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Submission to Productivity Commission – Draft Proposals

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1. Introduction

Health Workforce Queensland, formerly known as the Queensland Rural Medical Support Agency (QRMSA), is a rural workforce agency, established in 1998 and funded by the Australian Government Department of Health and Ageing. A forerunner of the current organisation was the Queensland Rural Divisions Coordinating Unit (QRDCU). Our purpose is:

- To facilitate the recruitment, retention and quality of general medical practitioners and primary health care teams in rural and remote Queensland communities.

Our primary objectives are:

- To increase the number of GP services and increase access to GP services in rural and remote Queensland
- Retain GPs in rural and remote Queensland
- Support upskilling of GPs and other supporting health professionals in rural and remote Queensland
- Develop sustainable models for general practice in rural and remote Queensland
- Establish benchmark workforce data and research to inform and direct policy.

In view of the invitation to comment on the Productivity Commissions' draft proposals, Health Workforce Queensland provides the following input.

2. Draft Proposal 3.1

We believe that endorsement of the National Health Workforce Strategic Framework by CoAG is an essential step in order to improve levels of integration and enhance cohesion between jurisdictions and the various areas and levels of government involved in health workforce policy.

3. Draft Proposal 3.2

We would support the recommendation that regular reviews of progress in implementing the NHWSF be undertaken. Similarly, we would endorse the suggestion that such reviews should be independent, transparent and publicly available.

4. Draft Proposal 4.1

Health Workforce Queensland supports the proposal that The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovations on a national, systematic and timetabled basis. We also appreciate the need for an appropriate balance of members with the necessary, health, education and finance knowledge and experience. We would strongly recommend that a representative from the Australian Rural and Remote Workforce Agencies Group (ARRWAG) should be a member of the proposed advisory health workforce improvement agency.

5. Draft Proposal 5.1

Health Workforce Queensland would have some strong reservations in relation to the proposal to transfer primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and

Training to the Department of Health and Ageing. We do not believe that ADoHA has the track record, ability or experience to effectively manage such a transition. While we support better linkages and co-ordination of health workforce training to meet emerging needs, we would suggest that the proposed advisory health workforce education and training council could explore improved funding allocations and mechanisms.

6. Draft Proposal 5.2

We would support the proposal that the Australian Health Minister's Conference should establish an advisory health workforce education and training council to provide independent assessments of opportunities to improve health workforce education and training approaches. As Rural Workforce Agencies are significant providers of Continuing Professional Development and skills maintenance for rural and remote medical practitioners, we would suggest that a representative from ARRWAG be a member of the proposed council.

7. Draft Proposal 5.3

Health Workforce Queensland would support the proposal that the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks. We do acknowledge that this is a complex area; however improved information in relation demand, costs and funding arrangements would be desirable. Similarly, we believe that alternatives such as the greater use of explicit payments to those providing infrastructure support or training services should be explored. We would further support measures to address regulatory impediments to competition in the delivery of clinical training services.

8. Draft Proposal 6.1

We would support the proposal that a single national accreditation agency for university-based and postgraduate health workforce education and training be established. Similarly, the development of uniform national standards upon which professional registration would be based is a desirable goal.

9. Draft Proposal 6.2

We support the proposal that the new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. We note that there has been considerable work already undertaken in relation to National Consistency in the assessment of overseas-trained Temporary Resident Doctors. We would also suggest that the assessment process requires funding by either ADoHA or state jurisdictions.

10. Draft Proposal 7.1

We support the proposal that Registration boards should focus their activities on registration in accordance with uniform national standards developed by the national accreditation agency and on enforcing professional standards.

11. Draft Proposal 7.2

We support the proposal that states and territories should collectively take steps to improve the operation of mutual recognition and streamline processes for the short term provision of services across jurisdictional borders.

11. Draft Proposal 7.3

We would support the proposal that jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioners retains responsibility for clinical outcomes and the health and safety of the patient. We would see this as a way of supporting increased workforce flexibility and note that task delegation already works well in many rural and remote areas.

12. Draft Proposal 8.1

Health Workforce Queensland would support the proposal that the Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medical Benefits Schedule and related matters. We would also support public reporting of its recommendations and the underlying reasoning.

13. Draft Proposal 8.2

We would support the proposal that for a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. We note that such rebates already occur for a limited number of items and believe that there is scope to expand delegation in appropriate circumstances. However, we would suggest that delegations by the practitioner be limited to appropriately qualified members of his/her primary health care team or practice.

14. Draft Proposal 9.1

We would support the rationalization of current institutional structures for numerical workforce planning including the abolition of AMWAC and AHWAC and their replacement by a single national secretariat. However, we note that AMWAC has produced some very good work with limited resources and if a new secretariat is to be established, it will need to be appropriately staffed and resourced.

15. Draft Proposal 9.2

We would support the proposal that numerical workforce projections undertaken by the new secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand and should be based on a variety of relevant demand and supply scenarios.

16. Draft Proposal 10.1

Health Workforce Queensland supports the recommendation that the Australian Health Ministers' Conference should ensure that all broad institutional health frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas. The health disparities between rural and remote communities compared with urban and regional communities has been well documented as has lower access to Medicare and health services in

rural and remote communities. We believe that the extra costs associated with providing health services in rural and remote communities should be factored into all funding allocations.

17. Draft Proposal 10.2

We support the proposal that the brief for the health workforce improvement agency should include requirements to access the implications for health outcomes in rural and remote areas and to consider major job redesign opportunities specific to rural and remote areas. Our agency strongly believes that practice sustainability and health outcomes can be improved in many rural and remote communities through job redesign, removal of some existing barriers and the exploration of innovative funding models[1].

18. Draft Proposal 10.3

Health Workforce Queensland supports the proposal that there should be a cross program evaluation designed to ascertain approaches or mix of approaches that are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia. Our agency would tend to support incentive-driven approaches as opposed to 'coercive' mechanisms but do appreciate that many communities are dependent on 'district of workforce shortage' doctors to maintain current levels of medical service. We would also support the provision of financial incentives through the MBS rebate structure as opposed to practice grants as we believe that in many cases the practice grant does not get distributed fairly to all practitioners. We would also support an assessment of the effectiveness over the longer term, of regionally-based education and training.

19. Draft Proposal 11.1

We would support the proposal that the Australian Health Ministers' Conference should ensure that all broad institutional frameworks make explicit provision to consider the particular workforce requirements of groups with special needs. In particular, we would suggest that the Aboriginal Community Controlled Health Sector is under funded and that there is a considerable amount of funding intended for Aboriginal and Torres Strait Islander health that tends to be mainstreamed and not used in an effective manner.

20. Summary

The draft proposals are, in the main sensible and have the potential to provide greater integration and reduce some of the many complexities inherent in our current health system. Some of the proposals will require considerable transitory timeframes for complete implementation. We also anticipate that there will be resistance from some vested interests in relation to some of the proposals. However, we acknowledge that there is scope for improved integration and efficiencies in the health, education and training sectors and see the proposals put forward by the Commission as an important initial step in engendering change and health workforce reform.

Chief Executive Officer
Health Workforce Queensland

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[1] Queensland Rural Medical Support Agency. (2004). *Solutions for the provision of primary care to rural and remote communities in Queensland*. Brisbane: QRMSA.