# *AUSTRALIA'S HEALTH WORKFORCE*

## PRODUCTIVITY COMMISSION

# NEW SOUTH WALES GOVERNMENT RESPONSE

**November 2005**

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# 1. Executive Summary

The Productivity Commission (PC) workforce study provides a comprehensive picture of Australia's health workforce and many of the issues impacting on the current capacity of governments at all levels to provide quality healthcare for the community.

> ***If you want to see the future, think health care***
>
> ***Ross Gittins, SMH October 5 2005***

At no other time has Australia been more in need of a new look at the health workforce. Heath and aged care are cited as the most significant source of potential stress on government budgets with the PC projecting a $40 billion increase in health spending by 2044. It is well known that unless we take serious action now, there will be no health workforce to deliver the care the Commission suggests we will need to buy in the future.

As noted in the Productivity Commission's 2004/05 Annual Report, Australia's federated system means that major public functions are often shared between differing levels of government. In reviewing the National Competition Policy implementation, the Productivity Commission cited the implementation of reforms as a landmark achievement and quoting the Council of Australian Governments comment that successful implementation required "a collaborative approach…(drawing) together the reform priorities of the Commonwealth, States and Territories."[1]

Consistent with this approach, all state and territory health chief executive officers have reached significant agreement on a consolidated response to the draft proposals from the Commission. While supporting the general directions contained in the proposals, there is concern that the focus on structures and systems aimed at facilitating reform in the longer term, may mean that benefits to be gained by more immediate and substantive intervention may not be realised. State and territory health chief executive officers considered this situation and have made a number of recommendations to support short-term improvements. Section Three of this paper includes the *Joint State and Territory Health Chief Executive Officer Response* where the joint recommendations and rationale are outlined.

The proposals and recommendations contained in the CEO response and in the NSW specific recommendations in Section Two, seek to build on the directions outlined by the Productivity Commission and effect some short, as well as longer term, relief for our communities.

[1] COAG, Heads of Government, COAG 2005 p4 cited in Productivity Commission 2005, *Annual Report 2004-05,* Annual Report Series, Productivity Commission, Canberra p 18

On 2 November 2005, the Hon John Hatzistergos, NSW Minister for Health, hosted a Ministerial Advisory Meeting. At that meeting, NSW consumers, clinicians from the peak NSW health care advisory council, industrial representatives and administrators met to discuss the proposals put forward by the Productivity Commission. The focus of discussion was on supply, workforce flexibility and outer metropolitan, rural and remote issues.

NSW Ministerial Advisory Meeting participants considered the need for:

- Real action in the short term
- A less fragmented, simpler approach driven by patient outcomes
- Focus on both recruitment and retention
- Improved capacity for self sufficiency in workforce supply
- Better use of the ageing workforce
- Focus on what needs to be done not what is already happening
- Recognition of the need for continued local innovation
- Need for better reflection that training and education is predominately done at a State level
- Better recognition of emerging new roles

It was agreed that solutions to national and state health workforce issues should more directly, and with greater urgency, support key focus areas outlined in the COAG reform agenda. These areas reflect reform priorities of the States, Territories and the Commonwealth and seek better workforce productivity and flexibility; improvements in integration of the health care system and resolution of skills shortages particularly for rural and remote Australia.

An example of a service model of importance to NSW in achieving COAG reforms is the establishment of Integrated Primary Health and Community Care Services (IPHCCS). With a focus on health promotion, disease prevention and management of chronic and complex conditions, this type of service reflects the modern approach to provision of care, particularly for our ageing community.

Clearly the success of the program depends on being able to create teams of professionals to provide this service. Current health worker shortages and systemic impediments do little to facilitate more efficient and sustainable models of care. It is NSW's view that the draft PC proposals as currently expressed will not adequately improve this situation and a number of recommendations have been included in both the CEOs response and the NSW response to address this issue.

Although recommending structures that allow further debate on strategies, the current PC proposals appear also to reflect the status quo rather than laying the foundation for the future workforce needed to provide new models of care, many of which are already developing. As an example the dramatic change in the way obstetric care is delivered has seen new models of care created to meet the disparate needs of mothers in metropolitan and rural settings. A significant rise in day surgery has changed the way many people

experience acute care hospitals and this new model with its associated increase in surgery has affected both the type and numbers of health workforce required.

Many economic levers are already available to better prepare for these new models of care:

- use of direct community funded mechanisms such as those supporting the Medical and Pharmaceutical Benefit Schedules,
- more targeted application of fringe benefits and other tax incentives and
- removal of structural disincentives for workforce attraction and retention.

While the current PC proposals provide a forum for discussion and possible actions, many solutions need to be more urgently implemented.

In developing the NSW government response, the views of medical, nursing, dental and allied health clinicians, managers and government bureaucrats have been incorporated. To better address the particular needs of NSW, a number of state specific recommendations have also been developed.

In its communiqué of June 2004, COAG expressed the benefits of governments working collaboratively and across sectors to address issues that can be resolved best by a whole of government approach. The PC paper highlights the barriers that the current intergovernmental and sectoral relationships pose. NSW wishes to reinforce the comments contained in the joint States and Territories response that "to achieve necessary change and long term reform, a whole of government perspective must be taken with direction provided by COAG".[2]

On this basis, NSW recommends that any new national agencies charged with provision of advice and/or implementation of changes affecting cross government responsibilities, should report to COAG.

Internal governance of these agencies will also need to provide for engagement of professional organisations and specialty colleges in a way that supports innovation over professional protectionism. Further resulting agencies, such as the Workforce Improvement Agency, should be established as a jurisdictional 'collaborative' given the states and territories role as the major employer.

In general, NSW considers that the issues and solutions proposed relating to special needs groups, rural, remote and outer metro regions and the co-location of GPs in or near hospitals on weekends would benefit from more substantive attention. It is also considered that the contribution the VET system can make to improving workforce supply, flexibility and the career path of workers should receive greater consideration in line with the COAG VET reform agenda.

[2] Joint State and Territory Health Chief Executive Officer's Response to the Productivity Commission p 4

Another area that the Commission was required to provide advice on was the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care. Clearly more needs to be done to facilitate these services and NSW recognises the constraints under which the Commission operated in examining this area noting that a broader review of intergovernmental financial responsibilities for primary and acute care has been suggested.[3]

In conclusion, the urgency of the current health workforce situation requires action to provide relief in both the short and medium term. To assist the situation NSW supports implementation of the joint state and territory chief executive officers recommendations and seeks consideration of these and NSW recommendations by the Commission in development of the final report.

[3] Productivity Commission 2005, *Australia's Health Workforce,* Position Paper, Canberra. p 218

# 2. Summary of All Recommendations

## 2.1 Joint State and Territory Health CEOs' responses

***Joint State and Territory Health CEOs' response 3.1***

*State and Territory Health CEOs support the proposal for COAG to adopt the NHWSF.*

*In regard to broadening the self-sufficiency principle it is recommended that COAG, through its senior officials, should gain agreement on wording to better reflect the imperative to increase local capacity at the same time as interacting in a global workforce market.*

*State and Territory Health CEOs (STHD) seek an explicit recommendation that addresses the current shortfall in the provision of funded undergraduate health places available in universities.*

***Joint State and Territory Health CEOs' response 3.2***

*State and Territory Health CEOs support this Draft Proposal.*

*The regular reviews of progress should also include consideration of the relative priority of health workforce education and training funding, including the size of the funding pool available, informed by the evidence about health care service need, and the effectiveness of new agencies established as a result of the Commission's proposals.*

***Joint State and Territory Health CEOs' response 4.1***

*Due to the inherent linkages between health workforce design and innovation, and education design and innovation, State and Territory Health CEOs support the proposed establishment of a national health workforce improvement agency that includes those functions proposed by the Commission for an advisory health workforce education and training council. Linkages with the accreditation agency will be important.*

***Joint State and Territory Health CEOs' response 5.1***

*State and Territory Health CEOs support the establishment of a process which identifies a separate quantum for health workforce education and training linked to health service need.*

***Joint State and Territory Health CEOs' response 5.2***

*State and Territory Health CEOs support the functions proposed for the health workforce education and training council, but do not support the establishment of a separate agency.*

*Instead, State and Territory Health CEOs recommend that these functions be undertaken by the national health workforce improvement agency. The*

*advantages of such an approach are identified in the response to Draft Proposal 4.1.*

***Joint State and Territory Health CEOs' response 5.3***

*State and Territory Health CEOs support policy effort to improve transparency in determination and allocation, contestability and evaluation of cost effectiveness of funding for all aspects of education and training of the health workforce*

***Joint State and Territory Health CEOs' response 6.1***

*State and Territory Health CEOs except the South Australian CEO support the establishment of a single national accreditation agency for university-based, postgraduate and VET health workforce education and training that also has responsibility for multiprofessional registration at a national level, whilst ensuring appropriate involvement of relevant professional expertise.*

*The South Australian CEO supports a single national multiprofession accreditation agency and a single national multiprofession registration agency, but not the creation of a single combined agency to undertake both functions.*

***Joint State and Territory Health CEOs' response 6.2***

*State and Territory Health CEOs support this Draft Proposal.*

***Joint State and Territory Health CEOs' response 7.1***

*State and Territory Health CEOs do not support this proposal. Refer response to Draft Proposals 6.1 and 7.2.*

***Joint State and Territory Health CEOs' response 7.2***

*State and Territory Health CEOs other than the South Australian CEO do not support this proposal. States and Territory Health CEOs support establishment of a national multiprofessional registration authority responsible for health professional registration and accreditation of educational courses.*

*The South Australian CEO supports a single national multiprofession accreditation agency and a single national multiprofession registration agency, but not the creation of a single combined agency to undertake both functions.*

***Joint State and Territory Health CEOs' response 7.3***

*State and Territory Health CEOs do not support any proposal that provides rigid demarcation between and within professions, either through legislation or policy.*

***Joint State and Territory Health CEOs' response* 8.1**

*State and Territory Health CEOs support this proposal, considering reform of funding mechanisms to be an essential step towards achieving the best possible utilisation of the health workforce.*

*In supporting this proposal, consideration must be given to how other key functions of MSAC including assessment of technologies and procedures, assessment of nationally funded centres and support for the health policy advisory committee on technology are provided.*

***Joint State and Territory Health CEOs' response* 8.1**

*State and Territory Health CEOs support both delegated and direct access to MBS rebate for a range of health professional services consistent with agreed models of care*

***Joint State and Territory Health CEOs' response 9.1***

*State and Territory Health CEOs support this Draft Proposal with reporting to the Australian Health Ministers' Advisory Council and other bodies. The proposal should ensure new models of care and roles can be appropriately incorporated in projection modeling and should value the input of specialised stakeholder groups.*

***Joint State and Territory Health CEOs' response 9.2***

*State and Territory Health CEOs support workforce projections being undertaken for major professions. These projections must be undertaken through a multidisciplinary approach using emerging models of care as identified by local service planning.*

***Joint State and Territory Health CEOs' response 10.1***

*State and Territory Health CEOs support this Draft Proposal but have made a range of recommendations to better support rural and remote communities later in this response*

***Joint State and Territory Health CEOs' response 10.2***

*State and Territory Health CEOs support this Draft Proposal.*

***Joint State and Territory Health CEOs' response 10.3***

*State and Territory Health CEOs support evaluation as an ongoing quality mechanisms but suggest that evidence exists on what is effective. Additional measures including the use of taxation and superannuation levers have been incorporated into the State and Territory Health CEOs recommendations later in this response.*

***Joint State and Territory Health CEOs' response 11.1***

*State and Territory Health CEOs support this Draft Proposal.*

## 2.2 State and Territory Health CEOs' recommendations

*ST 1.1 That, until the numbers of locally trained health practitioners meet demand, transitional Commonwealth funding is provided to public health services to meet the additional costs associated with recruiting, assessing the suitability of, and training of internationally trained health practitioners.*

*ST 1.2 That the Commonwealth lead the development of a national scheme for the assessment of the qualifications and skill of internationally trained practitioners, focussing on medicine in the first instance.*

*ST 2.1 That the Commonwealth develop options for providing subsidies to students undertaking rural clinical placements to encourage greater uptake.*

*ST 2.2 That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges mandatory rural rotations of 6 months or more for vocational trainees provided places are available, and with other professional colleges for rural rotations in the preregistration year or postgraduate courses.*

*ST 2.3 That the Commonwealth, States and Territories negotiate nationally with medical specialist colleges to develop advanced recognition/accelerated progression or other similar incentives in their training programs to encourage rural rotations.*

*ST 2.4 That Commonwealth, States and Territories consider specifying rural practice experience as a desirable attribute for career advancement.*

*ST 3. That greater alignment is achieved between allocation of MBS/PBS funding and service need by trialling mechanisms including: -*

*ST 3.1 Creating incentives for practise in areas of known speciality shortage including:-*

*ST 3.1.1 Increased scheduled fees for consultative items that promote coordinated multidisciplinary care rather than procedural items to address the complex needs of the ageing population*

*ST 3.1.2 Increased scheduled fees for less attractive specialties such as geriatrics, psychiatry or specialties involved in prevention activities on agreed targets eg screening.*

*ST 4.1 Creating incentives for practise in areas of known geographic shortage, including*

*ST 4.1.1 Differential payments for items performed in outer metropolitan, rural and regional areas*

*ST 4.1.2 Allocation of provider numbers to take account of relative over- and under-supply in a given geographic area*

*ST 4.2 Flexible use of health funding, including the MBS and PBS funds, to ensure appropriate services are available irrespective of where they are delivered*

*ST 4.3 Limited non-delegated direct access to medical and pharmaceutical benefit entitlements for non-medical practitioners, commencing in areas of designated GP shortage.*

*ST 5.1 That the Commonwealth consider a range of changes to fringe benefits tax exemptions to increase the attractiveness to health professionals of working in areas of designated workforce shortage and service need, including rural and remote areas.*

*ST 5.2 That the Commonwealth consider reducing HECS debt consistent with every year of completed public health service in a rural or remote area.*

*ST 6.1 That the Commonwealth, States and Territories work together to develop a national scheme that provides fiscally efficient mechanisms for recouping subsidies to health professional education that leads to private sector employment*

*ST 7.1 That the Commonwealth, States and Territories work together to consider a national scheme where graduates who have been trained in the public sector who do not subsequently work in the public sector:*

- *contribute towards the cost of clinical training, or*
- *treat an equivalent value of public patients in their private practice for a defined period after graduation, or*
- *contribute service in the public sector commensurate with the investment in their training.*

## 2.3 NSW Recommendations

*NSW 1. NSW recommends that the national Health Workforce Education Improvement Agency proposed by State and Territory Chief Executive Officers be responsible to COAG.*

*NSW 2. In addition to examining and recommending new health roles and innovative education models to create these roles, the Health Workforce Education Improvement Agency should support local innovation and be responsible for working with States and Territories to agree priorities for education based on identified community need (numbers, types of courses etc) for the current and emergent health workforce.*

*NSW 3. NSW supports determination of workforce priorities by COAG through its senior officials, on advice developed from State and Territory service planning advised through the Health Workforce Education Improvement Agency.*

*NSW 4. NSW supports a governance model that is consistent with the principles outlined in the Joint State and Territory CEOs Response, particularly in relation to membership.*

*NSW 5. NSW does not support the establishment of bilateral agreements for education and training or the use of the Australian Health Care Agreement for this purpose.*

*NSW 6. NSW supports determination of the quantum of funds to be applied to health workforce priorities being agreed by COAG on recommendations of the Health Workforce Education Improvement Agency as collated through State and Territory service planning.*

*NSW 7. NSW supports expansion of targeted programs to ensure equitable workforce representation that meets community needs (eg programs targeted to increasing the Aboriginal workforce).*

*NSW 8. NSW supports more flexible entry requirements across all health courses for people of Aboriginal background.*

*NSW 9. To increase rural undergraduate and post graduate training opportunities to address health workforce shortages and skill development in rural and remote locations NSW recommends:*

*9.1 increasing the number of undergraduate places for rural participants*

*9.2 establishing a co-ordinated undergraduate scholarship program across all health workforce groups with greater support for scholarship students*

*9.3 expanding bonded rural medical scholarships to all workforce groups*

*9.4 targeting cadetships in identified areas of skill shortage for school leavers and students in the second or third year of university and*

*9.5 agreeing an expanded role for primary health workers including Aboriginal Health Workers*

*NSW 10. That Commonwealth, States and Territories consider:*

- *requiring rural practice as a prerequisite for career advancement in either clinical academic or service positions*
- *providing preferential career advancement based on time spent in areas of need.*

*NSW 11. To improve recruitment and retention of health workers the Commonwealth should*

- *Exempt any childcare expenses currently subject to FBT incurred by public health care workers.*
- *Allocate community owned provider numbers linked to population need.*

# 3. The NSW Response

As identified previously, the NSW government supports the Joint State and Territory Chief Executive Officers response as it has been developed from a range of NSW consultative processes including a Ministerial Advisory Meeting with the NSW health clinicians and administrators.

The NSW specific recommendations expand on certain aspects of the State and Territory response and address issues of particular concern to the NSW community. Recommendations focus on the need for short-term relief as well as engaging in debate on structures to support medium to longer-term reform.

The NSW public health system is the largest health care employer in Australia, with almost 90,000 full-time equivalent staff (June 2004).[4] The doctors, dentists, nurses, allied health professionals, uniform ambulance and other health professionals involved in the provision of clinical services make up 64% of the health workforce, with remaining staff supporting patient care.

In 2001 the NSW health workforce supply fell well below national supply levels[5]. It has been well recognised that based on the significant shortages that already exist, continuance of the current supply approaches to the health workforce will not result in enough workforce to meet future demands.

In addition to shortages, the distribution of the health workforce in Australia inhibits the ability to respond to needs with maximum effectiveness. The most obvious reason for this in NSW is the State's size and geography, covering regional centres, large towns, small towns and remote localities. A demographic shift has occurred from inland to coastal areas and to the Sydney basin[6] resulting in a declining workforce population in rural and regional NSW. [7]

Rural NSW had an estimated population at June 1999 of 1,447,164 and a projected population for 2011 of 1,561,240. These population changes vary by geographical location with coastal areas experiencing significant population increases while decreases are anticipated in the far west of the State[8].

The projected increase and redistribution in population is not matched by a similar increase and redistribution of health professionals, as there are multiple structural and funding disincentives to moving away from the inner metropolitan areas

[4] 03/04 Annual Report – excludes third schedule hospitals
[5] Australian Institute Health and Welfare (2003) Health and Community Services Labour Force 2001 Series No: 27.
[6] Ibid.
[7] The public hospital medical workforce in Australia AMWAC Report 2004.3
[8] NSW Health, Rural Health Report, 2002

## 3.1 The Link to COAG Health Reforms

In the health sector, as in many other sectors, workforce planning needs to be critically linked to service planning. Unless there is agreement on what the workforce is required to do, now and into the future, it is not possible to agree on roles, numbers, clinical placements or any other aspect of the health/education interface.

COAG has already started to define the type of workforce required into the future by articulating necessary health care reforms. As an example, the COAG health reform priority of simplifying access to care for the elderly, people with disabilities and people leaving hospital means we need a team approach to care that our current system of workforce preparation is unable to provide. The focus would therefore need to shift to interprofessional education that supports a wellness, rather than illness model of care and has a much stronger grounding in primary health practice.

By focussing on agreed service priorities, workforce priorities can then be determined.

## 3.2 Governance for New National Bodies

As indicated in the State and Territory joint response, NSW supports the combination of functions for the national health workforce improvement agency and the advisory health workforce education and training council into one agency (a Health Workforce Education Improvement Agency). Combining these functions should ensure the focus remains on workforce improvement and innovation with subsequent development of curricula to meet education requirements for new roles.

In addition, NSW supports this Agency being responsible for reporting on national health workforce requirements to COAG. By including this function, the connection between creation of new workforce roles and recommendation of types of courses and numbers of placements for both current and future roles can be combined. This approach would maximise the opportunity for workforce flexibility and by reporting to COAG, the current disconnects between health and education should be avoided.

Governance of any agency should not allow individual professions to capture the education agenda and should also ensure that professional organisations and specialty colleges can be engaged in a way that supports innovation over natural professional protectionism.

The independence of the Health Workforce Education Improvement Agency reporting through COAG and outside the domain of both the health and education portfolios is important. This, together with an effective internal governance structure that is supported by the principles outlined below, will be essential to the success of the Agency.

Governance of any new bodies created at a national level should include:

- Membership representative of all jurisdictions (and community interests where relevant)
- Actions implemented through an identified national decision making forum
- Support provided by an independent secretariat with adequate resources
- A clear focus of effort on areas where national cooperation is required
- The priorities of the participating jurisdictions are reflected in work and directions
- New governance bodies only being established after considering opportunities to abolish or amalgamate any relevant existing bodies
- Meaningful engagement with health occupational groups to support innovation and a future sustainable, quality health workforce.

It is envisaged that the Health Workforce Education Agency would play a key role in bringing together employers and local innovation to provide advice on new workforce roles and innovative education approaches. These would then be recommended to, COAG through its senior officials where agreement on priorities for new roles, total workforce numbers and placements could be secured. Following this agreement, the accreditation/registration agency would adopt new models and types of education standards, with translation into new curricula and registration changes where necessary.

It is understood that the Community Services and Health Industry Skills Council model is being considered as a possible governance arrangement for the Health Workforce Education Improvement Agency. While the model includes some involvement of representative employers, the nature of that Council's relationship with employers does not sufficiently reflect the principles outlined above. In particular, it does not seem grounded in an employer approach consistent with the principle of membership being representative of all jurisdictions and community interests where appropriate.

### *Recommendation*

*NSW 1. NSW recommends that the national Health Workforce Education Improvement Agency proposed by State and Territory Chief Executive Officers be responsible to COAG.*

*NSW 2. In addition to examining and recommending new health roles and innovative education models to create these roles, the Health Workforce Education Improvement Agency should support local innovation and be responsible for working with States and Territories to agree priorities for education based on identified community need (numbers, types of courses etc) for the current and emergent health workforce.*

*NSW 3. NSW supports determination of workforce priorities by COAG through its senior officials, on advice developed from State and Territory service planning advised through the Health Workforce Education Improvement Agency.*

*NSW 4. NSW supports a governance model that is consistent with the principles outlined in the Joint State and Territory CEOs Response, particularly in relation to membership.*

## 3.3 Allocation of Funding for University-Based Education

The Commission has attempted to identify a model of funding that supports employer based need through its recommendation that funding transfer from the current funding authority the Commonwealth Department of Education, Science and Training (DEST) to the Commonwealth Department of Health and Ageing (DoHA). Rather than the fund holder needing to change, the significance of the health sector as the major employer of Australia's workforce means that a whole of government approach is required.

NSW supports the development of a model that identifies the quantum of funds proposed for health workforce education based on identified jurisdictional education and training needs. This model allows national priorities for health education to be developed through each state and territory to then be considered by COAG as part of determination of total national priorities for workforce education.

As outlined in the suggestion on the role of the Health Workforce Education Improvement Agency, it is recommended that national priorities for health education be advised through this Agency. In this manner the key current disconnect between health at a local level and DEST as the funder can be addressed. The quantum of funding is then agreed and applied to total workforce priorities that are shared and based on jurisdictional education and training needs identified through local service planning.

*NSW does not support bilateral agreements for education and training.* While the quantum of funding needs to be reviewed, application of funds to agreed priorities is a major issue. Consistent with this view, NSW agrees with the State and Territory Health CEOs that funding for health workforce education should not be linked to the Australian Health Care Agreement.

***Recommendation***

*NSW 5. NSW does not support the establishment of bilateral agreements for education and training or the use of the Australian Health Care Agreement for this purpose.*

*NSW 6. NSW supports determination of the quantum of funds to be applied to health workforce priorities being agreed by COAG on recommendations of the Health Workforce Education Improvement Agency as collated through State and Territory service planning.*

## 3.4 Aboriginal Health and Workforce Issues

The Position Paper has failed to make any specific recommendations to address the limited numbers of Aboriginal people entering health courses. The growing size of the Aboriginal community and the disproportionate prevalence of chronic disease with presentations occurring at much younger ages signal the need for an increased Aboriginal workforce across all work professions and categories. Due to the low rate of Aboriginal people completing secondary education, entry requirements for health courses need to be more flexible to encourage participation. This should to be complemented with provision for greater opportunity for professional and educational development once Aboriginal people are engaged in the workforce.

NSW believes there is a need for proactive initiatives targeting recruitment and retention of Aboriginal people. Aboriginal people have a strong link with their communities and would respond positively to the opportunity to work and train within their local areas.

***Recommendation***

*NSW 7. NSW supports expansion of targeted programs to ensure equitable workforce representation that meets community needs (eg programs targeted to increasing the Aboriginal workforce).*

*NSW 8. NSW supports more flexible entry requirements across all health courses for people of Aboriginal background.*

## 3.5 Revitalising Rural and Remote Workforce

To enhance the numbers of people training to become health workers, sustainable health care education and training systems in rural and remote communities are crucial. There is currently a mismatch between sites and content of postgraduate medical training in some areas of health care (paediatrics and child health is a good example) and where people will be practising in future. Issues around location of, and access to, education programs for outer metropolitan, rural and remote communities need to be addressed.

The greater activity in, and expenditure on, health as a proportion of GDP predicted to meet the increase in morbidity due to ageing in the population is likely to place the health professions under greater pressure than other sectors of the economy.

“As the workforce falls under greater pressure, there will be unequal distribution of skills between various parts of the State. The difficulty in attracting experienced health professionals is already being felt in regional and remote locations. In some professions, private employment is a more attractive option both in terms of salaries and working conditions. For

example, podiatrists are becoming very scarce in the public sector despite escalating demand for their services".[9]

It is increasingly being recognised that rural practice requires a greater proportion of generalist medical skills than in metropolitan areas. The increasing specialisation of health education programs may result in a decline in health professionals with generalist skills. The inclusion of a generalist advanced specialist stream in medical Psychiatry training is one example of the recognition of the need to maintain strong generalist medical education programs.

For these reasons, NSW believes that mechanisms to encourage professionals to rural and remote areas must be supported and implemented. Issues around location of, and access to, education programs needs to be addressed.

Competition for high achieving school leavers is increasing with a wide number of enterprises and government departments providing cadetships prior to students completing the Higher School Certificate. Greater use of cadetships either from high school or once university has commenced has the potential to influence both the postgraduate supply and distribution of the workforce.

Career progression is another area that influences health workers in their choices about where they work. Rural appointments are not seen as a career progression opportunity and may be viewed as a disincentive. To encourage new practitioners as well as experienced practitioners to rural areas, NSW is suggesting expansion of recommendations contained in the ST joint response to encourage practice in rural locations.

***Recommendation***

*NSW 9. To increase rural undergraduate and postgraduate training opportunities to address health workforce shortages and skill development in rural and remote locations NSW recommends:*

- *9.1 increasing the number of undergraduate places for rural participants*
- *9.2 establishing a co-ordinated undergraduate scholarship program across all health workforce groups with greater support for scholarship students*
- *9.3 expanding bonded rural medical scholarships to all workforce groups*
- *9.4 targeting cadetships in identified areas of skill shortage for school leavers and students in the second or third year of university and*
- *9.6 agreeing an expanded role for primary health workers including Aboriginal Health Workers*

[9] *A Model to Estimate Possible Health Service Requirements for NSW over the next 20 years*, prepared by Essential Equity for Funding & Systems Policy Branch, NSW Department of Health, April 2004

*NSW 10. That Commonwealth, States and Territories consider:*

- *requiring rural practice as a prerequisite for career advancement in either clinical academic or service positions*
- *providing preferential career advancement based on time spent in areas of need.*

## 3.6 Community Funded Solutions

At the Ministerial Advisory Meeting held in November 2005, participants acknowledged the major difficulties facing NSW in attracting and retaining health workers in all areas with particular issues for outer metropolitan, rural and remote locations.

The magnitude of the problem suggests that a packaged approach is required that addresses sustainable local need. This approach would include incentives to attract and retain health workers through consideration of family needs, lifestyle requirements and locum relief. In rural and remote areas any strategies developed must take account of both transport and accommodation issues.

Critical recommendations included in the state and territory joint response to address maldistribution of the scarce health workforce was the review of community-funded mechanisms such as the Medicare Benefit and Pharmaceutical benefit schemes, fringe benefits tax and superannuation. It is a strongly held view of clinical and administrative personnel that without this type of reform the maldistribution and subsequent lack of access to services for certain communities will continue.

*Fringe Benefits Tax*
Given that health is a predominately female workforce, the current limited childcare exemption from fringe benefits tax acts as a deterrent to women who may wish to re-enter or stay in the workforce. Revision of the current fringe benefits tax for childcare services is supported across industry as reflected in a recent submission to the Australian Treasury by a group of 37 of the top 200 Australian companies. The submission argued for expanding exemption to all family day care, before and after school care and child care centres to "bring legislation into the 21st century, better reflecting the needs of working parents and assisting employers with retaining quality employees."[10]

A range of other disincentives exists concerning the current FBT treatment of health care workers. Exemptions for relocation, living away from home, boarding fees for children of health professionals and other matters have been raised in the joint state and territory submission. To improve recruitment and retention, exemptions should be in place across all health care workers with superior incentives being provided to those engaged in remote and rural communities.

[10] Coleman, *E Daycare tax breaks' benefit everyone'*, Excerpt from pre budget submission to Australian Treasury by a group of 37 top 200 companies cited in *The Australian* Thursday 17 November 2005, p17

*Medicare /Pharmaceutical Benefits Scheme*
The current system is not working. As community funded health schemes, the application of Medicare and Pharmaceutical benefits needs to better reflect community needs. According to the Australian Medical Workforce Advisory Committee,[11] the shortage of general practitioners in around half the GP Divisions in Australia is equal to the oversupply of general practitioners in what are often described as the 'leafy suburbs" of our major cities.

Whether in Broken Hill or Double Bay, as primary funders, communities have a right to a certain percentage of the Medicare benefit pool. Application of provider numbers is a privilege bestowed on practitioners. A system of community owned Medicare provider numbers based on population should be established to better align service delivery with community need.

*Superannuation*
Superannuation reforms introduced in the 2005/06 Federal budget have reduced a number of perverse incentives, especially for higher income based health care workers. The current reforms do not go far enough, with around 50% of nurses, doctors and other professionals expected to retire in the next five to ten years. Suggestions for reform these areas have been included in the joint state and territory submission and these are supported.

***Recommendation***

*NSW 11. To improve recruitment and retention of health workers the Commonwealth should*

- *Exempt any childcare expenses currently subject to FBT incurred by public health care workers.*
- *Allocate community owned provider numbers linked to population need.*

[11] AMWAC *General Practice in Australia* 2005

# 4. Joint State and Territory Chief Executive Response