Australian Government

Department of Health and Ageing

Response to the Productivity Commission's

Position Paper on Australia's Health Workforce

November 2005

The Department supports the emphasis in the position paper on the need to address the efficiency of the workforce by tackling institutional arrangements and regulations that lead to reduced flexibility in health workforce training and workplace roles. Such issues are essential complements to the more usual focus on efforts to forecast and balance supply and demand in the workforce area.

The position paper identifies the linkages in a complex system well, and puts forward a range of interesting and challenging proposals to address current health workforce problems. In this regard, the Department agrees with the Commission that health workforce reforms need to be approached on an integrated basis which encompasses education and training; accreditation of education and training courses; professional registration; workplace change and job innovation; and funding and payment mechanisms.

However, the Commission's Final Report would benefit from a more in depth analysis of some issues, and more specific recommendations for action in the short term as well as the broad proposals it has put forward for structural changes.

Overall Workforce Position

The Commission has referred to submissions which highlight workforce supply concerns and initiatives that have been implemented to address these shortages. In the case of the Australian Government the major policy mechanisms used to date have included increases in education and training numbers and the increased use of overseas trained doctors to work in areas of workforce shortage. For example, measures to increase the number of medical school places and medical schools will expand the number of Australian students completing university medical studies from approximately 1300 in 2005 to 2100 per annum early next decade – an increase of over 60%.

The Commission has not, however, provided an assessment in its position paper of its view on the extent of current shortages in the major health professions or in the overall health workforce. Nor has it attempted to provide quantitative estimates of future workforce requirements. The Department believes that such assessments would add significantly to the value of the document.

In considering overall health workforce shortages, and the scope to reduce them, workforce participation and retention are important considerations. The issues here relate both to the proportion of professionals trained in a particular discipline that are actually working in that part of the health workforce, and to the average hours health professionals choose to practise in their discipline each week. The community's return on the substantial investment made in educating health professionals will be reduced to the extent that they do not practise in their field of training or they minimise their workforce participation in that field.

Workforce participation and retention rates are both significant problems for particular workforces, but receive little attention in the Commission's paper.

Workforce retention rates for enrolled and registered nurses, who make up more than 50% of the health workforce, are one example. About 10% of currently registered and enrolled nurses are not actually employed in the nursing workforce and it is estimated that there are almost as many formerly registered and enrolled nurses as there are currently registered and enrolled nurses in the workforce.

Given the size of current and prospective nursing shortages, this is a key area for attention, where considerable efficiency gains could be made by better use of existing and future trained nurses. Retention is linked in part, to job satisfaction. Accordingly, improving nursing retention rates can be linked to employment practices and conditions, and job redesign.

The Commission's Final Report should include a more detailed discussion of retention and participation issues and specific proposals for achieving improvement in these areas.

The Commission's various proposals to improve the flexibility of the health workforce will be an important driver of productivity improvement in the sector. However, the Commission's position paper has not argued in any detail its Term of Reference concerning the productivity of the health workforce and the scope for productivity enhancements.

We support the Commission's stated intention to give this area more attention in its Final Report. It is suggested that the Commission's work in this area should include an analysis of enablers to achieving a more productive workforce, including options for the better use of information technology and improvements to service delivery frameworks (discussed at pages 35 and 36 of the Department's submission). As part of its work, ways to provide an improved incentives framework for productivity improvement could be considered.

Workforce Planning

The Department supports the Commission's proposal that, in future, workforce projections should be based on a range of demand and supply scenarios, given the uncertainties in the estimation process. We also support the amalgamation of the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC), which would facilitate a more across-health-workforce, and less profession-specific, approach to workforce planning.

The discussion on workforce planning methodology in the position paper outlines the range of views held by study participants but overall, provides limited guidance for future workforce planners. The Department would like to see more detailed advice from the Commission in its Final Report as to the appropriate approach to be taken to workforce planning in response to the following challenges:

- The lack of agreed benchmarks about the appropriate level and composition of health services for the community.

- The long lead times for medical education and training, which mean that policy changes take 15 years or more to fully realise results, whereas changes in demand for medical services and some supply factors (eg productivity and hours of work) can shift over much shorter periods of time.

- Health workforce planning to date has been largely conducted on a profession-specific basis, rather than looking at the range of skills (divorced from specific professional roles), required to deliver particular services. However, for the latter approach to be effective some agreement is needed about suitable models of care for the delivery of particular health services.

- Data lags and deficiencies in labour force collections.

Health Workforce Flexibility

The Department supports the emphasis in the Commission's position paper on the need for a more flexible approach to training and a greater emphasis on teamwork and delegation of tasks among health professionals to improve the efficiency of the workforce. The main sectors of the health workforce have traditionally had clearly defined roles, and professional boundaries, often set out in legislation and regulations. However, in practice, the ranges of actual tasks that each group can competently undertake often overlap.

The Department agrees with the approach throughout the Commission's paper of promoting policy initiatives which encourage and enable health professionals to work at a level which fully utilises their training, competence and experience.

As discussed at page 30 of the Department's submission, the Australian Government has already taken steps to supplement the provision of primary care services provided by GPs with other health professionals including practice nurses, allied health workers and Aboriginal and Torres Strait Islander Health Workers.

There is scope to look at other new or extended health workforce roles. For example:

- The clinical skills of nurse practitioners would appear to be well suited to areas experiencing particular difficulties in obtaining medical professionals such as aged care facilities and some rural and many remote locations.

- The mid level clinical role performed by physician assistants in the USA and elsewhere, could be developed in Australia. Physician assistants, working under the supervision of a medical practitioner, could be suited to working in a range of areas in both the acute and primary care sectors.

Accreditation and Registration Issues

The Department agrees with the Commission that the current separate, complex, and profession-based accreditation and regulatory arrangements adversely affect health workforce capacity. A national approach to regulatory arrangements for health care professionals, which is centred on individual competencies, would encourage portability and workforce flexibility and help address workforce distribution issues.

There is merit in the Commission's recommendation for a staged introduction of a national accreditation system for health workers. This would enable future workforce training and design issues to be considered on a whole of workforce basis rather than in the current professionally compartmentalised framework.

The proposal to base future registration decisions on uniform standards to be developed by the national accreditation body also has advantages. However, while it would, over time, achieve national consistency in registration arrangements, it is a less complete way of delivering the benefits that could be potentially achieved through a national registration scheme. The Department believes that the mobility and flexibility of the health workforce will be better enhanced by a national registration scheme than by attempting to apply a nationally consistent set of standards to each State and Territory regulatory authority. Also, the process of enacting legislation for each jurisdiction against national standards would be extremely complex.

The Commission should give further consideration to this issue in preparing its final paper.

In recommending new arrangements for accreditation and registration, the Commission will need to have regard to ensuring that there is an appropriate degree of contestability in the system for the services being provided.

New Advisory Bodies on Workforce Innovation and Education and Training

The Department sees advantages in the proposals to establish new advisory structures, reporting directly to Health Ministers, on initiatives to promote health workforce innovation, and improvements to the education and training arrangements for health workers. Both of these areas currently lack a specific focus for promoting necessary changes. The creation of high level advisory bodies reporting directly to Health Ministers could achieve this, and enable the health workforce redesign, and education and training reforms, to be approached on a cross disciplinary, rather than profession-specific basis.

Establishment of these new advisory bodies should be contingent on rationalisation of the existing broad range of workforce advisory structures.

Funding and Payment Mechanisms

The Department notes that the Commission's draft proposals in relation to the Medicare Benefits Scheme (8.1 and 8.2) address two important issues, namely, the types of services subsidised under the Medicare program, and the range of health care professionals able to access Medicate rebates and prescribe Pharmaceutical Benefits Scheme items. These proposals potentially have major financial implications which would require careful consideration.

Strengthening the nexus between current processes for assessment of new services and technologies and the implementation of funding decisions is a priority for the Australian Government and some of the recommendations arising from the recent Review of the Medical Services Advisory Committee will assist in this regard. Mechanisms for improving the efficiency and transparency of existing consultative processes are being considered.

The draft proposal at 8.2 relating to services delegated by a medical practitioner is broadly consistent with the direction of recent steps taken by the Australian Government to supplement the provision of primary care services provided by GPs with those of other health professionals.

Existing initiatives have been narrowly focused on specific services and chronic disease management. Widening the arrangements can offer benefits in terms of improved access and more efficient use of the available primary care workforce, particularly in remote areas where GPs are in very short supply. However, to ensure cost-effective, quality service delivery a number of financial and other issues would need to be considered carefully. These include ensuring that services provided by professionals other than GPs either address genuine unmet need or reduce the pressure on GPs through effective complementary roles. It would also be important to avoid overlap with activity appropriately funded by State and Territory Governments.

Existing MBS practice nurse items provide a possible delegation and billing model. However, there may be a case for a different model in some circumstances. For example, concerns about GPs taking responsibility for services provided independently by allied health professionals have led to the development of a model for chronic disease management and allied health service provision that allows autonomy and separate billing arrangements for allied health workers. At the same time, highly targeted eligibility arrangements are maintained, including a gate-keeping role for GPs.

It has been suggested that current professional indemnity arrangements could pose an obstacle to further delegation of service delivery roles. The Commission may wish to consider whether that is the case and, if it is, how it might best be addressed.

The Department notes that the Commission has also referred in its report to broader health care funding and delivery mechanisms which impact on the provision of services by health workers (for example, the balance between public and private health service delivery). However, these have not been pursued on the basis that they are outside of its Terms of Reference.

Rural and Remote Health Workforce

The Commission proposes that the Australian Health Ministers' Conference (AHMC) initiate a cross-program evaluation designed to ascertain which policy approaches are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia (draft proposal 10.3).

This is, prime facie, a very complex exercise. While there is an ongoing need for evaluation, there are data limitations and in practice it is difficult to disaggregate effects of different initiatives. It is difficult to see how such an evaluation process might advance consideration of alternative policy approaches.

A further important issue is local variation and flexibility in response to community needs. In this context, improving capacity to share the learning on models that have worked or not worked well in different areas would be helpful. In considering further evaluation initiatives in this area, there may be value in seeking to draw on existing evaluation processes, including mechanisms that also incorporate a local focus, eg. rural workforce agencies.

The Department considers that a mix of strategies will continue to be necessary to improve health workforce capacity in rural and remote areas. From the Australian Government perspective these strategies include:

- The provision of a number of financial incentives to attract and retain GPs in rural areas.

- Education initiatives, including scholarships and other assistance to increase the number of students from rural backgrounds undertaking health studies; bonding arrangements; and the establishment of training infrastructure in rural areas.

- Requiring overseas trained doctors to practise in rural or other areas of workforce shortage.

- The development and provision of alternative service delivery mechanisms for rural areas.

The Department agrees with the Commission's view (page 179 of its position paper) that the provision of education and training opportunities in rural areas is a key strategy for improving the rural health workforce. As emphasised in the Department's submission to the Commission (page 41), it is too early to make any firm judgements on the overall success of many of the Australian Government's rural education strategies because of the time lags involved in medicine between individuals starting and completing their studies. For example, the first group of students operating under the Government's Medical Rural Bonded Scholarship Scheme will not be fully qualified until 2008 at the earliest and will not complete their bonding requirement until 2014. By the same token, however, these delays emphasise the need for ongoing efforts to maintain existing programs and, where necessary, develop further creative and effective shorter-term approaches.

The Department also supports the Commission's view that many of the changes which can flow from its broad structural reform proposals would be beneficial for rural and remote communities. For example, the proposed changes to accreditation and registration arrangements can facilitate desirable job redesign and wider scopes of practice in rural and remote areas.

Indigenous Health

The Department supports the Productivity Commission's emphasis on increasing capacity of the workforce in Indigenous health as a critical contribution to improving health outcomes for Aboriginal and Torres Strait Islander people. It supports Draft Proposal 11.1 and the need to ensure that health workforce reform activities pay particular attention to the needs of Indigenous Australians. Reforms should actively improve access for Indigenous people to health care.

The Department supports the Commission's view of the importance of a continued focus on increasing Indigenous participation in the health workforce, and the four directions outlined in Chapter 11. Given the international experience, efforts to encourage Indigenous people into the wide range of health professions should remain a key focus. Widening the scope of practice for Aboriginal Health Workers could be considered early in the life of the proposed health workforce improvement agency.

Non-Indigenous health workers will continue to play a critical role in the delivery of health care to Indigenous Australians. The Commission's Final Report would benefit from more discussion of interventions designed to improve the capacity of the non-Indigenous health workforce to provide high quality health care to Indigenous Australians. These interventions would include measures designed to address current workforce shortages in areas with high Aboriginal and Torres Strait Islander people, including those in urban areas, and the extension into other health disciplines of the work undertaken by the Council of Deans of Australian Medical Schools to ensure all medical graduates have reasonable knowledge and skills in relation to Aboriginal health issues.

Aged Care and Mental Health

The delivery of high quality aged care and mental health care services are key policy priorities for Government and an adequate well trained workforce in these areas is necessary to achieve this.

The aged care and mental health care sectors both face some major challenges in attracting and retaining health professionals. For example, the ageing of the population is magnifying the workforce shortage in aged care in two ways – the imminent retirement from the workforce of ageing health workers, and the increasing number of the frail elderly with complex health needs who will require residential and community care. The Pricing Review of Residential Aged Care (the Hogan Review) found that the shortage of trained nursing staff is greater in the residential aged care sector than in other areas of the health system.

The discussions in the position paper of aged care and mental health workforce issues are limited, and there is no indication of preferred policy approaches or priorities for these areas as was provided, for example, in the discussions of indigenous workforce issues. The Department considers that the health workforce requirements for the effective delivery of aged care and mental health services need to receive greater attention in the Commission's Final Report.

In the case of aged care, this needs to include consideration of personal care workers on whom both the community and residential sectors largely rely to provide basic health care to the elderly. It is important that this group of workers has in place the appropriate skills to perform their role; mechanisms to ensure competency, professional support and leadership; and training that has consistent standards and outcomes.

Timing Issues

It would be helpful if in its Final Report, the Commission could divide the final proposals into two categories covering specific issues that could be addressed reasonably quickly and matters involving systemic and institutional change.