Productivity Commission 'Health Workforce' Submission

by the

Health Services Union

Figures and Tables

Diagrams

[1] Ibid. Table S.48
[2] AIHW, Australian Hospital Statistics, 1999-00
[3] Australian Health Ministers' Advisory Council Submission To Productivity Commission's Study On Health Workforce August 2005

Productivity Commission Health Workforce Review

Submission by the Health Services Union

The Productivity Commission released its Position Paper 'The Health Workforce' on the 29th September 2005. Written submissions addressing major omissions and responses to the draft proposals in the Position Paper (PP) were requested.

The Position Paper (PP) made a number of recommendations to improve the supply and demand alignment of the health professions workforce. Key recommendations include:

- Enhancing workforce flexibility, productivity and effectiveness to address supply and demand disequilibrium and address areas of high need.

- Greater rationalization of health workforce planning, accreditation and registration by establishing single national agencies and a more central role for ministerial bodies.

The recommendations represent risks and opportunities for the health workforce and the community.

The Health Services Union (HSU) represents a broad spectrum of the health workforce, including allied health professionals, hospital ancillary and administrative staff. The HSU membership reflects the large number of health workers who do not believe that that governments or employers have an adequate interest in their aspirations for their working lives.

The HSU – Health Professionals, also represent professionals who identify themselves as health professionals not simply members of their professional group.

It is therefore important that the HSU represent the views and interests of workers in the health sector as a whole.

The HSU can be generally supportive of the reform directions contained in the PP to consider national consistency, more education funding and greater flexibility for health professionals to improve outcomes to the workforce and the community. The extent to which this creates career paths and opportunities for the workforce which better meet the communities health needs, it is potentially positive.

However, the government is equally at risk of introducing measures which will result in further shortages in the health workforce and result in declining quality of the health sector and population health.

We are therefore making a submission with a focus on the key considerations for the Productivity Commission (PC) to consider before it delivers its final analysis of proposed reforms to the health workforce.

In particular, the PP, fails to provide any information or analysis on a number of the 'Terms of Reference' for the Report. These Terms of Reference relate directly to the economic and financial factors which are impacting on the supply of the health workforce.

The PC has a responsibility to evaluate the financial and economic factors which are contributing to workforce supply issues, as well as the actual factors for declining productivity – in particular the increased cost inflation of private sector health care providers. In fact The PC would be in breach of its legislative duty if it did not consider income and workplace related factors to inform the supply of and the demand for the health workforce.

This is especially critical in light of the government's proposed Industrial Relations changes which threaten to magnify the exodus of health care workers from the health sector and the country.

Under the new IR framework the workforce already understands that there will be no certainty of their terms and conditions or career prospects and their existing entitlements will erode over time. Thus making Australia, and the health sector, even less attractive places to work.

It is only through an analysis of the actual causes of workforce supply shortages that appropriate measures can be introduced to re-create a sustainable health service.

The Productivity Commission was established to provide the government and the community with independent advice. It is strongly **recommended** that PC address all the Terms of Reference with the appropriate data before it postulates on the trends, challenges and inhibitors to workforce supply.

Health Workforce & Productivity Overview

The major omission in the Position Paper is data. The only references to health expenditure and productivity were from their own 'reports' from this year and are not substantiated by any credible sources.

The rare independent reference to the Organisation for Economic Co-operation and Development (OECD) data, shows that the Australian health sector is efficient and that there is no 'spending crisis'. Governments could afford to allocate a greater proportion of the nation's resources on the health sector and still be within industrialised world standards.[4] Government expenditure in the health sector has declined over the last decade relative to other sources. The Federal Government's contribution to the health sector has declined markedly.[5]

In fact, the true expenditure inflation burden has fallen on individuals, who are now paying a higher proportion of out of pocket expenditure on health care. In recent years (1999/00 to 2001/02) non-government funding has grown at 7.5% per year, outstripping the Commonwealth, 6.1% and the States 4.4%. The main non-government funding sources are out-of-pocket expenditure by individuals. Health expenditure per person was up to $3,292 in 2001/02. from $3,034 in 1999.00.[6] This has occurred in parallel with government policies to increase the commercial delivery of health services.

This directly influences current and future projected demand. Demand is likely to increase into the future as a result of the decreased accessibility of health services for the public. The multiplier effect of untreated conditions is such that within 1-3 years the costs of treating the condition can increase by over 1,000%.[7]The less accessible preventative, diagnostic and early treatments are, the greater the subsequent demand on the public sector from chronic illnesses.

The aggregate outcome of policies to increase private sector supply is the US experience. The US, which has a high proportion of commercial providers and decreased accessibility for the population actually spends 13% of its Gross Domestic Product (GDP) on health, with worse population health outcomes, compared to the UK with almost no commercial providers which spends 6% of its GDP on health with better healthcare outcomes. Australia is currently in the middle, spending approximately 8% of its GDP on health, but rising rapidly from the high inflation of commercially provided goods and services.[8]

Figure 1 demonstrates the relative expenditure of Australians on their health compared to other OECD countries.

---

[4] OECD Health Data 2002, 4th Ed.

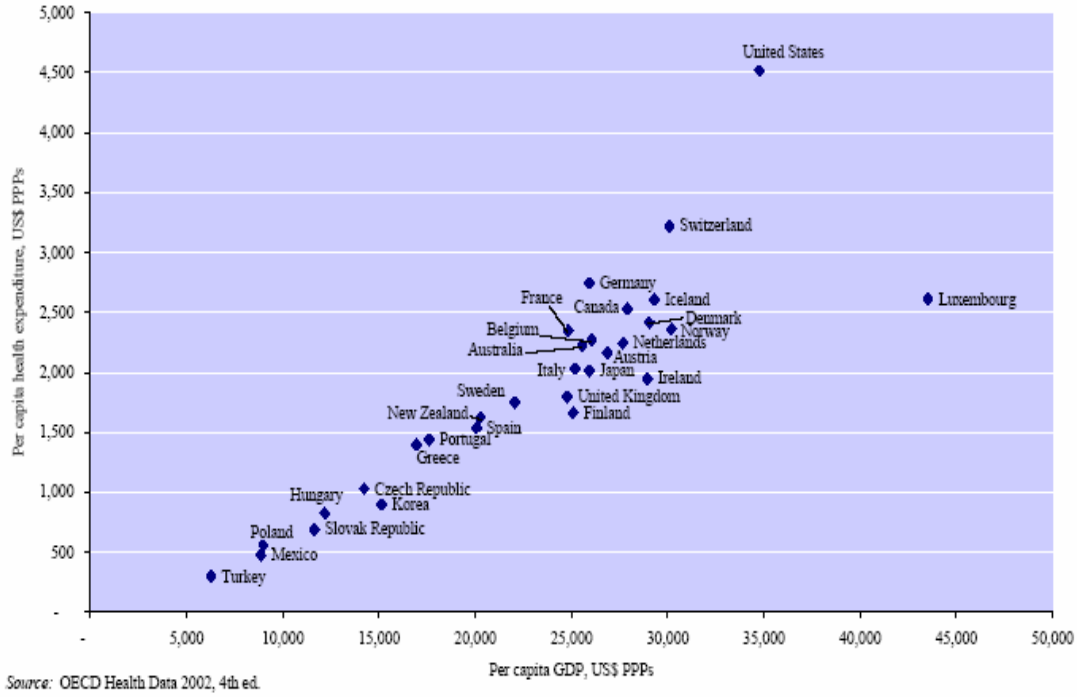
[5] Declined from 46.9% in 1999.00 to 46.3% in 2001.02 while territories and local governments' declined to 22.3%, compared with 23.0% in the earlier year.

[6] AIHW, 2003-04, constant 2000.01 dollars. (Table 5.3).

[7] As with the example of a tooth cavity, the longer the period of a minor condition is not treated, the greater the treatment costs over time, eg root canal See any 'early intervention' health literature.

[8] See following discussion

Figure 1. **Per capita GDP and per capita health expenditure, 2000**



Source: OECD Health Data 2002, 4th ed.

Table B.1 highlights the relative efficiency of the Australian health sector in achieving population health outcomes.

Table B.1 **Life expectancy and infant mortality, selected countries**

Male life expectancy at birth 2002		*Female life expectancy at birth 2002*		*Infant mortality rates per 1000 live births (latest available year)*	
Japan	78.4	Japan	85.2	Japan (1999)	3.7
Iceland	78.4	France	83.5	Finland (2000)	4.1
Sweden	78.1	Switzerland	83.4	Sweden (1999)	4.1
Australia	**77.9**	Spain	83.0	Korea, Republic (2000)	4.5
Switzerland	77.7	**Australia**	**83.0**	Czech Republic (2000)	4.6
Israel	77.4	Sweden	82.7	Norway (1999)	4.6
Singapore	77.4	Italy	82.5	France (1999)	4.8
Canada	77.2	Canada	82.3	Germany (1999)	5.0
Italy	76.7	Austria	82.1	Spain (1998)	5.2
New Zealand	76.7	Iceland	81.8	**Australia (2002)**	**5.4**
France	75.9	New Zealand	81.2	Canada (1998)	5.7
UK	75.8	UK	80.5	New Zealand (2000)	6.5
USA	74.6	USA	79.8	USA (1999)	7.7

Source: AIHW (2004a).

Public hospital productivity growth has been above national industry productivity and private health sector productivity. Public hospital separations have grown at an average of 2.1 per cent per annum since 1999/00.[9] Real growth in recurrent health expenditure averaged 5.7% per year between 1999/00 and 2001/02. The major drivers of this growth were expenditures on private hospitals and services and pharmaceuticals. Pharmaceutical cost inflation averaged 13.9% per year and private hospitals 5.1% per year. Meanwhile spending on hospital services declined as a proportion of recurrent expenditure to 35.4% from 36.6% in 1999/00.[10] Thus reinforcing the increased productivity of public sector hospitals.

A major productivity indicator for hospitals, the average number of days in hospital per treatment, demonstrates the relative productivity of the public sector. Across the ten most frequent treatments in hospitals longer than a day, the public sector is consistently more productive than the private sector. On average private hospitals take 33% longer to complete treatment.[11] Similarly, longitudinal data on hospital throughput performance such as average days per hospital separations demonstrate the increasing productivity of the health workforce over the past decade.[12]

Available expenditure data shows that in fact public hospitals and institutional settings have maintained or reduced their proportion of current expenditure, while they have been responding to higher demand.

Table 2. Proportion of recurrent expenditure on health (real prices) 1991-92 to 2000-01 (%) [13]

Area of expenditure	1991-92	2001-02
Public Hospitals	30.7	26.7
Public Psychiatric Hospitals	1.9	0.7
Private Hospitals	7.1	9.0
High level residential care	8.4	6.6
Ambulance	1.4	1.7
Total Institutional	***49.7***	***43.7***

It is these 'productivity gains' or increases in work intensity and non-commensurate remuneration incentives which are the primary factors influencing the decreasing supply of labour to the health sector.

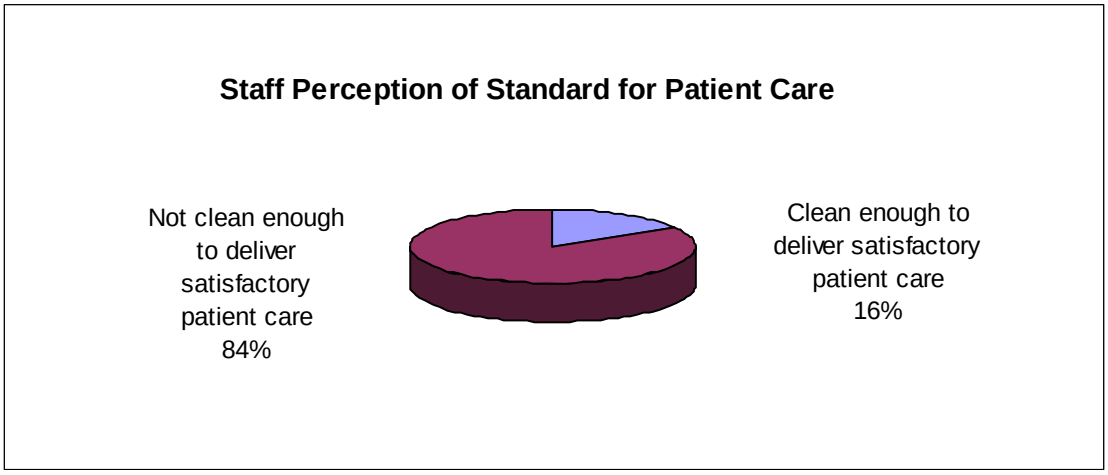
[9] .*Australian Hospital Statistics,*. AIHW, 2003-04
[10] Ibid. Table S.48
[11] [11] Australian Institute of Health and Welfare, Australian Hospital Statistics 1999-00. 'Average number of separations in top 10 diagnosis related groups with highest number of separations (excluding same day separations)' – See Appendix 1
[12] Australian Institute of Health and Welfare, Australian Hospital Statistics 2003-04
[13] Ibid. Table S.48

These productivity gains were made by the entire workforce in institutions, the majority of whom were overlooked in the report. Non-medical workers contributing to the quality of care to patients contribute between 30 – 60% of institutional labour. This labourforce is also crucial to workforce planning and policy development. They are often over looked for training and development and the development of careers pathways. This is a consequence of the definition and functions of the role design of this workforce. These are the semi skilled workers whose scope is more easily expanded with training to facilitate better focused more patient oriented care.

Many institutional workers have experienced real wage reductions, in particular as a result of outsourcing and privatisation whose profit motive has encouraged reducing wages. The contribution of their work contributes directly to the quality and esteem of the entire workforce.

A major indicator of a health professional's intention to remain in the workforce is the extent to which they feel they can provide quality care[14]. Reducing the number of support staff and their terms and conditions of employment directly affects the ability of the medical workforce to provide adequate patient care. A recent survey by medical staff following the outsourcing of hospital ward cleaners demonstrates this point.

Diagram 1 – Staff Perception of Standard of Patient Care



These decline in conditions also influence the perceptions of the community as to the Governments role in improving health and hospital infrastructure. In a recent Roy Morgan poll found that health was the most important issues to Australians. When asked to choose from a list of 11 issues, 'health and hospitals' was chosen by the largest proportion of people, 63 per cent.

[14] A study of job satisfaction of nursing and allied health graduates from a mid-Atlantic university Journal of Allied Health, Spring 2003 by Lyons, Kevin J, Lapin, Jennifer, Young, Barbara
139 general staff at Box Hill and Alfred Hospitals were surveyed between January 17 and February 14 2005 Response to the question: How do you rate the cleanliness of your department ? & Do you think that the cleanliness standards at your hospital are appropriate to deliver satisfactory patient care.

Terms of Reference 1 – Work pressure, satisfaction and hours of work or work productivity

The PC failed to seek any meaningful data or policy directions to respond to 'Terms of Reference 1… (e) to consider factors such as: Workforce satisfaction, work pressure, practices and hours of work or (f) the productivity of the health workforce'.

The qualitative and quantitative data available supports that the actual health workforce has produced enormous productivity gains over the last 10 years. It is this work intensity without commensurate remuneration that has resulted in:

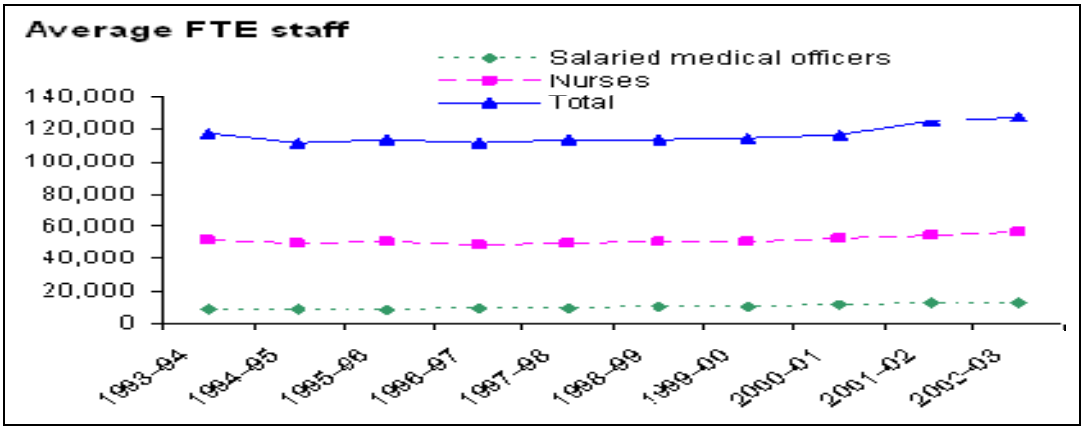
- Reduced work hours
- Lower retention rates
- Higher professional turnover (health workers leaving the health sector)
- Higher workforce migration from the country

The workforce has reached work intensity saturation point. For years the workforce has been functioning at an unsustainable intensity, literally. More health workers left the health sector than joined[15]. There are more qualified professionals than are practicing. The difference is being made up of overseas trained practitioners. Although it is unclear if they can stem the tide if reforms to improve workplaces and rewards are not introduced. Current indicators suggest that the terms and conditions of employments are insufficient to retain the majority of overseas trained health professionals.

Despite increased demand and increased throughput of hospitals over the decade, workforce numbers have remained relatively stagnant[16]. This is irrefutable evidence of the productivity gains by hospital staff over the past decade. Additionally, in Victoria, at least, waiting list have been reduced, despite increased demand and a relatively stagnant labourforce over the past decade. This is a very real indicator of the increase in workforce productivity. Overall waiting lists in 2003 were 6.6 per cent below the rate in 1999.[17] Meanwhile, overall the number of full-time equivalent staff increased an average of 1.0% per year between 1993-94 and 2002-03. The number of salaried medical officers increased an average of 4.5% per year over this period and the number of nurses increased an average of 1.0%[18].

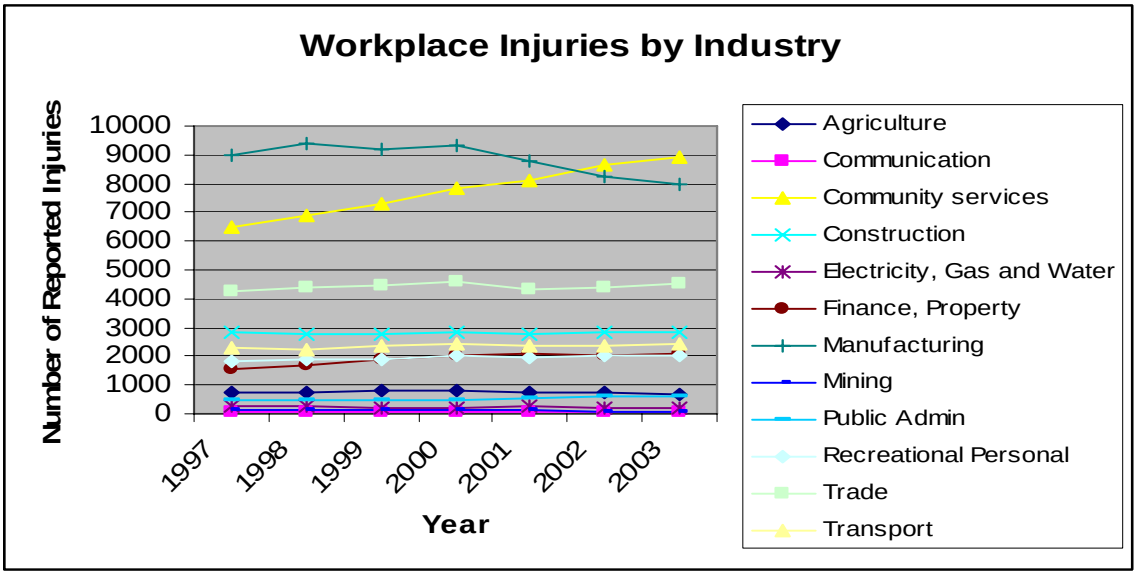
[15] Census Data 2001
[16] AIHW Hospitals Hospital Statistics 2002/03
[17] Victoria's Hospital Performance Report, 2003
[18] Ibid. Table 18

Diagram 2. Average Full Time Equivalent Positions in Hospitals 1993 - 2003



The increased intensity and productivity of health workers has been paralleled with increased workplace danger. Statistically, the community services sector (which includes the health sector predominantly) was the only sector to report consistently increasing number of accidents over the past several years. (the 2004/05 figures are not final because there is a lag in reporting).[19] The consistency of this trend proves that the health sector is becoming an increasingly dangerous place to work, worsening yearly.

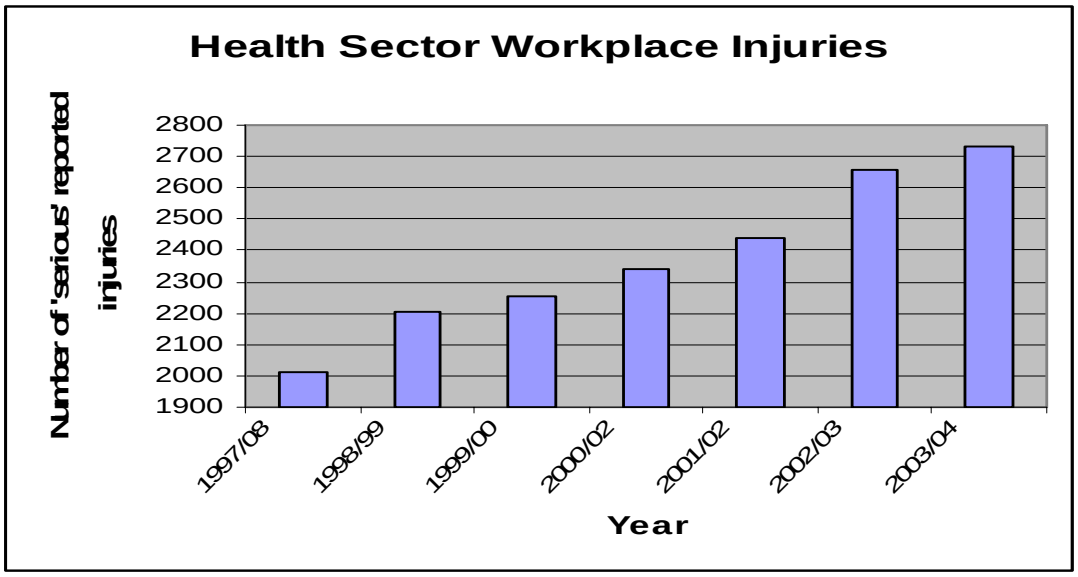
Diagram 3. Workplace Injuries by Industry 1997-2003



This trend is directly paralleled in the 'health' workforce, as demonstrated by the Victorian Health Sector workplace injuries reported.[20]

[19] Victorian WorkCover Authority, Statistical Summary 2004/05.
[20] Victorian Workcover, Summary Statistics 2004/05

Diagram 4 Health Sector Workplace Injuries 1997 – 2003



In light of this evidence it is foolish and unconscionable to consider reforms to the health workforce, and their retention, without considering policies to improve their health and safety in the workplace, such as work intensity.

The only advantages of working in the health sector is the flexibility of hours and corresponding penalty rates due to their 24 hours nature. Seventy seven percent of the workforce is female and need this combination in order to work and raise a family. The greater the work pressures however, the greater the opportunity they will leave the sector or plan to retire early[21].

Almost ironically, it is the government's obsession with making the health sector more 'efficient' and less focused on patient care which is driving many excellent workers out of the sector.

Academic studies show that when health professionals have been working in environments which have been undergoing prolonged 'efficiency measure' their motivation to remain in the workforce is reduced. They report that staff have less time to spend with patients and believe the health system is more wasteful now despite attempts to increase efficiency. These findings generally confirm other findings in the literature that reflect a perception of a deteriorating health care system.[22]

[21] See Department of Human Services Victoria 'PC Workforce Submission'.

[22] Professor James Buchan and Lynn Calman, "Skill-mix and Policy Change in the Health Workforce OECD Health Working Papers no. 17,: Directorate for Employment, Labour and Social Affairs Employment, Labour and Social Affairs Committee, 24-Feb-2005

Academics caution, "These conditions should raise concern for all decision makers involved in health care because they have resulted in the current shortages of many health professionals, which is expected to increase over the next few years. If these shortages continue, it is doubtful that many of the negative changes that were identified could be remedied in the near future".[23]

Felix Rigoli and Gilles Dussault, from the World Health Organisation provide the following diagram of the interconnectedness between health workforce reform and human resources responses. They stress the point that because workers *are* the health sector, how they respond to reforms will be the primary determinant of how the reforms are shaped or their likelihood to achieve their objectives. [24]

Diagram 5 . Health Care Reform and Human Resources Responses

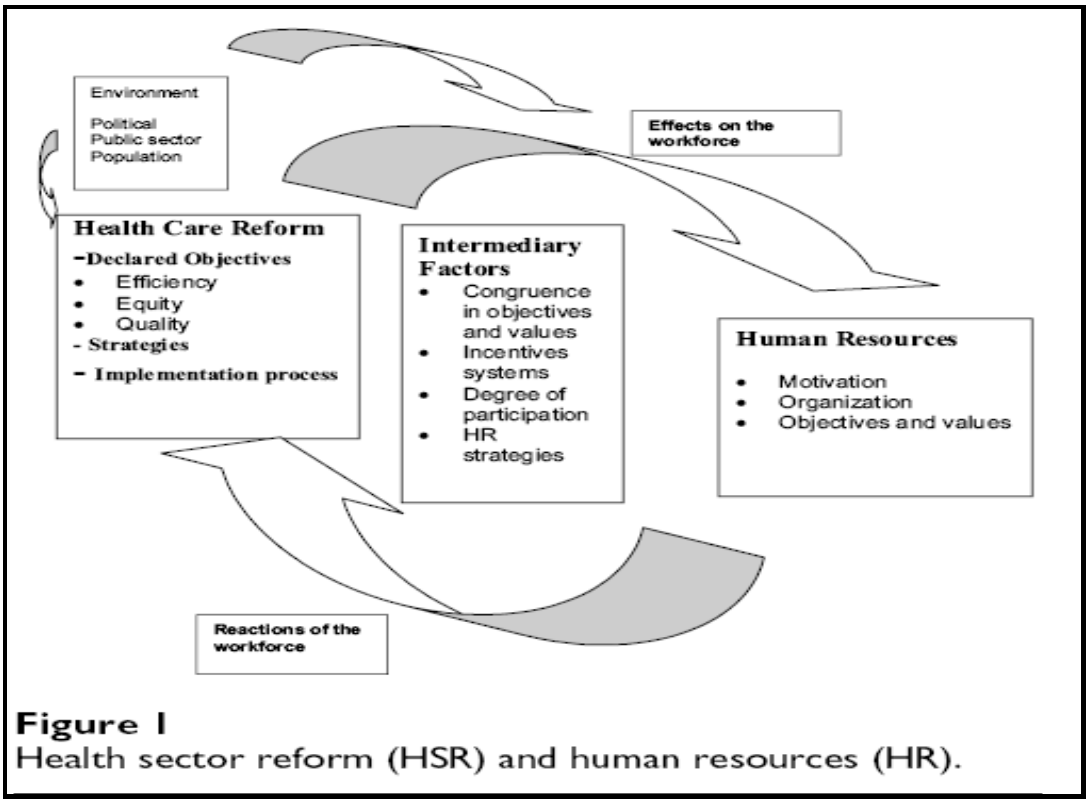


Figure 1
Health sector reform (HSR) and human resources (HR).

The importance given to the human resources factor cannot be disregarded in the strategic planning and implementation of the reform process. In one way or another, the reactions of workers will influence the process and affect the plans.

[23] Lyons, Kevin J, Lapin, Jennifer, Young, Barbara 2003

[24] 'The interface between health sector reform and human resources in health', Felix Rigoli1 and Gilles Dussault 2Address: 1Regional Adviser, Human Resources Development Program /World Health Organization,Washington, DC, USA and 2Senior Health Specialist, World Bank Institute, Washington, DC, USA

The World Health Organisation's experts stress: "In labor-intensive industries such as health services, the importance of capital and technology is high, but never as much as the knowledge, attitudes and efforts developed by the persons in direct contact with the final users. This justifies a closer look at workers' reactions to changes resulting from reforms that can be regarded as changes in the rules of the employer-employee relationship. Getting workers involved in the design and implementation of the reform is important. Participation of workers' representatives such as professional associations or unions is a necessary but not sufficient condition to successful reform design and implementation".[25]

Thus, governments will miss an opportunity to for a smooth transition to a more sustainable health workforce if it does not consider how the reforms aim to protect and improve the existing terms and conditions of the health workforce.

[25] Ibid.

Terms of Reference 2 – Analysis of expenditure and supply of clinical and health workers & distribution of workforce

The PC also failed provide any data to respond to Terms of Reference 2, to consider the structure and distribution of the health workforce, and 2 (b) analysis of the current expenditure and supply of clinical and health workers, (c) the distribution of the health workforce.

(b) analysis of the current expenditure and supply of clinical and health workers

The most overwhelming change in health expenditure has been a 100% reduction in the taxation contribution to health funding since 1997-98. Current taxation contributions are over 100% below 1999 – 2000 levels.

Table 3.Health-related taxation expenditures, constant (a) prices, 1997/98 to 2001/02 ($ million)[26]

Year	Constant prices
1997–98	307
1998–99	330
1999–00	362
2000–01	150
2001–02	154

These statistics show that Government policies have been successful in the short term in reducing their proportion of health costs. Policies to further reduce the tax contribution to the health system will only result in exacerbating workforce shortages which have occurred in parallel to reduced funding contributions.

This has increased the cost to individuals who have limited disposable income. The supply and demand for health services is increasingly being mediated by the financial capacity for an individual to pay for services. The impact of increased private provision of health services and fee rises on the ability for people to access health services needs to be more thoroughly investigated.

An analysis of the current expenditure on clinical and health workers shows that the highest proportion of funding growth has been from out of pocket expenses of private individuals. Expenditure from out of pocket expenses by individuals rose by almost 8 percentage points over the decade to 2000–01. It has continued to rise at approximately 8 % per year, while Commonwealth and State government expenditure rose by 6 and 4 % respectively. Private health insurance funds provided 23.7% ($4.3 billion) down from 34.7% in 1990–91. The remaining 18.5% ($3.4 billion) came from other non-government sources (mainly

[26] : AIHW Health Expenditure Database Table S42:

compulsory motor vehicle injury insurers and workers' compensation insurers), which experienced a rise in its share of funding of health, by 3.1 percentage points, over the decade.[27]

The following table demonstrated the true contribution of individuals versus government and private health insurers contribution to the cost health professional services. In particular it shows that individuals are the primary source of funding for health professional services.

Table 4 Health Expenditure on Medical Services and Health Professions by Source of Funds $m 2000/01

Table S43: Total health expenditure (current prices), by source of funds[(a)], 2000–01 ($ million)

	Government sector			Non-government sector				
Health service type	Common-wealth	State and local	Total	Health insurance funds	Indivi-duals	Other[(b)]	Total	Total all sectors
Medical services	8,419	—	8,419	287	1,078	492	1,857	10,276
Other professional services	525	—	525	224	1,462	230	1,915	2,440

This data indicates the best way for government to respond to labour shortages is to increase the proportion of taxation expenditure to levels which were are sufficient to maintain the health workforce required to meet the communities needs.

c) the distribution of the health workforce.

The distribution of the health workforce is critical to understanding the potential available workforce and the creation of incentives to:

- Increase the number of health professionals and workers in the health industry and
- Increase the incentives for non-professionals to support a flexible and responsive health system.

A scant view of the health services industries shows that:

- Approximately a quarter of the health workforce are not working in the health industry
- Approximately a quarter of the health industry are not health professionals

Diagram 6 demonstrates these facts.

[27] Health Expenditure Australia 2000 – 01, AIHW p 30

Diagram 6. The relationship with of health occupations to the health services industries and other industries[28]

	Health services industry	Other industries	Total
Health occupations	356,088 employed persons e.g. doctors, nurses, dentists, allied health workers, ambulance officers, etc.	94,704 persons employed in health occupations in other industries e.g. retail pharmacists, safety inspectors, environmental health officers, etc.	450,792
Other occupations	201,693 persons employed in other occupations in health industries e.g. clerical workers, service workers, welfare professionals, etc.		
Total	557,781		

Note: Within the following discussion, the total number of people employed in health occupations differs between tables due to random adjustment of Census figures to protect the confidentiality of individuals, as well as the exclusion or inclusion of non-respondents.

Source: AIHW & ABS 2003.

The distribution of health professionals across the public and private sectors is also critical to understanding how to reform the distribution of providers. As noted, more private providers will most likely, increase costs to individuals, decrease productivity of the health sector and increase health cost inflation.

Table 5. Number and distribution of Allied Health Practitioners in the public and private sector, Victoria, 2004[29]**

Allied Health	Public	Private
Medical Radiation Technology	370	419
Occupational Therapy	503	140
Pharmacy	450	1783
Physiotherapy	865	901
Podiatry	128	228
Psychology	470	617
Speech Pathology	282	108

[28] Australian Health Ministers' Advisory Council Submission To Productivity Commission's Study On Health Workforce August 2005

[29] Source: Victorian Allied Health Labour Force Survey, 2004. **Note, There appears to be problems with this data, based on our own source information indicating that there are in excess of 600 MRT's in the public sector.

Terms of Reference 3 – Future demand for services & local and international supply of the health workforce

The PC also failed to respond to Terms of Reference 3, 'to consider the factors affecting demand for services, especially (b) likely pattern of future demand for services including the impact of diagnostic and health services and (c) the relationship between the local and international supply of the health workforce'.

(c) the relationship between the local and international supply of the health workforce.

More long term migration of Health Professionals out of Australia

In the latest available census data in 2001/02, 8,122 health professionals left Australia for stays of 12 months or more. During the same period 10,394 temporary health professionals entered the country, with an unknown number of permanents. These arrivals include holiday makers, so therefore cannot not be equated with additions to the health labour force.[30]

Net loss of Allied Health Professionals

In the most recent census data, the total number of professionals arriving in Australia outnumbered those departing, but there were some occupations with a net loss in 2001/02. These losses are predominantly Allied Health Professionals. These were occupational therapists, physiotherapists, speech pathologists, and 'other' health professionals. (not defined by the data) [31]

Table 6 Net Loss Migration of Allied Health Professionals[32]

Allied Health Professional	Departed	Arrived (not necessarily to work)
Occupational Therapists	310	246
Physiotherapists	580	564
Speech Pathologists	102	86
Other (not nurses)	202	196

The suite of evidence available suggests that there are a sufficient number of health practitioners qualified in Australia, they simply do not want to work in Australia's health sector. They are choosing to work overseas or in other sectors which provide greater career prospects, higher remuneration, safer, less stressful, less intensive environments.

If these factors are not considered, high proportions of health workers will continue to leave the sector. If the bucket has a hole in it, it is wasteful and redundant to just keep filling it up.

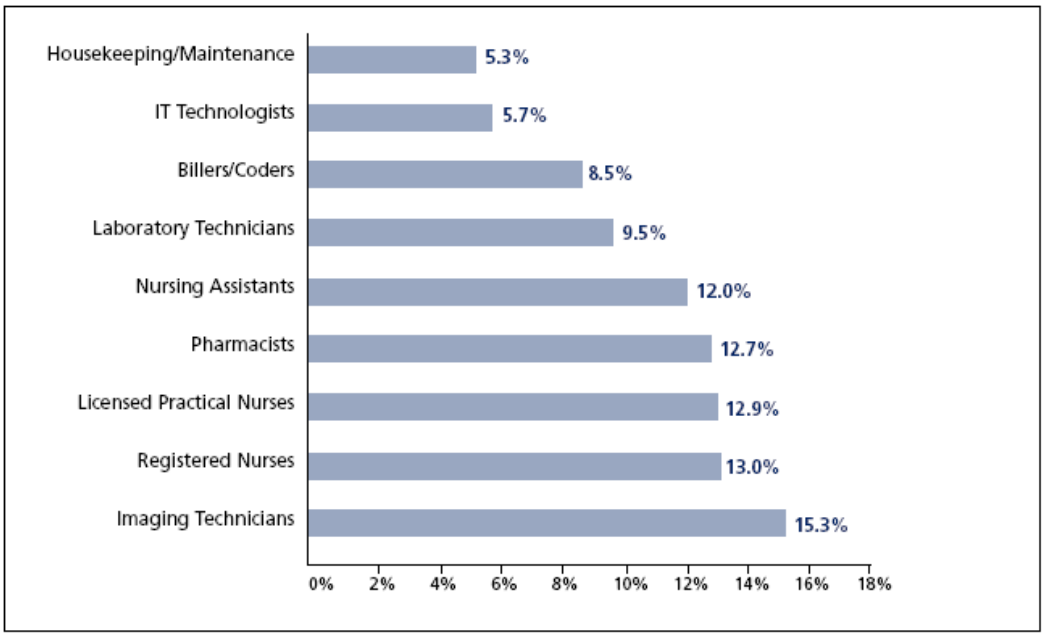
[30] AIHW, Australia's Health 2004, p.272
[31] AIHW, Australia's Health 2004, p.272
[32] Ibid.

The shortage of health workers is an international problem. Many countries who failed to adequately plan for health demand or turnover and exit trends in the workforce, such as the UK and the US, are experiencing shortages in, allied health, some medical and nursing specialties.

The World Health Organisation, in their 'Combating the Global Health Workforce Crisis Report 2006', made the following summary assessment: 'All countries face health workforce challenges, although the problems vary. The most common problem is an overall health workforce shortage, which is further aggravated by skewed distribution geographically between urban and rural areas and between the private and public sector. The net result is very low productivity; exacerbated by insufficient investment in pre-service training, migration, work overload, inadequate salaries and negative working environments'.[33]

Figures 1and 2 indicate the levels of shortages currently being experienced in some countries. The first shows vacancy rates for various classifications of health workers in the USA. The second is a better indicator of the problem, showing vacancy rates for positions which have not been filled for 3 months or more. [34] Both countries have been implementing efficiency reforms to their health sectors, and both countries are expecting increasing shortages.[35]

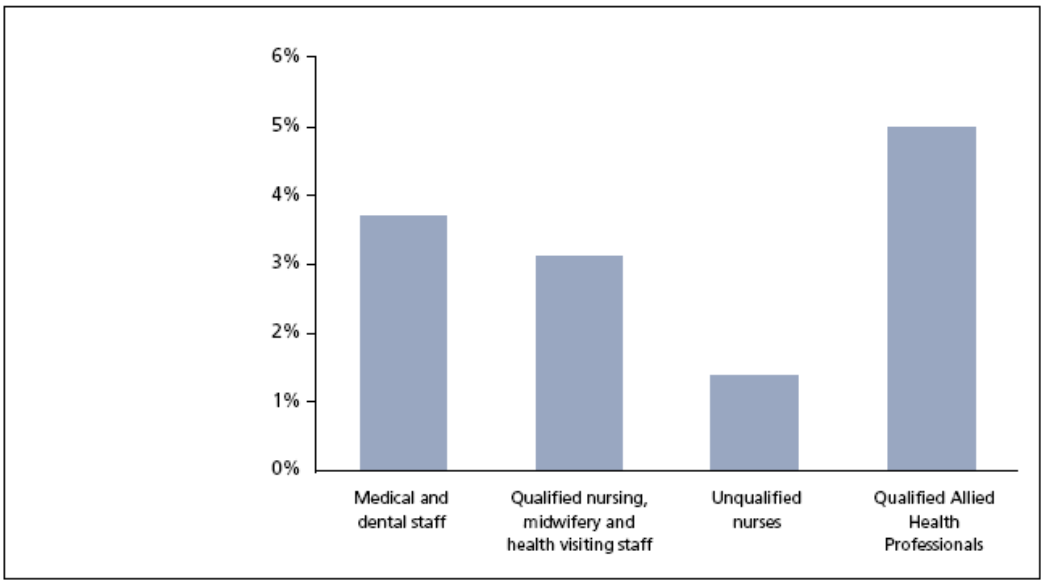
Diagram 7: Vacancy Rates in USA Hospitals by occupation 2001



Source: First Consulting Group (2001).

[33] Combating the global health workforce crisis, World health organization, World Health 2006. p1
[34] World Health Organization, Department of Human Resources for Health, Barbara Stilwell, Carmen Dolea, Pascal Zurn
[35] Ibid.

Diagram 8 Three month vacancy rate in the UK, 2003



Source: Department of Health, vacancy surveys (2003).

Remuneration, terms and conditions

It is notable that in the enormous number of pages of the PP, remuneration was paid scant attention. The health workforce in Australia cannot be analysed without consideration to their remuneration. The supply and distribution of the workforce can be better understood with an analysis of the incentives and disincentives remuneration creates to practicing. As economic analysis is the Productivity Commission's legislated sphere of expertise it is reasonable to expect deeper analysis of the impact of remunerative disparities between and among health workers.

The latest available census data of 2001 showed that the majority of allied health workers earn very modest to average incomes, with 37.7% in the range $20,800–$41,599, and a further 38.2% reporting in the range $41,600–$77,999.[36] The latter range is very broad and conceals the fact that the majority of allied health workers are at the lower end of the spectrum.

Allied health professionals earn on average half the income of salaried medical officers, and one eighth of a medical specialist. In many instances allied health professionals earn less than their nursing counterparts, notwithstanding their equivalent or superior education and equally taxing work environment.

[36] Table A.22.

Table 7. Average Salary of Full Time Earnings in Victorian Public Hospitals[37]

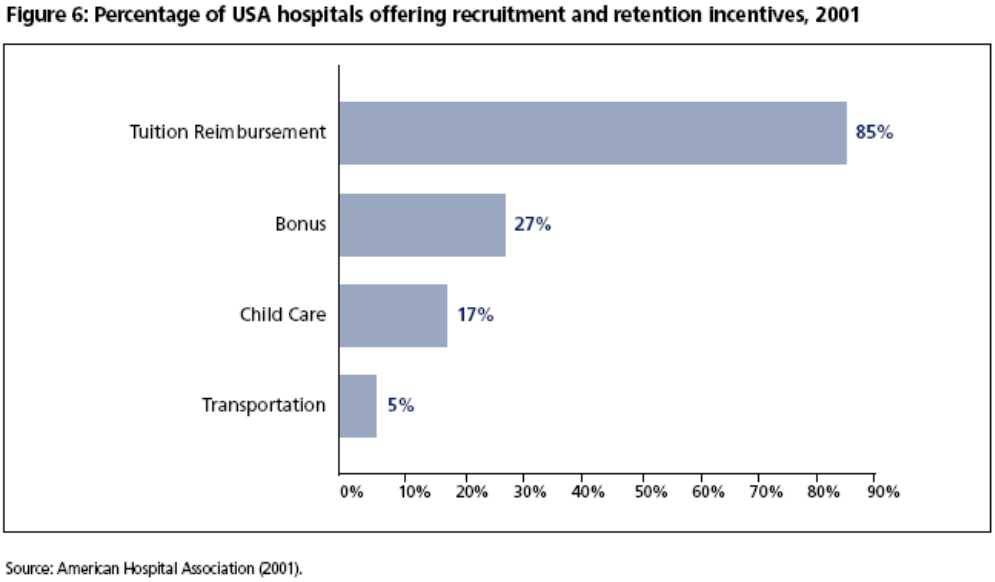
Staffing Category	2000-01 $
Salaried Medical Officers	109,515
Nurses	50,802
Diagnostic and Health Professionals	48,764
Admin and clerical	43,896
Domestic and other	37,996

It is important to note the comparison of health professionals and workers wages in comparison to the Average Weekly Ordinary Time Earnings, and the relative attractiveness of employment in other 'ordinary' sectors.[38]

Average Weekly Ordinary Time Earnings (2003)	**48, 500**

In relation to the migration of health workers, it is notable that international countries experiencing shortages are providing substantial remunerative and non-remunerative incentives to health workers.

Diagram 9. Percentage of USA hospitals offering recruitment and retention incentives, 2001



[37] AIHW, Australian Hospital Statistics, 1999-00
[38] AIHW & ABS, 2003

Remuneration has been identified in a number of studies on Australian and international Allied Health Professionals to provide sufficient grounds for its deeper investigation.

There are large disparities in the remuneration of health professionals and workers which are producing undesirable outcomes in medical workforce supply and demand, migration and immigration incentives.

The PC must acknowledge that the low value of the Australian Dollar relative to the currencies of other industrialized countries, eg. Euro, Pound, US dollar etc, reduces the relative incomes of Australian health professionals. While not much can be done about the relative value of the dollar while the government seeks to support the export sector, it does make working in Europe, England or the US more attractive to Australians and foreign practitioners. In lieu of a higher dollar we believe there is a strong role for the government to play in addressing the relative income disparity disincentives to work in Australia.

The government also has a role in investing in non-remunerative terms and conditions which make Australia, and Australian institutions, a preferable place to work.

Studies show, in health care in particular, remuneration is often not the sole reason people decide to remain in or leave the professions.[39] Reasons for leaving or changing professions are also influenced by other factors such as; intensity of workload, degree of autonomy and respect in the workplace, work/life flexibility, career development opportunities. These are not perfunctory issues. These components of the environment for the health workforce need to be integrally considered in workforce redesign reforms.

The PP did not give sufficient attention to the remuneration and terms and conditions factors which influence the recruitment and retention or high turnover of exiting health professionals and workers. This needs to be addressed in the final Report.

(b) likely pattern of future demand for services including the impact of diagnostic and health services

Australian Department of Employment and Workplace Relations data on the shortage of Professionals March 2004, Showed that of the 16 occupations grouped under the category of 'professionals' which are in high demand in, 12 were health occupations. Of the 'Key Areas of Shortages Identified', all classes of Medical Radiation Technologists are included on the list.

Medical Radiation Technologists are critical to the early diagnosis and treatment of patients. The majority of productivity gains to the health sector and the population generally has been through improved early diagnosis and treatment of conditions[40]. This is particularly evident for cancers, neurological diseases, HIV, diabetes and heart conditions. This has influenced the degree of diagnostic technology and workers sought by the health sector. Unmet supply

[39] Department of Human Services Victoria, Submission to the PC Workforce Review July 2005
[40] Reference to the importance of early diagnosis.

of this workforce thus directly relates to increase in the incidents of more chronic health conditions and high costs.

Number and distribution of Medical Radiation Technologists in the public and private sector, Victoria, 2004[41]**

Allied Health	Public	Private
Medical Radiation Technologists	370	419

Remuneration was identified in the National Strategic Plan for Radiation Oncology as being of critical importance to radiation therapists. The major reasons for losses from the profession were remuneration, career change, job satisfaction and career pathway. Of the group of 10% per annum leaving the profession 35% cite the reasons job satisfaction or career path, 27% remuneration and 20% career change.

In the current global market it is important that Australian develop a strategy with addresses both professional climate and remuneration Salaries for radiation therapists in Australia are significantly lower than those attainable in the global market place.

Variations in pay rates from international levels are evident, but most particularity at based grade staff levels. Currently considerable discrepancies in salaries exist between States and this may be a factor in the higher vacancy rates in lower paid States. While remuneration is important issue, appropriate career pathways must also be part of the retention strategy[42].

Access to diagnostic services is also a central issue to health inflation costs. As a greater proportion of MRT's work for private institutions, the cost of diagnostic services has increased. This acts as a disincentive for individuals, particularly from high risk demographics, from seeking appropriate medical attention in the early stages of experiencing symptoms.

The perverse outcome in the supply and demand of MRT diagnostic services is that there are Medical Radiation Imaging machines and workers who are not working at capacity in the private sector, and extensive waiting lists and 'gate keeping' measures in the public sector. For example, there are 10 weeks waiting lists in some public hospitals which will only provide a 'public sector' MRI, if the patient has not accessed one within the previous 10 years[43].

[41] Source: Victorian Allied Health Labour Force Survey, 2004******Note, There appears to be problems with this data, based on our own source and registration board information indicating that there are in excess of 2,500 registered MRT's in Victoria.
[42] Radiation Oncology Inquiry, Australian Institute Radiography Submission – Jan 2002
[43] Waiting lists at MRI facilities Victoria, hospital data.

Private Practitioners and Employed Practitioners

In relation to workforce flexibility, private practitioners are seeking to increase their own revenue by creating roles which support their practice, for which they can earn additional practice income. By contrast employees are seeking to develop roles which create better outcomes in a networked system. Working professionals also seek to be appropriately rewarded for their skills and capabilities and increasing expertise over time.

The increase in private sector provision of health services has increased the cost of many services to the government and private individuals. Private practitioners have an incentive to provide services on a piecemeal basis. Thus, they can increase their revenue by increasing the number of services they provide or the duration of those services. A comparison of average length of bed stay in public and private hospitals is an indicator of where the inefficiencies exist.

By contrast, employees deliver services in accordance with demand. As demand is at overcapacity in many health services, their income remains stagnant while their workload intensity increases.

Under the Productivity Commission's proposed incentive scheme to improve supply and demand through a broader allocation of the MBS, there is a real risk that the government will increase incentives for services by private practitioners which increase costs and disincentives for working in the public sector. This will increase the intensity of the demand on public sector health professionals while creating supply driven demand in the private sector.

The cost inflation of private practitioners needs to be considered, as well as the relative distribution of revenues on wages versus profits. The PC should famliarise themselves with health cost inflation factors, and the contribution of private sector in increasing costs and reducing wages to achieve profits.

It is the opinion of the HSU that any reforms which promote profit over real wages growth would be unsustainable and therefore unsupportable. We also recommend that the PC consider the other income and expenditure incentives and disincentives, in addition to MBS incentives, to attract and retain a high standard health workforce.

Registration and Accreditation

The HSU supports the initiative to provide an improved national framework for the registration of health professionals and accreditation of educational institutions and courses.

Current health professionals' registration requirements in Victoria are inefficient and costly for practitioners and are considered insufficiently transparent and accountable for their decisions. A brief summary of the operating revenues, costs and cash holdings of only 7 of Victoria's 12 Registration Boards provides a good example of the level of inefficiency of multiple registration boards for each profession across the country.

Health Professionals Income, Registration Fee and contribution to profits of Registration Boards

Registration Board	Number Regis-tered	Ave' Income $ '000	Registr-ation Fee	Board Revenues	Board Expenses	Board's Cash Holdings
Psychologists	5075	60	$ 336	$ 1,841,532	$1,506,540	$ 1,975,255
Physiotherapist	3974	52	$ 150	$ 516, 563	331,639	$ 1,467, 984
Optometrists	950	130	$ 240	$ 255,948	$ 148,252	$ 804,947
Podiatrist	780	52	$ 330	$ 256,212	$ 166,109	$512,333
Medical Drs	18,016	400[44]	$ 330	$ 6,534,683	$6,200,000	$ 5,188, 540
Nurses	77,144	60	$ 120	$ 5,715,000	$ 7, 075,000	$ 5, 365, 744
Osteopaths	322		$ 500	$ 185,682	$ 93,000	$ 462,482

According to the picture this paints, the total cost to the country in 'registration of health professionals' is in excess of $1 billion dollars per annum funded by the health workforce.

Registration Board	Number Registered	Average Income $ '000	Registr-ation Fee	Restoration to register	Late application fee	Extract register/certificate
Psychologists	5075	60	$ 336	**$ 570[45]**	$ 504	$ 50
Physiotherapist	3974	52	$ 150	**$ 160**	$ 40[46]	$ 25
Optometrists	950	130	$ 240	**$ 310**	$ 55	$ 13
Podiatrist	780	52	$ 330	**$ 430**	$ 100	$ 10
Medical Drs	18,016	400[47]	$ 330	**$515**	$130	$ 60
Nurses	77,144	60	$ 120	**$ 200**	$ 80	-
Osteopaths	322		$ 500	**500**	$ 552	$50

[44] This is an approximate average practice income, AMA 2004.
[45] The formula is 'renewal fee plus late fee plus 20% of renewal fee', Psychologists Registration Board, 2004
[46] additional renewal fee
[47] This is an approximate average practice income

The HSU **recommends** that arrangements in relation to health professionals regulation consider the impact of fees to health workers, in particular the Health Professionals Registration Board/s to set fees which:

- are proportionate to the earnings of practitioners
- are not a disincentive for people, predominantly women, to return to work or to work part time
- are not a disincentive for health professionals to practice in Australia

Professional Bodies' conflict of interest

It is observed that the majority of professional bodies' submissions sought predominantly to advance the interests of their own body and their private practitioner members.

It is noted that there are sometimes conflicts of interest in the functions performed by professional bodies and their relationship with providing information regarding registration and practicing requirements.

Secondly, professional bodies are sometimes dominated by the interests of teaching practitioners and private practitioners, as distinct from employed professionals. This is often done at the expense of the interests of professionals employed by the government or NGO sector.

Workforce Reform Partnerships

Our analysis of the majority of submissions to the Productivity Commission found that a large proportion referred to the positive experiments contained in the English National Health Service (NHS) Reforms. We concur with the view that there are valuable lessons to be learned from the NHS reforms.

The Victorian Department of Human Services Workforce Strategy is using NHS guidance material as the main source of its reform agenda.[48] However the strategy is as yet very piecemeal and has limited opportunity of leading to successful or meaningful reforms to Australian supply and demand issues. Nonetheless there is a wealth of experience in their reform processes which would be instrumental to informing improved outcomes from any similar reforms throughout Australia.

[48] Department of Human Services Victoria, Health Workforce Policy and Planning, Strategy Overview, May 2005

In particular, the reforms acknowledged the highly networked functioning of the health care sector and the importance of developing true partnerships to achieve improved outcomes. One of the features of the successful reform to the NHS was to secure a path for transition through a genuine partnership with the workforce representatives. Terms, conditions and remuneration for workers was secured prior to major transitions. This facilitated cooperative outcomes during change processes.[49]

The nature of health workforce reforms is that the workforce has the detailed knowledge of the service delivery interventions and processes which would optimise patient outcomes. Their active participation is paramount. Successful reforms require absolute participation.

Health Outcomes

Evidence based health outcomes need to form the drivers of major reforms. Health status and outcomes need to inform priority areas and be integral to how reforms are evaluated. Australia currently has very high health outcomes by international standards across the majority of indicators (Indigenous health being the major aberration).[50] The reforms proposed by the PC should not have a negative impact on the health status. The only way to ensure that is to ensure that the policy and planning of the health workforce is aligned with clinical need and performance statistics.

Evidence based health policies based on health outcomes are more likely to achieve 'productivity gains', in terms of reducing the overall demand on health services. The following table represents evidence on areas that health workforce reforms need to address.

Governments' primary objective is to facilitate a healthy and productivy community, not to cry poor over spending the population's taxes on an adequate health system.

There are potential problems with the PP's recommendation to create a more central role for Ministerial Bodies. There is a real risk, as with the NCP process, that the agenda will focus on short term budgetary measures, and not longer term health outcomes. A balance of responsibility needs to exist with the public sector experts with a long term interest and responsibility in the health sector. The reforms must maintain Australians' health status as central to any major changes.

Total Health Workforce

This labourforce is also integral to the functioning of the health sector. The labourforce also consists of workers in the aged, disability, community and residential care sectors. They were not considere, except by fleeting reference in 'special needs' chapter.

[49] NHS Modernisation Agency, 'Improvement Leaders' Guide, Managing the human dimensions of change. 2003

[50] World Health Organisation, International Health Status Comparators 1997 – 2004.

Special Needs:

- **Indigenous health -** The HSU represents the indigenous health workforce. We strongly support greater measures to improve the salaries, terms and conditions of indigenous health workers in Australia. Victoria currently does not even have a representative on the National Taskforce into the indigenous health workforce taskforce. The issues surrounding the needs of this group of people and the workforce are critical to Australia's human rights standing internationally.

- **Disability sector –** There are enormous opportunities exist to improve outcomes and reduce costs by having better trained and respected workforce. The HSU supports further investigation into improving outcomes in the disability sector.

- **Aged Care –** the majority of the aged care workforce are personal care workers yet scant attention is paid to this workforce or their supply and demand issues.

Summary of HSU Recommendations:

.

1. It is strongly recommended that PC address all the Terms of Reference with the appropriate data before its postulates on the trends, challenges and inhibitors to workforce supply

2. It must be acknowledged that the only way to secure a path for transition of the health workforce is through a genuine partnership with the workforce representatives. The HSU recommends that any proposed reforms of the Australian health workforce also be subject to broad consultation and partnership with workers in the sector and their industrial representatives.

3. The HSU believes that the Productivity Commission's Position Paper did not give sufficient attention to the remuneration and terms and conditions of employment as factors which influence the recruitment and retention or high turnover of exiting health professionals and workers. We recommend that the incentives and disincentives provided by relative incomes of health professionals is provided in the PC's final report.

4. The HSU believes that there is a strong role for the government to play in addressing the relative income disparity disincentives to work in Australia, compared to health professionals working overseas.

5. The HSU recommends that the government also has a role in investing in non-remunerative terms and conditions which make Australia, and Australian institutions, a preferable place to work.

6. The HSU is concerned that the PC proposal to allow a broader allocation of the MBS, contains a real risk that the government will increase incentives for services provided by private practitioners which will increase the costs and disincentives for working in the public sector. This will increase the intensity of the demand on public sector health professionals while creating supply driven demand in the private sector. Therefore the HSU recommends that the PC should avoid any reforms which promote profit over real wages growth as these would be unsustainable and therefore unsupportable.

7. Further, the HSU recommends that the PC consider the other income and expenditure incentives and disincentives, in addition to MBS incentives, to attract and retain a high standard health workforce.

8. The HSU supports the initiative to provide a more efficient and effective national framework for the registration of health professionals and accreditation of educational institutions and courses.

9. The HSU recommends that any reforms proposed by the PC should not have a negative impact on the health status of Australians. The only way to ensure that is to

ensure that the policy and planning of the health workforce is aligned with clinical need and performance statistics.

10. The HSU expresses reservations at the PP's recommendation to create a more central role for Ministerial Bodies. There is a real risk that the agenda will focus on short term budgetary measures of interest to politicians rather than the longer term sustainability of the health sector and Australia's population health outcomes. The HSU recommends that the governance of health professionals' workforce reforms be balanced with non-political health authorities and experts.

11. The HSU recommends that the PC take a more holistic look at the health labourforce. The HSU is concerned that the PC analysis only considers one part of the pie – and not the total labourforce which is crucial to workforce planning and policy development. Often bottlenecks and outcomes in delivering health care are a consequence of the definition and functions of the role design of this workforce.

12. The HSU recommends that arrangements in relation to health professionals regulation consider the impact of fees to health workers, in particular the Health Professionals Registration Board/s to set fees which:
    a. are proportionate to the earnings of practitioners
    b. are not a disincentive for people, predominantly women, to return to work or to work part time
    c. are not a disincentive for health professionals to practice in Australia

13. The HSU recommends that a high priority be given to measures to improve the salaries, terms and conditions of indigenous health workers in Australia. The issues surrounding the needs of this group of people and the workforce are critical in themselves, but also to Australia's human rights standing internationally.

14. The HSU recommends also that there be further investigation into improving outcomes in the disability sector. There are enormous opportunities exist to improve outcomes and reduce costs by improving training, terms, conditions and respect for the workforce in the disability sector.

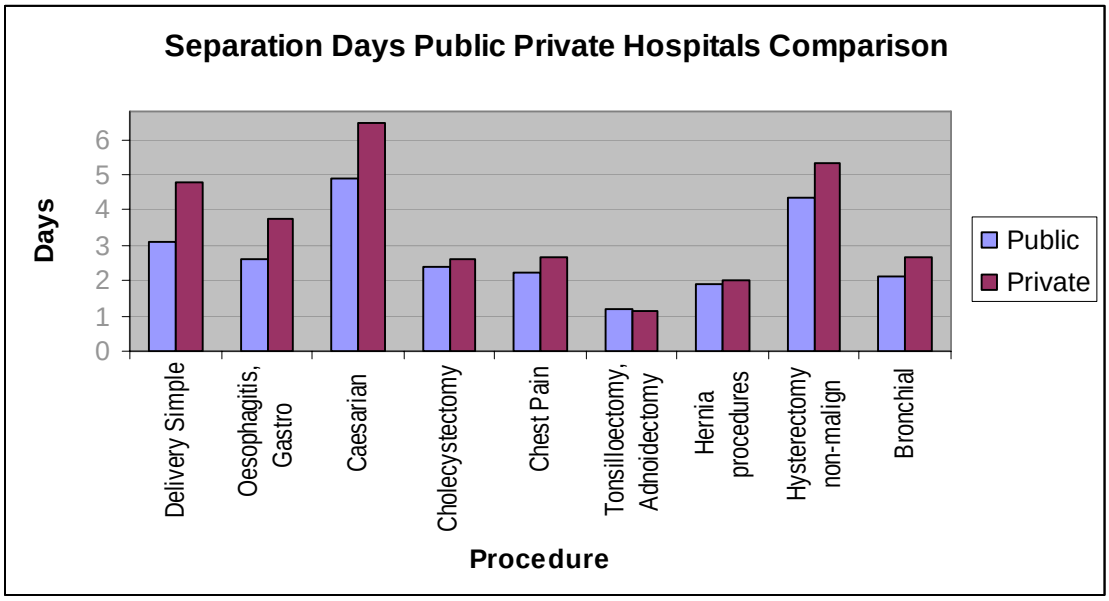
15. The HSU urges that more attention be given to the non-nursing workforce in the aged care sector. The majority of the aged care workforce are personal care workers yet scant attention is paid to this workforce or their supply and demand issues, yet they inevitably impact on other parts of the health system.

For further information contact:

Kathy Jackson (National Assistant Secretary)
kathyj@hsuvic.asn.au

Ruth Kershaw (Author)
ruthk@hsuvic.asn.au

Appendix 1



Average length of stay for most frequent procedures[51]

Procedure	Public	Private	% More Productive
Vaginal delivery without complications	3.08	4.80	%64.6
Oesophagitis, Gastro & digestive system	2.63	3.74	% 42.2
Caesarian delivery without complications	4.90	6.48	% 60.7
Cholecystectomy	2.37	2.61	% 9.2
Chest Pain	2.22	2.67	% 17.3
Tonsilloectomy, Adnoidectomy	1.22	1.14	% -3.8
Hernia procedures	1.89	2.02	% 5.0
Hysterectomy for non-malignancy	4.37	5.33	% 36.9
Bronchitis and Ashma age <50 without catastrophic cc	2.10	2.68	% 22.3

[51] Australian Institute of Health and Welfare, Australian Hospital Statistics 1999-00. 'Average number of separations in top 10 dagnosis related groups with highest number of separations (excluding same day separations)'

Heart and shock without catastrophic concequences	6.38	8.43	% 78.8
Total Average Productivity Margin			33.3

Appendix 2

NHPA	Prevalence[a] (2001)		Disability (1998)		Deaths[b] (2002)	
	Number '000	Per cent population	Number '000	Per cent persons with disability	Number '000	Per cent all deaths
Cardiovascular problems	3,185.9	16.8	312.2	8.6	50.3	37.6
Cancer	267.6	1.4	60	1.7	37.6	28.1
Mental disorders[c]	1,812.6	9.6	529.2	14.7	3.2	2.4
Injury and poisoning[c]	2,241.9	11.9	245.7	6.8	7.8	5.8
Diabetes	554.2	2.9	64.4	1.8	3.3	2.5
Asthma	2,197.3	11.6	171.1	4.7	0.4	0.3
Arthritis[d]	6,058.1	32.0	1,240.2	34.4	1.0	0.8
All NHPAs	**9,765.5[e]**	**51.6[e]**	**2,622.8**	**72.7**	**103.6**	**77.5**

(a) Self-reported, estimates based on 2001 National Health Survey. All health conditions are long-term except injury which is recorded if occurring in the four weeks prior to interview.

(b) Deaths registered in 2002.

(c) Suicide is included with Injury and poisoning.

(d) Arthritis and musculoskeletal conditions.

(e) Because of the presence of more than one NHPA disease or condition, the total for all NHPAs is less than the sum of numbers in the columns above.

Sources: ABS 1998; ABS 2003; AIHW: Mathers et al. 1999; AIHW National Mortality Database.