clear where and at what price they believe they should be able to access such treatment. Criteria underpinning service provision and location of delivery are not always clearly understood, or widely agreed.[21] Expectations of public service delivery need to be constantly guided in order to avoid limitless demand and encourage utilisation of services in locations which are transparently determined.

Consumers may not always be well placed to assess which treatments will be most effective for them, and may generate demand for treatment that does not actually meet their need.

Conversely, in giving advice to consumers, health care professionals hold a position of influence, and may make recommendations which are more in their direct economic interest than of benefit to the consumer. The Productivity Commission suggested in 2002 that such practices (which may amount to supplier induced demand) are more likely where a fee-for service income model is in place, or substantial differences exist with regard to the information able to be appropriately utilised by client and service provider.[22]

[18] Ibid., p18.
[19] Productivity Commission, 2005, *Economic Implications of Ageing*, p 148.
[20] AHWAC/AMWAC 2005 (forthcoming) *Technology and Workforce Planning*: Health Workforce Information Paper 2, p20.
[21] Richardson, J, 2004, *The Tasmanian Hospital System: Reforms for the 21st Century*, Department of Health and Human Services, Tasmania, p 39.
[22] AHWAC/AMWAC 2005 (forthcoming) *Demand for Health Services and the Health Workforce*: Health Workforce Information Paper 3, p 14.

Tasmania's population has relatively low levels of formal educational qualification attainment[23] and is therefore arguably more susceptible to both behaviours.

Consumers are also seeking convenience. Desire for services which are available at convenient times and locations is also evident in the strong use of after hours general practice services that use simple access processes and staff with suitable levels of knowledge to screen clients by phone or in person. While this service in Hobart is not particularly close to the major hospitals, it has been able to treat a range of cases which would otherwise contribute to workload in Departments of Emergency Medicine. The service is well established and accepted by the public. The processes used, including screening arrangements, are estimated to have decreased the out of hours work of subscribing General Practitioners by 80 per cent, and contributed to the lower rates of usage increase for Hobart Emergency Medicine facilities than is the case in other jurisdictions. ***(TOR 5)*** However, Tasmania also has an interest in understanding other successful models for managing Primary Care Type Emergency Department presentations and would support further cooperative work between the Australian Government and States and Territories to explore such models.

In seeking to meet the health care needs of Tasmanians, the Department of Health and Human Services is working toward an improved evidence base for workforce planning in Tasmania, and its integration with planning for service delivery. Collaborative efforts with other jurisdictions to establish common data sets and potential benchmarking opportunities are welcomed.

Supply of Health Services in Tasmania (TOR 2)

In focusing on workforce below, it is acknowledged that health service supply depends on availability of a range of factors, of which access to an appropriately skilled and distributed workforce is only one. Enabling factors, such as facilities which are suitably sited and equipped, equitable access and the use of supportive systems and relevant innovation, can greatly influence the productivity of the workforce as well as influencing scope and quality of outcomes.

Workforce (TOR 2a, 2b, 2c)

Tasmania's health workforce is mirroring workforce issues for the State as a whole. It suffers from supply difficulties because of declining participation levels, an inability to train all of the occupations it requires, and competition for the graduates it does produce. Both worker attraction and retention are seen as increasingly difficult for a wide range of occupations, particularly for regional and remote service delivery. Tasmania relies on interstate and overseas immigration for a small but significant part of its workforce, particularly for regional areas. ***(TOR 3c)*** Distribution issues and diseconomies of scale make education and training challenging for vocational, undergraduate and postgraduate levels. Current investment in a number of areas, particularly mental health, cancer, disability and children's services, is likely to increase requirements for health and wellbeing workers.

Current workforce

The current health workforce in Tasmania is ageing along with the population generally. Together with the low levels of natural increase, relative discrepancy in population

[23] ABS Education and Training Experience, Cat No. 6278.0

movement for Tasmania between younger (emigrating) and older (immigrating) persons means there is a diminishing number of workforce entrants in the lower age cohorts. The workforce profile is therefore skewed towards the higher ages[24].

For instance, the nursing workforce is the oldest of that in any jurisdiction[25], has the highest percentage of nurses working part time (60.8 per cent compared with the national average of 52 per cent), and the lowest average weekly hours (29.2 compared with 30.7 nationally).[26]

Older workers are staying in paid employment longer than has been the case in the past, causing the average age of retirement to slowly rise overall, but the high numbers of older workers mean that rising retirement rates are not far away. At present, 17.1 per cent of the Tasmanian health workforce is eligible to retire (21.1 per cent of doctors and dentists), with another 16.5 per cent within five years of eligibility.[27]

The exit ratio (number of workers exiting the labour force compared to the number of workers entering) is projected to rise significantly over the next ten years. Tasmania is likely to lose two workers to retirement for every worker entering the labour force – sooner and more dramatically than will be experienced by other jurisdictions.[28]

Most medical practitioners and a number of nurses and other professionals work in both the public and the private sectors.*(TOR 2c)* For medical practitioners, their visiting status in public hospitals gives rise to some issues concerning availability and responsibility for teaching. Particularly in regional areas, debate exists as to the productivity benefits and net gain to the consumer of employment of full time staff specialists relative to visiting medical officers, and generalists compared to specialists. *(TOR 1f)*

There is tension between the need to provide a broad range of services to a dispersed population, with the growing body of knowledge and clinician interest in, and consumer expectation of access to treatment from, specialist areas of practice. This results in gaps between the areas in which people are prepared to work. There is some debate about how realistic it is for professions to stay abreast of developments across the board, the expectation of the public about the level of expertise which should underlie treatment, and the risk to which this exposes both the clinician (complaints) and the patient (lack of frequency with a particular procedure). Generalist staff, although highly valued for their flexible contribution to the workforce, are often less well remunerated than their specialist colleagues. This is the case across the health sector, not only in medicine. *(TOR 2c)*

At the opposite end of the scale, the lack of widespread use of multi-skilling in operational roles in the public sector, reinforced by industrial precedent, limits workforce flexibility and efficiency in supporting service delivery.

[24] DHHS Workforce Strategies Unit, 2005 (Unpublished), *DHHS Workforce Age Profile.xls* Human resource information system data.
[25] AIHW, 2005, *Nursing and Midwifery Labourforce 2003*, Catalogue No. HWL 31, p 18.
[26] AIHW, 2005, *Nursing and Midwifery Labourforce 2003*, Catalogue No. HWL 31, p4.
[27] DHHS Workforce Strategies Unit, 2005 (Unpublished), *DHHS Workforce Age Profile.xls* Human resource information system data.
[28] Tasmanian Government, 2004, *Tasmanian Government Submission to the Productivity Commission Study into the Economic Impact of an Ageing Population.*

Participation and hours worked *(TOR 1d)*

Tasmania's health workforce has high levels of part time work and low reported average hours worked by a range of occupations.[29] The average establishment full time equivalent (FTE) of the public health workforce was 0.65 at June 30 2005.[30] Analysis of actual hours paid in the pubic sector by professional stream and service delivery area over the past 5 years is underway. *(TOR 4b)*

Lower numbers of hours worked per week have been associated with the ageing of the workforce, particularly for fixed term and casual workers, and also with family responsibilities – increasingly elder care.[31] Desire for, and engagement in lower levels of participation can also be linked in some instances to levels of workforce satisfaction, and as a reaction to workplace pressure.[32] *(TOR 1e)* This has implications for workforce capacity and the need for productivity in order to meet health care needs for Tasmania.

For instance, Tasmania had the lowest number of hours per week reported by medical practitioners in 2002 (41.4 compared with 44.4 for all practitioners, and 38.5 compared with 41.1 for primary care practitioners).[33]

While workload is sufficient to provide the current or greater numbers of hours of employment, a need to balance commitments to work, family and lifestyle is seeing increasing desire for reduced participation and more flexible working conditions.

The take up of recently established re-training and refresher courses for nurses has been moderate, indicating that desire of the latent nursing workforce to return to activity in this area is somewhat limited. *(TOR 1d)*

Maldistribution is also evident on a geographic and service (including specialty) basis. Attraction and retention are more problematic in areas which do not have ready access to a wide range of other services for health workers and their families. In addition, difficulties are experienced in community-based workforces, such as allied health services, child protection and youth justice. Although work around these issues is being undertaken through the Community and Disability Services Ministerial Council (CDSMC), it is likely to remain problematic as supply in general tightens.

Development of the employed health workforce

Development of the health workforce is undertaken through worksite training (which may or may not be accredited), as well as through further study.

A small number of bursaries (mostly for Allied Health professions) and scholarships (Mental Health) are offered, as well as enabling mechanisms such as the public sector's post-graduate loan scheme, and incentives such as the Australian Government's HECS reimbursement scheme for rural medical graduates.

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[29] AIHW, 2005, *Nursing and Midwifery Labourforce 2003*, Catalogue No. HWL 31, p 18., AIHW, 2004, *Medical Labourforce 2002*, Catalogue No. HWL 30, p 14

[30] DHHS Workforce Strategies Unit, 2005 (Unpublished), *DHHS Workforce Age Profile.xls* Human resource information system data.

[31] DHHS Workforce Strategies Unit, 2005 (Unpublished), *DHHS Workforce Age Profile.xls* Human resource information system data.

[32] DHHS, 2004, (Unpublished) *Nurse Work-Life Balance Survey*

[33] AIHW, 2004, *Medical Labourforce 2002*, Catalogue No. HWL 30, p 14

However, opportunities to take up further study are limited by viability considerations for local education and training providers, as well as by the study modes offered in conjunction with, or independently by, those further afield. In addition, many Tasmanian professionals choose to go interstate to access the post-graduate education they are seeking. *(TOR 1b)* This can result in the Tasmanian health workforce losing that person's expertise for some years, if not indefinitely.

Professional development opportunities are likewise somewhat constrained. Professionals have a responsibility to maintain their expertise through professional development, and do so through face-to-face sessions, video and teleconference, online learning and other distance education.

Where possible, collaborative arrangements are put in place to maximise the benefit derived from "hands on" education and development opportunities (usually within a particular profession, or service delivery area), leading to creative partnerships between colleagues in different locations, or from different sectors. *(TOR 1b)* Interdisciplinary development is currently not common, although a number of service delivery areas are considering ways in which developmental opportunities may more tightly integrate their professional teams.

Although considered by many staff to be the best manner of delivery, such opportunities are not always viable for the health workforce in regional and remote locations, where technology options may limit participation from a distance. Smaller locations such as these also have greater difficulty releasing staff to travel to attend education and training, as there are fewer staff to provide backfill, particularly if any degree of specialisation is involved in the role. Travel is time consuming and costly, particularly if interstate travel is required. Workload considerations can make it difficult to make time for development and planning activities.

Opportunities to undertake clinical placements in support of further education can be constrained by a lack of positions at appropriate levels in service staffing structure, and lack of clarity around budgetary issues and supervisory responsibility. *(TOR 1c)*

Likewise, some service delivery areas engage in vocational education and training of current staff with good results, but this is not particularly widespread. Awareness of the potential value of vocational education and training is not high, and the costs of implementation are often perceived to be too much trouble for managers to pursue. Pathways for individuals are often not well understood, and current skill levels are not explicitly recognised, although each work environment actually requires a certain standard in the tasks particular to its function.

Some work is currently occurring to incorporate modules of competency – which can contribute to qualifications at some point – into orientation for new staff. In principle agreement has been reached that the Tasmanian public health workforce should be qualified. This would mean that current employees would require assessment of their current competencies towards qualifications in the Australian Qualifications Framework, that new employees would start work with the expectation that they will be engaged in education and training as an accepted part of their work, again moving toward first or further qualifications.

Non-government, or community service organisations are realising that their staff may need development, but often encounter difficulties arising from budgetary constraints, workload and ability to backfill. A number of larger organisations have become

registered training organisations to help meet their own needs, and those of others in the sector. *(TOR 1c)*

Making health workplaces desirable to join and to stay in seems to be a challenge shared by many organisations, which struggle to make it a uniform reality.

The productivity of the health care workforce can be significantly affected by the introduction of technology. Tasmania is pleased to be piloting HealthConnect, and recognises the desirability of connected and supportive systems which generate cohesive data and enable service self-adjustment. Implementation of such systems involves significant infrastructure investment, as well as ongoing investment, to enable organisations realise the potential of the systems available, and keep them technology ready.

Potential workforce

The number of entrants to the workforce is declining, while demand is rising. Even if health occupations are able to continue to attract the current percentage of the total Tasmanian workforce, other productivity factors will have to contribute significantly if the quality of healthcare outcomes is to be maintained.

The National Skills Shortage List shows child care, registered and enrolled nursing in a wide range of areas, midwifery, dentistry, pharmacy, occupational therapy, physiotherapy, speech pathology, podiatry, radiography, sonography and nuclear medicine technology to be health-related areas of shortage. Recent consultation tends to confirm this impression among service management, citing workload, vacancies, skill mix and geographic imbalances. Other areas perhaps too small in Tasmania to be included, independently identified a range of very similar issues.

Vocational education and training options around healthcare are not particularly widespread or well marketed in Tasmania. Young people and those considering a change of employment or re-entry to the workforce may not be aware of the range of current and emerging opportunities for work in areas such as child care, aged care, disability support, and enrolled nursing.[34]

Again, and even in the event of strong marketing, the ability of local education and training providers to sustain viable services is made problematic by low numbers overall, particularly if attempting to provide services in a decentralised fashion or with a significant component of "in the workplace" training. It can be quite difficult to negotiate sufficient workplace training opportunities for the number of participants required for a viable course, and ensuring appropriate guidance is available and issues such as confidentiality, indemnity and other legal concerns are dealt with thoroughly but sensitively. *(TOR 1c)*

Vocational education and training is, however, seen to present significant opportunity to provide skills for health care in Tasmania. The Department of Health and Human Services has engaged in promising arrangements with registered training organisations, including TAFE, with which a memorandum of understanding exists which focuses initially on the training of Enrolled Nurses.

[34] Office of Post Compulsory Education and Training, 2005 (unpublished), *OPCET Policy and Planning Response.*

At the undergraduate level, Tasmania offers training for medical, nursing, pharmacy, psychology, biomedical science and social work students. However, it is not able to offer education for all of the occupations required for its health workforce, although it is widening offerings in partnership with interstate institutions. This means that some Tasmanians go interstate to train, with the strong possibility that they will not return for some time or at all. As a consequence, Tasmania has limited ability to forecast supply for the occupations it does not train locally.

At all levels, clinical education of students and trainees can be problematic. Many experienced professionals consider that in particular, new graduates do not have the depth of clinical understanding needed in the workplace. However, it is difficult to find sufficient places for them to gain such experience, and simulation environments are not readily accessible. In the current environment, the effectiveness of placements and the quality of the learning outcomes can vary significantly. *(TOR 1c)*

Investment by the Australian Government through full funding of the costs of clinical education would have a significant impact on supply mechanisms.

Engagement of both the health, and education and training, sectors is vital.

In Tasmania, the Department of Health and Human Services (DHHS) and the University of Tasmania are pursuing such engagement through the Partners in Health collaboration, one focus of which is the provision of a flexible and sustainable health workforce. This is likely to require new roles, as discussed at a series of workshops sponsored by Partners in Health early in 2005 with Debra Humphris of Southampton University's New Generation Project, considering future service provision and workforce implications.

As the public health workforce employer, DHHS needs the flexibility to match roles to required service delivery. Nurse practitioner roles and alternative service configuration and models of care are being considered. In some cases, this may mean changing the skill mix within service delivery units to provide support and enable focus on using skills efficiently. It may also mean investing in simplifying processes so that more can be provided in the home, or closer to home, with complex treatment provided to fewer locations.

Multi-skilling, workplace reform and role substitution contribute to appropriate solutions. An approach to education and training is needed which more tightly integrates workplace need with student numbers, learning approaches and competencies. This should include the articulation of tertiary courses with vocational education and training. The latter may need greater emphasis given the lower formal education profile of Tasmania.

It is expected that different qualifications will result, with multiple paths into, and out of particular qualifications and employment options. Maintenance of quality and safety in modular pathways for career progression and inter-disciplinary transition will be facilitated by streamlining current course accreditation requirements and regulation of professions to accommodate a more multidisciplinary focus, and national scope.

To sustain supply, Tasmania needs to optimise local education and training, and encourage local retention. Through closer relationships with students and trainees, ongoing contact and graduate employment options such as cadet and trainee roles, Tasmania hopes to encourage greater uptake of health employment required for a robust health care system.

Higher education providers need to be persuaded to establish in their offerings core health competencies which are aligned with workplace needs, progress multidisciplinary

education models, and are assessed on competence attainment rather than duration or contact hours. A much tighter integration with vocational education and training provision is needed to allow more strategic and systemic approaches to health education.

In addition, where it is impractical to provide a sustainable course for particular health care workers locally, collaborative arrangements are required so that the needs of smaller jurisdictions are factored into the education and training provided in other states and territories.

Adequacy and action *(TOR 4)*

Tasmanian health workforce action and adequacy

Future factors seem likely to increase the pressure on Tasmania's health workforce.

The size of the Tasmania health and the education and training sectors presents special challenges for the State to secure a sustainable health workforce. These challenges arise in a number of ways.

The first challenge relates to the lack of capacity to train the full spectrum of health occupations. This presents a recruiting challenge, as there are obviously no locally produced graduates in some health occupations. Further, there is limited capacity to offer clinical training in the particular occupations because of size and access to professional and educational support. This in turn exacerbates an existing recruiting difficulty due to geographical location and isolation.

These matters can only be addressed by effective health service planning and national workforce planning that takes account of the needs of Tasmania and other small jurisdictions or regions. The size of interstate or national training programs must consequently take account of the need to ensure reasonable access to health care for Tasmanians. This is also relevant to the allocation of funding to education and training programs that are able to be provided in Tasmania.

Recognising that decentralised populations will always have more difficulty in accessing health care, the development of alternative health care roles that supplement or complement existing models of health care is also vital for Tasmanian health service delivery. Again, size and resource constraints limit Tasmania's capacity to develop new health care roles. The greater the flexibility of roles, the greater the capacity of the public and private health sectors to develop health care services to meet the needs of the community. Tasmania's issues in this regard are similar to other jurisdictions or regions, so the development, endorsement and accreditation of such roles on a national basis would greatly benefit health care in Tasmania. This could be achieved through national accreditation of roles and education and training courses.

Notwithstanding the potential initiatives mentioned above, it is likely that other mechanisms will still be necessary to achieve an effective distribution of the work force.

Allocation of provider numbers to medical practitioners based on areas of health care need, greater access by health professionals other than doctors to the Medical Benefits

Scheme and the Pharmaceutical Benefits Scheme, and taxation and other benefits are all necessary instruments required to achieve distribution of the workforce in Australia's public/private health care system. There may also be capacity to use differential MBS payments to encourage practice in areas of shortage, both geographic and discipline. Tasmania would support the common application of such measures.

Finally, Tasmania would support a national reform process that considered:

- a clear understanding of the capacity, composition and productivity of the existing workforce;
- planning processes that took account of the health care needs of regional Australia;
- effective national decision making about the education and training of the health workforce; and
- the development of new workforce roles.

National Action

Effectiveness and efficiency of the workforce could be enhanced by action to:

- Clarify health needs of the population, by:
  - Creating a national body to undertake whole-of-health workforce planning with a long range outlook, including workforce data collection and analysis, as well as assessment of innovation which may enhance productivity through changes to roles, models of care, processes and technology. This could replace the Australia Medical Workforce Advisory Committee (AMWAC) and Australian Health Workforce Advisory Committee (AHWAC). This would benefit all jurisdictions through greater consistency of data and process. Smaller jurisdictions such as Tasmania would benefit from holistic consideration of needs which may require cross jurisdictional supply.
  - Ensuring that all decision making bodies relevant to health workforce supply have some health sector representation, in order to improve the alignment of their decisions with workplace needs and known directions. This would benefit smaller jurisdictions by giving them some input to the processes contributing to their supply, but beyond their normal span of control.
- Create clear opportunities in health and wellbeing to influence supply and distribution through:
  - The creation of clear career options for health service workers with alternative path options, modular competency gain, and employment options at each step. This would enhance the probability that health care career options would be chosen by entrants to the workforce. In Tasmania, maintaining or increasing the proportion of workforce entrants choosing health will be important to maintaining service delivery. Clear options will make this more possible.
  - Ensuring that courses and apprenticeships offered take into account industry priorities and qualifications are awarded on demonstration of competence, rather than focusing on duration of training. This will benefit all health service employers by reducing the duration required to achieve standard competency sets,

and make explicit the competencies which can be expected of graduates. In regional, rural and remote areas, this will give greater certainty to recruitment processes, clarity to support and development requirements, and confidence to graduates.

- Increasing the funding for VET and undergraduate health places, with the number and distribution of places based on identified needs of the jurisdictions, taking into account needs which cannot be met within smaller jurisdictions. Alignment of education and training places, and their funding, with the needs for health care service delivery will enable jurisdictions to plan services with greater certainty regarding probable staffing supply and skill mix. For smaller jurisdictions it is vital that this consideration is holistic, so that occupations unable to be fully trained locally are not overlooked and therefore inclined to fall into shortage, or encourage poaching of students whose overall numbers were designed to supply another state or territory.
- Adoption of common evaluation methods for policy and programs, particularly in relation to recruitment and retention in areas of shortage. This would include the identification and expansion of successful strategies, for instance, with regard to attracting latent workforce back to health care and provision of after hours GP services in locations suitable to the consumers of those services. Common evaluation methods will enable systematic identification of successful policy and programs, and enable their wider deployment and adaptation for broader benefit and better consumer outcomes. This will benefit Tasmania by providing both the ability to contribute in a standard way to the benefit of other jurisdictions, and to access evaluation undertaken by others for which resources would not otherwise be available.
- Development of incentives for students and trainees, and structural imperatives for education and training providers, to increase the number of rural placements and encourage uptake of rural employment. By introducing structural imperatives for rural placement, this practice can be encouraged to become an accepted feature of training in Australia. Greater exposure to regional and rural practice will enhance the probability that students will consider employment options in those communities. This could assist in addressing geographic maldistribution, to the benefit of all jurisdictions with regional rural and remote supply issues, including Tasmania.
- Extending access to medical and pharmaceutical benefits to other health practitioners whose services may acceptably substitute for those of a GP or specialist, giving greatest emphasis to the most effective treatments. This can reduce the workload of medical practitioners who are overstretched, and encourage greater involvement of other practitioners in the areas for which the benefits are defined. In some instances, such as regional and rural Tasmania, this could make resident practice viable for a number of allied health professionals. This would support the principle of the most productive use of the available workforce.
- Ensuring maximum benefit from fringe benefit taxes to provide incentives to work in areas of shortage. In combination with collegial support, education, lifestyle and cultural concerns, monetary incentives through changes to taxation could influence the distribution of health care workers toward areas of need. This

would benefit areas in all states and territories, where attraction and retention is problematic, if appropriately targeted and reviewed.

  - Exploring funding arrangements that would enhance cooperation and recognise mutual benefit for private and public health care training and practice, especially in regional and remote areas. This would help make better use of infrastructure, and encourage awareness of the issues facing each sector, through co-location. There would be greater likelihood of collegial critical mass, which may help foster joint coverage of after hours treatment, and professional interests such as teaching and research.

- Streamline regulation and accreditation, by:

  - Making a single national body responsible for: (1) course accreditation in Australia or overseas, including identification of competencies required at various levels across health occupations; and (2) the assessment of skills and qualifications, including recognition of current competence and assessment of internationally trained practitioners. This would include the specification of any additional requirements of the practitioner for participation in the Australian health workforce. Such a body would need to lead reform and support innovation to maximise use of training capacity through new models, and ensure that education and training remain responsive to the evolving needs of, and for, the health workforce. This would benefit all jurisdictions by making clear the requirements for various roles including interdisciplinary roles yet to be well defined, and the sources from which suitable candidates may be drawn. A consistent approach in this area would benefit Tasmania when considering, as it must, individual candidates who have trained outside of Tasmania, as well as collaborative arrangements with providers of education and training.

  - Nationally regulating health practitioners through a single body using uniform categories and requirements, such as those pertaining to character, competence, and ability, commissioning local investigations as required. This would benefit practitioners through greater mobility and consistency of requirements nationally. It would also benefit jurisdictions by consolidating administration and making possible streamlined arrangements for recognition of interdisciplinary competencies which could be defined once, rather than in each jurisdiction.

- Develop responsive mechanisms to optimise skill supply, mix and distribution, by:

  - Encouraging better integration of the health, and education and training sectors, including clear capacity for health sector involvement in decision-making structures that impact on the health workforce. This would help sustain supply to small jurisdictions, regional and remote locations through the networking of health service providers and education and training providers.

  - Revising funding models to enable jurisdictions to purchase the vocational and higher education and training places they need from education and training providers. This would ensure the better alignment of courses and their content offered by education and training providers, and enable cross-jurisdictional negotiation for suitable places to be offered that target the needs of smaller jurisdictions which cannot provide all training locally.

- Ensuring the full costs of clinical education are funded from the course provider. This would help reduce bottlenecks in training where responsibility is currently not clearly defined. Including all costs of clinical education in course provision would make explicit what is being provided, by whom, and make it more possible for jurisdictions and health care services to host placements with confidence.
- Considering ways of ensuring return on public investment in training where graduates choose to work in the private sector. This would benefit the public sector by encouraging greater, and ongoing participation in the wider range of services necessarily provided publicly. Such involvement, or suitable penalties for the individual or their private employer would assist particularly where socioeconomic factors significantly influence the numbers and case-mix of those presenting in public and private facilities, such as in Tasmania.
- Recognising and funding the interim requirement for internationally trained health practitioners (including recruitment and necessary training) until the numbers of locally trained health practitioners meet demand. This would assist all jurisdiction – but particularly those with significant areas of need – to meet interim needs from international recruitment in a manner that ensures quality through support and training. At present, the costs of this support and training are not formally recognised, and disproportionately impact those jurisdictions which are small and/or in greater shortage than their counterparts.