Queensland Government submission to the Productivity Commission report on Australia's Health Workforce

November 2005

Introduction and context of this submission

Queensland's Demography and Health Characteristics

Queensland has a number of demographic and health characteristics that pose a range of challenges for the delivery of health services. Queensland is the most regionalised state in Australia with almost four million people spread over 1.7 million square kilometres. The majority of Queenslanders reside outside the State's capital city of Brisbane. The population is also widely dispersed with high concentrations in South East Queensland, populous provincial cities and towns along the coast and smaller and more isolated communities in the north and west.

Queensland is experiencing the fastest population growth in the country. For the twelve months to March 2005, Queensland's population increased by two percent, compared with the Australian population growth of 1.1% for the same period. Net interstate migration to Queensland continues to be the highest of all the states and territories. By the year 2051, the Queensland population is expected to increase by 69% to 6.4 million. With higher life expectancy and higher birth rates, the proportion aged 60 years and over in Queensland is expected to grow from 16% in the year 2003 to 33.5% in 2051.

These changing patterns of population distribution and composition have important implications for the provision of health service delivery and specialist services. Queenslanders have expressed a preference for living close to the coast and particularly in South East Queensland. As the population becomes increasingly concentrated in a relatively small part of the State, two main impacts will occur. Firstly, a concentrated population in a small area will lead to escalating demand for specialist services in the South East Queensland region while secondly creating issues of delivering these services to an ever decreasing population in some areas of the State. The State's ageing population will have an impact on the future demand for health care services as older people tend to access health care more frequently than younger age groups.

When compared internationally, the Queensland population generally has good health status. However, this is not shared across all sectors of the community as Aboriginal and Torres Strait Islander people, socio-economically disadvantaged groups, and some communities from non-English speaking backgrounds experience a disproportionate share of the burden of disease. This is particularly significant for Queensland given that in June 2001, Queensland Indigenous persons accounted for 27.5% of Australia's total

Indigenous population. Queensland also has a higher rate of lower income earners than the national average (25.3% of Queensland families in occupied private dwellings earn less than $500 per week compared to 23.7% nationally).

Queensland has the highest rate of preventable deaths of any state in Australia. More than one-third of all deaths in Queensland are the result of a chronic disease that could have been prevented – including heart disease, heart failure, stroke, respiratory disease, diabetes and kidney disease. Due to lifestyle factors and the ageing of the population, the increasing incidence of chronic disease will place an increasing burden on the State's health care system.

These demand issues are exacerbated by health workforce supply issues, detailed as follows.

The health workforce in Queensland

Queensland has the most widely distributed health workforce in Australia. Our population is geographically dispersed and the majority of population growth is concentrated in the State's south east corner. The growth in Queensland's medical workforce has not kept pace with our population growth. The compounding effect of demographic factors and the issues facing medical workforces globally result in even more critical workforce challenges for Queensland.

In 2002, Queensland had the lowest number of registered doctors per head of population of any state or territory. The number of Queensland doctors per 100,000 population decreased from 236 in 1997 to 220 in 2002. This is in contrast to the Australian average where numbers increased from 260 to 275.

In 2002 Queensland had the lowest number of full time equivalent practitioners (working medical practitioners) per head of population of any state or territory. The Queensland full time equivalent practitioner rate fell from 247 per 100,000 population based on a 45 hour week in 1997 to 217 in 2002. This was a fall of 30 FTE practitioners per 100,000 population and is 54 FTE practitioners less than the national average. It was the biggest fall of all the states and territories. Across Australia the full time equivalent practitioner rate fell from 275 per 100,000 population to 271.

Queensland has the lowest number of primary care practitioners per 100,000 population, of all the states and territories. The full time equivalent practitioner rate for Queensland fell from 94 in 1997 to 82 in 2002, compared to the national figure of 101 primary care practitioners per 100,000 population.

Queensland Health is the largest employer of health professionals in the State. As at September 2005, 53,866 people were employed across the organization, equating to 44,504 full time equivalent (FTE) staff. On a headcount basis, nurses constitute the largest proportion (40.7%) of the health workforce with 21,928 staff (17,125 FTEs). Operational staff are the next largest group at 19.7% or 10,577 staff (8,600 FTEs) followed by managerial or clerical staff at 17.4% or 9,607 staff (8,766 FTEs). The

professional category which includes allied health professionals makes up 10.7% or 5,765 staff (5,002 FTEs). The 3,648 Medical staff (3,433 FTEs) and 850 Visiting Medical Officers (VMOs) (244 FTEs) comprise 8.4% of the total workforce.[1]

On an FTE basis, the number of medical practitioners employed by Queensland Health has increased by 69% since 1996 from 2,027 FTE medical staff to 3,433 FTE staff in 2005. However, a significant proportion of the growth in salaried doctors has resulted from the employment of overseas trained doctors with special purpose registration. Overseas trained doctors account for approximately 27% of Queensland Health's medical workforce.

Nursing numbers have not kept pace with demand, growing by only 13.3% over the same period from 15,118 FTE staff in 1996 to 17,125 FTE staff in 2005. Allied health staff has increased by 61% from 3,112 FTE staff in 1996 to 5,002 FTE staff in 2005 however staffing levels are still lower than other States.[2]

The current Queensland Health medical workforce is also ageing. As at September 2005, 933 or 20.7% of the doctors (including VMOs) in Queensland Health were over 50 years of age and the average age of a nurse is now approximately 43 years.

Nationally, on average health professionals are working fewer hours per week than previously due to a variety of factors including work/life balance, the age of the health workforce, changes in medical workforce roles, and the feminisation of the health workforce. This has significant workforce planning implications and creates supply pressures as more staff is required to maintain the same level of service.

The demand for doctors in Queensland, and within the Queensland public health system, is expected to continue increasing for the foreseeable future, and will not be satisfied by recent increases in university medical student intakes. Other professionals are also in short supply in Queensland with experienced nurses increasingly difficult to recruit. Medical workforce shortages are not homogenous across the State, nor across specialities or levels of seniority. The Queensland public health system experiences chronic shortages in rural and remote areas, and in the specialities of anaesthetics, cardiology, orthopaedics, obstetrics/gynaecology, psychiatry and surgery. Other professions follow a similar pattern geographically, with greatest difficulty experienced in recruiting and training the health workforce in rural and remote areas.

The Queensland Health Systems Review and the Government's Health Action Plan

Health system reform is not costless. It requires funding commitment, new and innovative solutions to problems, and coordinated action from stakeholders at all levels of the health system including the Commonwealth Government, State and Territory

[1] Queensland Health Workforce Data Management Information System, September 2005.
[2] Queensland Health Workforce Data Management Information System, September 2005.

governments, medical colleges and professional bodies, and the people who comprise the health workforce.

On 26 April 2005, the Queensland Government announced a Queensland Health Systems Review, led by Mr Peter Forster. On 30 September, Mr Forster presented his 491-page final report, which contains 388 recommendations for improving Queensland Health's workforce, performance management and administrative systems. The report was the result of five months of extensive research and consultation, including some 1,300 submissions.

The report from the Queensland Health Systems Review represents a turning point for the delivery of public health care services in Queensland, providing a very frank and comprehensive assessment. Many of the systemic challenges and proposed solutions identified in the report are transferable to all Australian jurisdictions.

On the one hand, the report found that Queensland's health service is a good service, performing as well as any other in Australia, and with a lower cost structure than other jurisdictions. The report also recognised the dedication of the workforce of health professionals, support staff and administrators. On the other hand, the report found that Queensland Health is experiencing unprecedented demand. In many cases, it is showing increasing signs of strain and in some cases, it is failing. Accordingly, the report's recommendations are far reaching. While some recommendations can and will be implemented immediately, others will take at least five to ten years to implement in full. Some recommendations raise complex policy issues that will need further consultation and debate.

For the reforms to be successfully implemented, Queensland's public health system needs, as a foundation, a sustainable and flexible health workforce that is:

- sufficient in numbers to manage current and future growth in demand;
- educated to be mobile, flexible and multidisciplinary in approach;
- trained to a high standard to deliver safe and quality patient care; and
- funded through payment systems which recognise a wider group of practitioners who could deliver clinical services.

On 25 October 2005, in conjunction with the mini-budget, the Premier and Treasurer and the Minister for Health released the Health Action Plan: Building a better health service for Queensland, which marks the biggest single injection of health funding in the State's history - a $6.367 billion package in just over five years to 2010-11, of which $4.431 billion is new money.

The plan responds to the Queensland Health Systems Review report, presenting a blueprint for health reform, better patient care and a healthier Queensland. It recognises the value of the health workforce; provides a substantial funding boost to address immediate pressures; and presents a long term budget strategy to reform and sustain Queensland's health system.

Under the plan, the Government will relieve immediate pressures through the allocation of $547.6 million in 2005-06. Funding will grow in the following five years to an extra $1.5 billion 2010-11, which will address key health areas to cut waiting lists, maintain and improve hospitals, and purchase new technology and equipment. The funding package includes:

- workforce training - $127 million
- elective surgery - $259.7 million
- emergency departments - $280.3 million
- intensive care units - $229.8 million
- cancer services - $463.7 million
- cardiac services - $210.9 million
- mental health services - $201 million
- renal services - $44.5 million

The plan will also cover pay increases negotiated recently with Queensland doctors and provisions for future enterprise bargaining negotiations with nurses and other clinical staff. The plan targets the recruitment of 1,200 additional staff to Queensland's public health system over the next 18 months, comprising about 300 doctors, 500 nurses and 400 allied health professionals. A comprehensive State-wide Health Services Plan will be developed in 2006 to target further substantial funds to areas of greatest need.

Reform of Queensland's health system is not a job for the State Government alone. The Premier has written to the Prime Minister about how the Commonwealth Government can partner with Queensland on health issues. For instance, it is possible that, all things being equal, reforms in any single jurisdiction (such as increased salaries) could lead to outcomes which, in the absence of an increase in supply, could result merely in an increase in the cost structure of the health system without necessarily delivering efficiencies and productivity benefits. Hence a partnership is crucial, given the Commonwealth's responsibility for the allocation of university places; the number of general practitioners who can practise in Queensland; and the Medical Benefits Schedule including access to Medicare billing.

The Queensland Government response to the package of reform proposed by the Productivity Commission

The core package of proposals contained in the Productivity Commission's position paper provides a rare opportunity to make significant cohesive reform in policy and institutional arrangements to address one of the most perplexing and important challenges facing governments in the 21st century. There is little doubt that the current composition of the health workforce has its origins in the 19th and 20th centuries and the models are neither sustainable nor necessarily best placed to respond to the demographic changes which impact both on demand and supply; the changes in the burden of disease; changes in consumer expectations and the ever accelerating technological changes. The implementation of this package would directly challenge the current fragmentation in roles, responsibilities and regulatory arrangements by embedding a 'whole of health workforce' perspective in the new institutional arrangements.

Key to the success of this proposal will be the capacity of all stakeholders to set aside vested interests and act in the public interest in formulating governance arrangements. There is a risk that each sectional interest will seek to be represented on the proposed new agencies, bodies and councils and result in oversight by large unwieldy committees immobilised by representative's interests.

Obviously, the Queensland Government would have an expectation that these mechanisms should not be dominated by one level of government. However there are many examples of forums that are well placed to reflect State Government's interests without each State and Territory Government participating on the body itself. Similarly, it would be unwieldy for each category of health worker to be represented on the proposed new agencies, bodies and councils – especially in the context of our expectation that new categories of workers must emerge to meet current and future challenges.

However any new arrangements should not have less access to expertise in their decision-making. Measures should be in place to ensure this access, especially in areas in which it could impact on the quality and safety of health services. It would helpful if the final report of the Productivity Commission could address further the challenges of implementation of the core package of reforms and the importance of the governance arrangements as a facilitator of change.

The interaction of two of the elements of the package, the advisory health workforce improvement agency and better focused and more streamlined projections of future workforce projections, provides a particular opportunity to improve the evidence upon which future planning is undertaken. The success of both elements relies on research, robust data analysis and scenario planning and would benefit from a degree of independence from all levels of government and other stakeholders. As an independent source of information and advice, the body would have greater capacity to act as a 'circuit breaker' in circumstances in which custom is embedded and change must occur.

The integrated body could be established along lines, not dissimilar to the Productivity Commission. While not proposing that these elements of the package should be separated from the other elements, there would appear to be an opportunity to progress them if other elements of the package do not attract support. It would be helpful if the final report of the Productivity Commission could address both the possible integration of the two elements and their capacity to be established as a 'stand alone' reform measure.

The Queensland Government's comments pertaining to the specific areas of reform are provided in the following section.

The proposal to progress a national agenda on health workforce reform through COAG

The Queensland Government supports the report's proposal for the National Health Workforce Strategic Framework (NHWSF), already endorsed by Australian Health Ministers, to be elevated to COAG to obtain high-level and whole-of-government agreement on principles.

In this context, it is useful to consider the Productivity Commission's reform proposals contained in the Position Paper from the perspective of these principles. While generally they are consistent with these principles, there appears to be a lack of attention to Principle 3 - that all health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration. The terms of reference for the Productivity Commission study did list workforce participation, workforce satisfaction, hours of work, and productivity of the health workforce as areas that need to be considered in reporting on Australia's health workforce. However, it seems that this aspect has not been fully explored.

The Queensland Health Systems Review identified organisational culture as a vital factor in ensuring effective service provision across the health system. In particular, the Review concluded that a dysfunctional organisational culture resulted in substantial negative outcomes in terms of accountability, accuracy of information, staff retention, staff satisfaction, tolerance, performance and leadership. These factors interfere in the efficient provision of health services and are to the detriment of patient care. If Australia is to continue to have a world class health system, policy makers must seek to address the prevailing culture, particularly in light of the substantial pressures that have developed on health workers over recent years. These pressures are set to increase in the future as fiscal constraints, technological evolution, workforce shortages and liability issues further strain the already heavily burdened health workforce.

An organisational culture that is inclusive, accountable, encourages tolerance and provides staff with a supportive environment in which to develop professionally is integral to securing positive outcomes for the health system. For health workers, this is especially important as managers and clinicians operate inside a system which demands effective patient outcomes yet requires the managing of wider system needs and

budgetary constraints. As such, a positive workplace culture can serve to assist in balancing of these dual requirements, with the wider benefits including greater staff satisfaction, retention, and participation. This has been identified by the Queensland Health Systems Review as a key factor in securing a better health system.

While acknowledging that such a perfect system is difficult to achieve, the Review identified several areas in which government policy can have a positive impact in transforming a dysfunctional workplace culture. While interdependent, all are essential to affecting a positive organisational culture in which health workers can thrive. These areas include the recruitment, development and professional support of effective workplace leaders; focused team building in an atmosphere of trust and co-operation; the promotion of an atmosphere of trust between staff and managers; a fair and effective grievance process; ongoing monitoring of organisational culture; and an emphasis on accountability.

The Queensland Government considers that the Productivity Commission's final proposals should therefore incorporate these concepts for Australia's health system to operate effectively and efficiently.

Facilitating workplace innovation

The Queensland Government welcomes the proposal to establish an advisory health workforce improvement agency to examine major workforce innovation including job redesign opportunities. Lack of national co-ordination on workforce innovation and the barriers created by a lack of a cohesive vision among different professional groups and levels of government have hampered initiatives to create a more flexible workforce. Having one body allows for a brokering role among stakeholders and a relevant single reference point for governments.

Such an agency has the potential to provide policy makers with a common, robust, relatively independent source of advice on the nature and extent of the change required to the size and composition of the health workforce in Australia in the 21st century. Furthermore, it could provide a detailed assessment of the barriers to implementation (legislative, institutional, professional, financial and cultural) to change and proposals to address these. It would be crucial that governance arrangements ensure that the 'public interest' is the agency's first concern and that it does not replicate or embed vested interests that exist in current arrangements.

As discussed earlier, the Queensland Government believes there would be benefit in integrating the proposed advisory health workforce improvement agency with the proposed secretariat to undertake better focused and more streamlined projections of future workforce projections. This would provide a demand-led approach to future workforce planning through an independent evidence-based model.

The position paper suggests that job redesign potentially could result in a greater shortage of nurses as they move into substitute roles for doctors. The recent Queensland Health Systems Review recognised the consequential flow on to other professions as a result of

multi-skilling and enhanced roles for nurses and the resulting need to train substantial numbers of nurse preceptors, examine enhancing the roles of enrolled nurses and assistants in nursing and substantially increasing the numbers trained.

Decisions as to which job innovation opportunities could form the basis for the agency's initial investigations need to be driven by the future workforce requirements of population and consumer-focused models of health service delivery. Such decisions would also need to be informed by jurisdictional and other health service planning processes. It is not clear whether ideas/proposals for this agency are to be nominated solely through AHMAC. The agency would potentially serve significant cross portfolio interests and it would be appropriate for the VET and Education sector to also have a voice on what constitutes a sound proposal for job redesign. This might be achieved by effective collaboration between the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA), the Ministerial Council on Vocational and Technical Education, and AHMC or their standing bodies/senior officials' groups.

It may be useful in the prioritisation of innovation opportunities to identify possible key groupings of tasks and/or competencies that have become the recent focus of change in service delivery. Groups identified may include, for example, those associated with:

- procedures – for example endoscopy or sedation/anesthesia;
- health education/self management – for example diabetic therapy including dietary education or podiatry care; or
- care/support – for example care in the home of a post-surgical patient or peer support from a mental health consumer.

In each of these groupings it may be possible to identify particular areas of focus in relation to new ways of working within current roles, expanding current roles, or developing new evolving or devolving roles.

Other options for prioritising innovations may include urgent national health reform drivers such as:

- the National Bowel Cancer Screening Program or the introduction of digital mammography
- Indigenous health care, mental health care or the management of chronic disease.

The Queensland Government is currently examining the development of the Rural Generalist role for senior medical staff. Such medical staff would choose rural general medicine as a specialty career path that allows them to practise independently across a number of specialty areas. Rural Generalists would be senior medical staff, practising at the registrar or consultant level. Similar initiatives may be appropriate for other health workforce professionals, and should serve to ensure that the medical workforce is more appropriately distributed between major centres and rural communities.

The Queensland Government is increasingly addressing industry training through the Vocational Education and Training (VET) sector using a model to ensure that education and training is contextualised in workforce development. Under this model all relevant parties from an industry sector (including unions, workers, and employers) are engaged in

considering the issues that affect the development of the sector's workforce. This includes analysis of the factors determining the demand, supply and use of skills within specific industries and regions. Particular factors examined include the quality and duration of employment in an industry, government policy and regulation, the training culture of an industry, and the level and quality of vocational education provision available to firms and workers. This model may be relevant to the strategic approach of an advisory health workforce improvement agency.

The Enrolled Nursing and Aged Care sector in Queensland is currently using this approach in considering the issue of casualisation of the workforce: The Queensland Nurses Union, professional educators, trainers, industry, and relevant institutions are collaboratively using this approach to seek to better understand issues such as the role of 'casualisation' of the workforce in their sector and specifically the implications of casualisation to current health workforce issues.

More responsive education and training arrangements

On 26 October 2005, the Queensland Government announced it will spend an extra $127 million over the next five years on training programs to strengthen the health workforce and improve patient care for Queenslanders. The new training initiatives under this funding will increase the professional development of doctors, nurses and allied health professionals in Queensland's public hospitals. Part of the package will be spent on an additional 55 specialist training positions in public hospitals. These include an extra 12 radiologists, 20 pathologists, five general medical specialists, three rural generalists, and positions in orthopaedics, anaesthetics, neurology and general surgery.

Expanded training for nurses will also be delivered in the next five years. The Queensland Government will train 1,000 experienced nurses immediately to become preceptors, or mentors, to support new employees during their transition phase in public hospitals.

A key area highlighted in the Queensland Health Systems Review because of its negative impact on health care for Queenslanders is the Commonwealth Government's reduction in medical student intakes at Australian universities resulting in a shortage of doctors generally and an increasing reliance upon overseas trained practitioners. The Review estimates that Queensland Health requires an estimated additional 160-180 doctors, 500-600 nurses, and 200-250 allied health professionals every year. The Review recommended the Commonwealth Government provide an immediate increase in medical, nursing and allied health student places. This is fundamental to the long-term sustainability of Queensland's health system.

The position paper recognised that the education of most health workers are university based and many submissions claimed that the major contributor to workforce shortages is insufficient education and training places, particularly in universities. The terms of reference for the study included the provision of advice on the factors across health and education that affect supply of workforce preparation through undergraduate and postgraduate education and healthcare priorities including education measures to improve

recruitment, retention and skills-mix within the next ten years. In this context, the Queensland Government considers that the Productivity Commission's final paper should make proposals that address the quantum of funding of university places.

The Queensland Government sees little value in the proposal that the Commonwealth Government consider shifting the primary responsibility for allocating the quantum of funding available for university based education and training from the Commonwealth Department of Education Science and Training (DEST) to the Commonwealth Department of Health and Ageing (DoHA).

Coordination failure is reported to be between DEST and State and Territory health authorities in relation to university-based health workforce education and training. There is no doubt that DoHA has an existing close relationship with State and Territory health authorities and there would be benefits in this informing decisions about need and allocation of funding. However, we reiterate, the real problem behind the allocation of university places lies with the quantum of funding, rather than the body that administers it. It would be regrettable if the solution to an apparent failure of two Commonwealth agencies to work collaboratively is to just shift responsibility to a new "silo" rather than ensuring that the combined expertise of these bodies and a strengthened relationship with State and Territory authorities provides the basis of decision making.

Greater levels of coordination and a more informed allocation process are most desirable outcomes for Queensland. The allocation of university places is a complex process. There is, however, no evidence that DOHA has the expertise or understanding of issues (such as institutional capacity, capital development or clinical placement requirement) associated with determining health training places. Moreover the proposed shift from DEST would result in a fragmentation of the funding process and educational institutions receiving funded places would have to deal with a second agency in relation to funding agreements and reporting requirements. Universities are dealing with an already significant reporting burden.

The Queensland Government recommends that a mechanism be developed which incorporates the expertise and knowledge of both health and education sectors and also ensures that state and territory governments have a role in determining the number of health workforce university places that should be available at tertiary institutions.

The Queensland Government supports the draft proposal to establish an Advisory Health Workforce Education and Training Council to provide for systematic and integrated consideration of different education and training models (including VET) and their implications for courses and curricula (draft proposal 5.2).

The real value that this council could provide would be consideration of health workforce education and training across professional and disciplinary boundaries. It would have the potential to draw together the views and expertise of various stakeholders to develop holistic health workforce strategies across professions and across jurisdictions.

The position paper suggests that the VET sector currently has a lesser role than the university sector in the education and training of the health workforce. This characterisation could be misleading. The role of VET in the health workforce is extensive and covers both health-specific and clerical and administrative training. Nearly 40% of the Queensland Health workforce in either the operational or administrative areas use a range of VET training packages. These include training packages for the public service, business, finance, information technology, community services, and asset maintenance. VET options are also available in aged care, enrolled nursing, laboratory operations and Indigenous health.

The position paper suggests that it would be desirable for the Education and Training Council to report to AHMAC. The Queensland Government considers that to effectively improve coordination and secure agreement on the education and training of health workers it should also report to the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) and the Ministerial Council on Vocational and Technical Education. The reporting could be achieved through the formation of a senior officials' group that comprises representative interests from each of the three ministerial councils.

A key challenge for the health workforce is the sustainability of clinical training. There is currently no clarity with respect to funding frameworks for clinical training. It is not that this funding has been hidden but rather it effectively has been provided on a pro-bono basis using an apprenticeship model. It is important to consider the implications of clinical training at both an undergraduate level and a postgraduate level and how these aspects link to the training models being utilised and the service provision.

In considering the issue of clinical training, it is clear that additional funding will need to be provided to develop new model(s) of clinical training. In future this may be additionally funded under the Australian Health Care Agreement (AHCA). Currently, AHCA does not meet costs of clinical training and this must be recognised. Work needs to be undertaken to clarify and make transparent the current vast majority of clinical training being provided on a pro-bono basis. Only then will governments be in a position to assess feasible options. In this context, the Queensland Government supports the draft proposal to enhance the transparency and contestability of institutional and funding frameworks for clinical training (draft proposal 5.3).

Current policy frameworks do not separately identify or disaggregate the notional costs of components of a student's educational experience. There is no separate identification of the costs of clinical training. Though DEST claims that the rates of funding provided by discipline include a clinical training component, it is not realistic to expect that universities can fund the clinical costs of delivering theoretical and practical components of health-related disciplines from the rate of funding that currently exists (in 2005 was $9,511 for nursing and $15,047 for medicine and dentistry).

The position paper suggests that increasing student university fees to fund clinical training is unlikely to present major issues in the short term. The Queensland

Government considers that an increase in fees would be likely to create a disincentive to public sector practice and to the choice of health careers in general.

New funding, determined by the real costs of administering and delivering clinical programs across the health professions, would be essential to remedy this shortcoming. The possibility of providing incentives, such as HECS-liability rebates, for graduates to commit to bonded periods of employment in the public health system might also be considered. Further, as the costs of travel and accommodation are prohibitive to some students undertaking rural clinical placements, subsidies could be provided to undergraduate students as part of the Commonwealth Government's funding of clinical training to encourage greater uptake in rural and remote locations.

The Queensland Health Systems Review concluded that the quality and extent of clinically related teaching, training and education for the health workforce suffered under the strains of an overburdened system in Queensland. It identifies medical specialty training as an urgent priority. The Review also calls upon the Commonwealth Government to provide additional support to increase the level of funding available to:

- support the teaching and training of medical students on clinical placements within Queensland's public health system; and
- support the clinical placement of nursing students and allied health workers.

Currently all specialty training in Queensland, with only a few exceptions, is carried out by the public sector. Despite this, a large proportion of trained specialists in all fields decide to work wholly or partly within the private sector. As private health service providers clearly benefit from the availability of a trained health workforce, it could be justified that they should make a contribution towards the cost of that training. The Queensland Government recommends that the Productivity Commission's final report address this issue.

In addition to the funding required for medical specialty training positions in the public sector, models for the provision of training in the private sector and within universities, with relevant funding, need to be considered. There is support from Queensland tertiary institutions for an expanded role for universities in clinical training and for simulated clinical training.

The Queensland Government acknowledges the attraction of a system where public funding follows the trainee/student or a "voucher" system. The Queensland Government is cautious about this approach. Such a system would immediately advantage large hospitals with infrastructure that can provide training more efficiently due to economies of scale. Such a system would need to ensure appropriate safeguards to develop infrastructure for training in a range of settings. This is a particular concern for smaller and emerging rural and remote hospitals such as those found in Queensland, where the majority of the population lives outside the capital city.

A consolidated national accreditation regime

The Queensland Government supports the Productivity Commission's general direction to address the current lack of consistency across different accreditation agencies and acknowledges that the current arrangements can reinforce traditional professional roles and boundaries and thus impede job redesign. The concept of national accreditation principles and processes for university-based and post graduate health workforce education and training with national uniform standards upon which registration would be based is appealing. Such a system would improve mobility of the health workforce and allow initiatives for the improvement of health workforce education to be applied nationally and consistently.

Ideally it would work towards the development of a cross-disciplinary, cross-sectoral approach to education and training. Some aspects of health workforce training are held in common across the disciplines, and may be appropriate for a competency-based assessment. Such an approach could allow for the portability of educational modules between courses or between locations. This approach has been used successfully in the VET sector and that success could be more widely applied in this way.

The Queensland Government agrees with the Productivity Commission's view that the staged approach proposed by AHMAC, to consolidate functions for various professions within one national framework, coupled with the work of the national workforce improvement agency, would represent a significant movement of health workforce policy away from the current profession-based approach.

The first stage, which would establish improved mechanisms for collaboration within and between professions, employer bodies and education and training providers to ensure consideration of workplace requirements in accreditation processes is supported. The second stage, which would develop a national framework containing principles and process guidelines to be progressively implemented across the different accreditation processes as a national standard is also supported. However, the Queensland Government considers it premature to make a commitment in the longer term for a national health education and training accreditation body to apply across all health occupations and managing related accreditation arrangements. The diversity and complexity of professional education and training requirements for the health workforce and the reality that a single basis for accrediting programs – spanning vocational education, higher education and professional colleges – means it may not be desirable. A "one-size-fits-all" approach may actually confound the aspirations of all stakeholders to deliver optimal outcomes. In the case of the VET sector, the Queensland Government would continue its commitment to the National Training System.

The Productivity Commission may not have fully considered the current accreditation functions that are carried out by State and Territory Governments for the growing number of private providers engaging in higher education provision in health areas – at this stage, mainly in relation to courses on counseling and complementary medicine. Any proposal to remove health workforce accreditation requirements from the current statutory framework would result in fragmentation of what is currently a coherent, national, quality

assured, higher education framework. Queensland's *Higher Education (General Provisions) Act 2004* allows for accreditation work to be undertaken by expert panels appointed by the State Minister who is the decision-maker with respect to accreditation decisions. The Queensland Government considers that any consideration to amend current statutory arrangements may not be necessary once the aforementioned stages and streamlined accreditation processes are in place and in any case could only be contemplated after a proper evaluation of their effectiveness had been undertaken.

The costs associated with a national accreditation agency need to be considered by the Productivity Commission. There is a risk that moving away from the silos of professional accreditation could incur substantial unanticipated costs if professionals are no longer prepared to continue to contribute as part of their professional obligations. Accreditors often undertake these tasks as part of their professional obligation. The significance of this risk is highlighted with the recent development of an economic template for the proposed federal government's recognition of new medical specialities. This was costed at $250,000 by a commercial firm of consultants but developed at a cost of $2,000 by an expert sub-committee of the accrediting organisation (Australian Medical Council). Ideally, the national accreditation agency should be able to continue to access this expertise in this manner.

The position paper suggests that assessment of overseas trained doctors should be consistent across all jurisdictions (draft proposal 6.2). Until there is a sufficient locally trained health workforce, Queensland, like other jurisdictions in Australia, will be required to employ suitably qualified overseas trained health professionals. In the interests of safe practice a national scheme for the assessment of the qualifications and skills of overseas trained practitioners, focusing on medicine in the first instance, should be developed. This could involve accreditation of selective university courses in countries with similar training to Australian health care practitioners. In the first instance this could involve courses in countries with similar histories in health professional training to that of Australia such as New Zealand, Canada, Ireland and the United Kingdom. In the longer term, this accreditation may be best to focus on the suitability of courses in terms of the competencies of graduates rather than the countries of origin.

The Queensland Government supports draft proposal 6.2. In addition, the Queensland Government considers that until the numbers of locally trained health practitioners meet demand, and in the absence of increased funding for university places, transitional Commonwealth Government funding is required to assist public health services to meet the costs associated with recruiting, assessing the suitability of, and training internationally trained health practitioners. This should also be accompanied with provision for orientation and communication programs.

Supporting changes to registration arrangements

The Queensland Government recognises that nationally uniform registration standards are urgently required to assist with ensuring the competence and suitability of health professionals and the national mobility of the health workforce. The Queensland Government supports draft proposal 7.1 which recommends that registration boards

should focus their activities on registration in accordance with the uniform national accreditation standards and on enforcing professional standards and related matters. The Queensland Government considers that a national system of registration should be pursued.

In this context, the Queensland Government also supports draft proposal 7.2 which proposes improvements in the operation of mutual recognition. The position paper notes the work that is being undertaken to streamline medical registration in Australia. Jurisdictions are exploring a deeming model for registration of medical practitioners which, if successful, could be extended to all nationally regulated health professions. Under this arrangement, if the model uniform legislation is progressed by AHMC, a medical practitioner who was registered in Queensland would be deemed to be able to automatically work in any other state or territory at a minimal cost. A national system of registration would be an optimal outcome.

The Queensland Government considers that draft proposal 7.3, which would require jurisdictions to amend legislation and/or regulations to implement a formal regulatory framework to support task delegation needs to be approached in a way that does not stifle job redesign and workforce mobility.

Improving funding-related incentives for workplace change

The Commonwealth Government's major focus of health investments in the private sector through the Medicare Benefits Scheme, Pharmaceutical Benefits Scheme and Private Health Insurance Rebate are supposed to be designed to ease the burden on the public health system. However, due to the varying jurisdictional demographic and system characteristics, access to services funded through these mechanisms is not equitable across jurisdictions.

The position paper accurately identifies several aspects of the operation of the MBS that impact on the efficient deployment of the health workforce. These include

- access to the MBS by other than medical practitioners;
- the structure and relativities of MBS rebates;
- the scope for delegation of MBS-supported services; and
- referral and prescribing rights under the MBS and PBS.

The operation of the MBS is currently opaque but its structure seems largely based on a model of service provision which is no longer appropriate to health care in the 21st century and changes seem to be reactive, incremental and largely restricted to the current paradigm. Consequently, the Queensland Government strongly supports the proposal to establish an independent standing review committee to provide the Commonwealth Minister with expert advice on the MBS (draft proposal 8.1). Not only would this provide much-needed reassurance that decisions regarding the operation of the MBS are informed by expert knowledge of current health care demands, but it would increase the transparency of decisions relating to the range of services under the MBS. While the Minister, as with the PBS, would retain the prerogative to finalise decisions, the community could be more confident that decisions are based on the public interest.

The connectedness of the public and private health system is complex. Key issues for Queensland that impact on the public system's capacity to access third party funding or reduce pressure on the public system include:

- lack of private hospital capacity and limited role, particularly in rural and regional areas;
- lack of incentives to use private health insurance in public hospitals due to the growing proportion of policies with high front-end deductibles – the incentive to use private health insurance is particularly low for day only procedures where the front-end deductible may represent the entire hospital fee; and
- the growing gap between salaries of doctors in private practice (who provide services eligible for MBS rebates) and public hospital salaried doctors - this gap is particularly apparent for proceduralists.

Currently, the MBS is failing to provide universal access to health care in some areas of Queensland where general or specialist medical practices are not viable. In 2004-05 the average annual Medicare benefit drawn down for Queenslanders was $464 per capita, compared to the national average of $474. Queenslander's access to benefits under the Pharmaceutical Benefits Scheme is also lower than the national average.

In Queensland, innovative funding arrangements allow GPs to provide care in acute-care settings in rural areas. Medical Superintendents with Rights of Private Practice (MSRPPs) are paid a flat amount to provide cover for rural healthcare facilities, while at the same time providing GP services under the usual Medicare arrangements. This funding model could be trialled more widely. Similarly, exemptions to S.19(2) of the *Health Insurance Act 1973*, which are in place for specified sites in Queensland, allow for Medicare benefits to be paid in respect of professional services rendered or provided by salaried medical practitioners in public hospitals.

MBS subsidisation of referral arrangements within the public hospital system, referred to in draft proposal 8.1, are detailed in the current Australia Health Care Agreement (AHCA), which is due to be renegotiated by 30 June 2008. Any changes to referral pathways for public hospitals, including those applicable to private patients in public hospitals would need to be negotiated in the context of the AHCA. Currently, some specialist services that are referred and provided to private patients in public hospitals, such as radiology and pathology services, can be billed to the MBS. Whereas all services provided to public patients in public hospitals (with the exception of some magnetic resonance imaging) are not eligible for MBS rebates.

The Queensland Government supports the proposal for the payment of delegated rebates as outlined in draft proposal 8.2. The Queensland Government recommends that coverage should also be extended in the future, where appropriate, to other providers in their own right. New and extended roles will be particularly important for the future, given the shortfall in the medical workforce that all health services will face. Any concerns expressed by medical bodies should therefore be constructively addressed with a view to moving forward with this proposal.

The MBS has the potential to be a powerful tool in the development and support of new and innovative models of care, and to provide targeted solutions to specific health workforce shortages. In addition to expanding access to the MBS to other providers, the Queensland Government considers that the opportunity exists to ensure greater alignment between the allocation of MBS and PBS funding and service needs by trialing a range of funding mechanisms to create incentives for practise in areas of known specialty shortage and geographic shortage. Such incentives could include:

- increased scheduled fees for consultative items that promote coordinated multidisciplinary care rather than procedural items (to address the complex needs of the ageing population);
- increased scheduled fees for less attractive specialties such as geriatrics, psychiatry or specialties involved in prevention activities on agreed targets such as screening;
- differential payments for items performed in outer metropolitan, rural and regional areas; and
- allocation of provider numbers to take account of relative over- and under-supply in a given geographic area.

Queensland is developing the nurse practitioner role, and plans to increasingly use this role into the future. Nurse practitioners and other similar advanced practice roles such as physician assistants and proceduralists will play an important part in maintaining quality healthcare services to the public and should be provided with appropriate incentives. Financial support for such roles will enable improved approaches to chronic disease and rural and remote healthcare.

In examining the role of nurse practitioners and other expanded health practitioner roles, issues that need to be considered include the whether the existing legislative requirements confer prescribing rights under the PBS or allow these new positions to provide services which would be eligible for a rebate under the MBS.

Queensland Health recently provided comments to the Australian Senate Community Affairs Legislative Committee on the proposed Health Legislation Amendment Bill 2005. The amendments included changes to sections 19A (3) and 19A (4) under the *Health Insurance Act 1973* which would give the Federal Minister for Health discretion to determine that Medicare benefits are not payable in respect of professional services rendered in specified circumstances. Queensland did not support providing such discretion to the Minister for Health to make such determinations without restriction, as this amendment would allow the Commonwealth Government to cease payment of Medicare benefits for any professional service for any reason. Any move to limit patient access to Medicare benefits through the private health sector could result in an increase in demand for those services from the public sector.

The Queensland Government notes that the Productivity Commission's proposals do not include a mechanism to explore the implications of federal policy initiatives designed to encourage private health insurance. The Forster Review found that this issue was one

area of federal government policy that created a negative impact on health care for Queenslanders. Such policy initiatives have contributed to the growth in some types of services provided in Queensland's private hospitals, a climate of heightened private demand and an increase in potential earnings for doctors in the private sector. These factors have all resulted in the public sector losing increasing numbers of doctors to private practice. While the Productivity Commission's paper raises this as an issue (page 118), it does not explore this in any detail. The Queensland Government proposes that the proposed independent standing body to evaluate the benefits and costs and budgetary implications of changes to the MBS and PBS should also explore proposals for changes to private health insurance arrangements.

Better focused and more streamlined projections of future workforce requirements

The paper proposes that formal projections (and scenario planning) on the key workforce groups needs to be better managed. The Queensland Government supports the proposals presented. Queensland is developing processes to undertake future modelling of workforce needs, reflecting projected demographic changes, consumer focused service planning and models of care, and taking account of emerging technology and treatment methods. This will be associated with planning for adequate supply across the key workforce groups and the monitoring and analysis of key workforce trends. Such workforce planning, analysis and reporting requires improvements in the collection, analysis and sharing of workforce information and the identification, utilization and dissemination of best practice workforce planning and design methodology.

The Queensland Government considers that in the current environment it would be inefficient to continue with two workforce committees (AMWAC and AHWAC), when many of the issues faced by the health professions are the same. The issues examined within the existing AHMAC workforce sub-committee structure tend to be skewed towards the medical workforce, and their concerns can unduly dominate discussions. The proposal for a single secretariat acknowledges that the issues for the health workforce apply much more widely than for the medical workforce alone. Many of these issues are inter-related between the disciplines and also encompass the non-professional workforce, and thus health workforce issues need to be examined as a whole without undue focus on one group.

The current Australian Health Workforce Officials Committee (AHWOC) secretariat co-ordinates work undertaken by officials in the various jurisdictions, which they perform in addition to their existing duties. This secretariat is under-resourced, and is unable to undertake a full analysis of health workforce issues and plan for future requirements. A new health workforce secretariat would need to be appropriately resourced to fulfil these functions. In addition, this secretariat would need to engage with all agencies set up as a result of the recommendations of the Productivity Commission. Ensuring that health workforce issues are given the necessary level of priority on the AHMAC agenda would be a top priority.

The proposal to undertake workforce planning for the major groups – medicine, nursing, dentistry, and larger allied health professional groups – is regarded as necessary as an immediate initial step for the secretariat. National projections of the number of professionals likely to be available in each of these groups, the likely requirements for these groups, and analyses of possible methods of meeting requirements, are urgently needed. However, equally required for the longer term is more complex scenario planning that encompasses the entire health workforce. Such planning needs to project requirements based on different workforce profiles that may exist should different health service scenarios be implemented.

In addition, the secretariat would need to be resourced to identify and utilise best practice workforce planning methodologies and to establish consistent and reliable sources for the collection of the workforce data to be analysed.

The functions described above could be fulfilled by a secretariat as proposed, or could be undertaken by an independent agency. In the latter circumstance there would still be a need for a reasonably-resourced workforce secretariat for AHMAC. Alternatively, the functions could be combined with those of another agency suggested by the Productivity Commission, provided that workforce planning deliverables are clearly defined and the governance and resources of this agency support the achievement of these deliverables.

Even if these functions are not co-located in the one body, the secretarial would need to be closely linked to the health workforce improvement agency to ensure that there is consistency of the work programs being pursued by the two bodies. This integration of the functions of workforce planning and work redesign is essential.

More effective approaches to improving outcomes in rural and remote areas

The Queensland Government challenges the Productivity Commission's view that fully overcoming workforce shortages in rural and remote areas would simultaneously generate considerable oversupply in the major centres. This notion appears to suggest that to avoid a potential oversupply of the medical workforce in major centres there should be a limitation or restriction of the labour supply of the medical workforce. It would seem more likely that increasing the labour supply of the medical workforces in the major centres would reduce the competitive pressure for upward salary movements in major centres as well as addressing the medical workforce shortages in rural and remote areas.

Anti-competitive proposals to artificially restrict the supply of labour to maintain income levels or to minimise the Commonwealth Government's potential fiscal exposure (MBS and PBS) on the basis that this is in the public interest must be balanced against potential higher salary costs and poor medical outcomes (in both the public and private systems) created from artificially restricting the free flow of labour into the medical workforce. Whilst a number of factors underlay the recent issues in Queensland regarding the practicing of Jayant Patel, had the supply of the Queensland trained workforce been

adequate to meet the needs of Queensland Health there would not have been the need to recruit such a high proportion of the medical workforce from overseas.

Queensland faces particular demographic challenges in the provision of healthcare services, in that it has the most decentralised population in Australia. Approximately sixty percent of Queensland's population lives in metropolitan areas with the remaining forty percent residing in rural and remote parts of the State. The Queensland Government would be supportive of efforts to increase regional/rural based training.

Rural and remote communities are entitled to expect safe and timely health care. However, geographic isolation and smaller, widely-dispersed populations necessitate different and innovative models of care from metropolitan areas. The Queensland Health Systems Review identified that different models of care and more "generalist" workforce roles are crucial to the sustainability of services in these locations. The Review also made recommendations for a universal service obligation for these communities, and re-weighting of the MBS in favour of rural and remote practice.

The position paper discusses the incentive and coercive approaches to boost workforce supply in rural and remote areas. While an incentive approach is a preferable method there is a strong argument for more coercive measures such as scholarship requirements.

The Queensland Government supports the draft proposals outlined in chapter 10 but considers that they could be strengthened. Draft proposal 10.1 is somewhat limited in scope. This draft proposal currently recommends that AHMC ensure that the proposed new institutional frameworks consider the workforce requirement of rural and remote areas in their deliberations. The Queensland Government would like this extended to prescribe similar requirements on <u>all</u> of the proposed new mechanisms, particularly the Independent Standing Review Body to review MBS and PBS.

In addition, it would be more effective if draft proposal 10.2, which suggests that the Health Workforce Improvement Agency assess implications for health outcomes in rural and remote areas of job redesign, as proposed in draft proposal 4.1, was prescribed within draft proposal 4.1. Moreover, this proposal could be strengthened to require that the health workforce improvement agency make it a priority to examine major job redesign options for rural and remote areas.

Draft proposal 10.3, whereby AHMC should initiate a cross program evaluation exercise to ascertain which mix of approaches are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote areas, is vague. The risk is that such a study would be undertaken with no commitment to implementation. This proposal could be more action-oriented and include commitments to action following evaluation, nominating a responsible agency and providing a timetable for such a review. In addition, chapter 10 discusses arrangements for practice ownership and support that would ease entry and exit for medical practitioners and different options for funding models but does not include these issues in

the aspects to be evaluated. It is likely that this exclusion could result in these aspects being left out of any subsequent study or evaluation.

Ensuring the requirements of groups with special needs are met

The position paper recognises that the health workforce system needs to urgently address the needs of such groups as Indigenous Australians, people with mental illness and the aged. The paper notes that the Productivity Commission has not had sufficient time to examine these areas in detail and the draft proposal appears to be reflective of this. The Queensland Government supports the general intent of the proposals and provides further information to support strengthening of this aspect of the report.

The Queensland Government acknowledges that regional demands need to be considered locally. Queensland has a significant proportion of Aboriginal and Torres Strait Islander peoples in Australia (27.5% of the total Indigenous population). The Indigenous population also are more likely to live in regional and remote areas of the State and comprise a younger population profile. On average, Indigenous Queenslanders die 20 years earlier than their non-Indigenous counterparts and experience a much higher burden of disease, including chronic disease, injury and many infectious diseases. New approaches must be developed to address the health inequities of these people and these approaches must be enshrined within the philosophy of self-determination.

There are three significant factors in the current workforce that need to be addressed:

- the under representation of Indigenous people in all levels of the health workforce;
- the current fragmentation of training and education programs for Indigenous health workers; and
- the need for skilling and support of the non Indigenous workforce to provide culturally competent health services.

A disproportionate number of Indigenous students leave school before completing year 10, and of those who enter senior secondary years, Indigenous students are less likely to obtain a year 12 certificate than their non-Indigenous counterparts. Nationally, the proportion of Indigenous students who attained a year 12 certificate in 2002 was 54.9 per cent compared with 82.3 percent for non-Indigenous students (*Overcoming Indigenous Disadvantage: Key Indicators 2005 Report,* Steering Committee for the Review of Government Service Provision, 2005).

The Queensland Health Systems Review found that just over one percent of Indigenous school students attend university. Additionally, Indigenous students who relocate from their community to attend university have poor completion rates, given difficulties in living alone and being away from family support. This compounds the social and economic disadvantage experienced by Indigenous people and limits the potential supply of Indigenous health professionals.

The Review suggests that to address this issue, recruitment from and teaching in Indigenous communities should be a major policy priority. Specifically, efforts should be made to:

- Develop partnerships with education and training providers to increase Indigenous entry and retention into health professional education and training.
- Develop health professional education and training which involves less travel away from communities either by using technology or developing training based in Indigenous communities. Queensland Health has developed a registered nurse training program that enable Indigenous people to complete training while remaining in their community.
- Provide support and mentoring for Indigenous people throughout their studies.
- Develop the role of Indigenous Health Workers and recruit these roles locally.

To address this issue, recruitment from and teaching in Indigenous communities should be a major policy priority for all levels of government.

In September 2005, the Queensland Government endorsed the *Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People's Health 2005-2010.* Implementation of the Strategic Policy will include measures to provide supported learning and development through mentoring programs, cadetships, scholarships, traineeships, academic support, training options and management development.

The Strategic Policy also includes strategies to develop and implement distance education and support networks for health workers in remote and rural settings or settings where they are professionally isolated, and engage schools and local communities to encourage participation of young people in the health workforce, for example, through VET training programs in schools and paid or volunteer peer educator programs.

Nationally, the *Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards & Qualifications Project* is currently underway and nearing completion. It will provide a national framework for education and training of Health Workers. Upon completion, Queensland Health will use the national framework to identify the core and elective competencies required to develop its Indigenous health workforce. The framework will also allow Indigenous Health Workers broad access to workforce opportunities including national skill recognition across State & Territory jurisdictions.

The *Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards & Qualifications Project* could provide a national framework for education and training of Indigenous Health Workers. Each State & Territory will identify the core and elective competencies required to develop its Indigenous Health Worker workforce. The Education and Training sectors in each State & Territory will develop its skills sets based around the framework of Core Competencies and Elective Competencies.

The position paper suggests a wider scope of practice proposed for Indigenous Health Workers. In principle, the Queensland Government supports a wider scope of practice.

A wider scope of practice has the potential to improve the capacity of the Indigenous health workforce to deliver quality services within more collaborative multidisciplinary models of care. The broadening of skills would allow the Indigenous Health Worker opportunity to work in many locations and across varied levels of service delivery.

The position paper proposes that all jurisdictions provide local education and training opportunities for Indigenous communities (in health). The Queensland Government supports this notion. The VET sector offers a core set of accredited training competencies relative to support the development of Indigenous Health Workers, wherever their geographical location. These programs are nationally accredited and transferable from State to State. The VET system is a flexible and responsive option for this aspect of the position paper.

A model of delivery which is achieving very positive results with respect to the education and training of teachers is the Remote Area Teacher Education Program (RATEP). This program involves the training of teachers in their remote indigenous communities. It is an initiative delivered in cooperation between Queensland universities and the Queensland Department of Education and the Arts. It is a practical and successful model that could be adapted for a range of health workforce needs.

Burden of disease predictions indicate that mental health is likely to rank second only to cardio-vascular disease by 2020. In Queensland, gains made through the first wave of mental health reforms have proven increasingly difficult to sustain. While a restructure of the mental health system has occurred, and funding for mental health services has increased, reform is struggling to keep pace with population growth, perpetuating difficulties in access and availability.

Existing and future demands on the mental health workforce are difficult to meet and will continue to be, particularly in light of current supply. Issues for Queensland include:

- Insufficient tertiary places to meet demand;
- Difficulty recruiting and training mental health staff in the public health sector, particularly in rural and remote areas;
- The need to prepare and develop a workforce capable of delivering innovative and sustainable models of service delivery;
- Difficulty developing effective initiatives to address education and training of the existing mental health workforce; and
- Training takes place only in the public sector but the expertise then moves from the public to the private sector.

A key mental health service development issue is the need for greater multidisciplinary presence and influence in delivering specialist mental health services. The current workforce mix strongly influences the type and range of treatment approaches used. Treatment options tend to be determined on the basis of skill available as opposed to the best available evidence as to effective and appropriate treatments and interventions.

There is a compelling need to standardise at a national level the application of evidence-based treatment approaches throughout the mental health service system. A focus on workforce, training, staff development issues is required as it is essential that mental health practitioners possess an appropriate level and range of competency in regard to evidence-based treatment and therapeutic interventions. Significant work is required by all governments in addressing the complexities of developing a suitable mental health workforce.

Future investigation of the role of the private sector in mental health (both private psychiatric hospitals and psychiatrists in private practice) should consider the way in which skill development of the private sector mental health workforce has been resourced; to a large extent through infrastructure and funding originally provided by public sector mental health during undergraduate clinical education, postgraduate training and subsequent employment. The consequences for public sector mental health of the significant 'drain' of public sector trained mental health personnel to the private sector will need to be addressed

Queensland recognises that consumer and carer participation is integral to recovery-oriented service delivery, both at an individual and systems level. The Queensland Government has recently developed and piloted a training package for the mental health workforce to improve consumer and carer participation at the individual care planning and management levels.

At a systems level, consumer consultants are employed in many district mental health services. Future work will be undertaken to address current variations in the job descriptions and employment conditions for the consumer workforce. The establishment of a statewide network of consumer consultants has provided needed peer support and opportunities to address broader consumer/carer issues and a future statewide consumer and carer advisory model based on statewide and zonal consumer/carer coordinators is planned.

Peer support has been identified as an important element of a recovery-oriented service system. There is an opportunity for greater emphasis on consumer employment in national and state mental workforce planning. Queensland Health will strengthen the part played by consumers through consideration of new roles and new ways of working in future service and workforce planning. Current Queensland Health trials that use peer support workers include Indigenous spiritual liaison support, consumer companions, and mental health recovery support workers.