



**Australian Government**

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**Department of Health and Ageing**

**Submission to the Productivity Commission**

**Health Workforce Study**

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## **Executive Summary**

The aim of this submission is to provide a review of the current health workforce situation; outline some of the responses to workforce shortages in countries similar to Australia; and consider some of the possible future directions in health workforce policies and planning.

### **1. Health Workforce Trends**

#### 1.1 Australia

The strength of the increase in consumer demand for health services in recent years is the major factor underlying the current workforce situation. While the health workforce has grown substantially over the last two decades, it has not been able to match the increasing demand for health services from the community.

The demand growth being experienced is a result of a combination of factors, including higher incomes, a growing and ageing population, Government subsidies to promote access to health services, the availability of new technology and greater consumer expectations.

As a result of these trends, national health workforce policy has undergone a shift from a concern about oversupply in some professions and a focus on maldistribution in rural and remote areas, to concern about shortages across a wider range of health workforce groups and locations.

Most health professionals have considerable freedom to choose, within their broad professional groupings, the geographic location and hours which they will work. These choices do not always match where health services are most required.

#### 1.2 Overseas

The OECD has noted health workforce shortages in all but a few regions among its member countries. They are responding with policies to increase training numbers, recruiting overseas trained health professionals, and incentives to improve workforce distribution. They have also adopted, or are embarking on, a range of programs designed to improve workforce productivity by encouraging new workforce roles.

## **2. Health Workforce Policy Issues**

### 2.1 Demand

A range of demand side measures are being introduced to improve the health of the community, which more effectively utilises the existing health workforce capacity. These include programs designed to increase consumer health information, encourage patient self-management and strengthen health prevention activities. Smoking, diet, physical activity, obesity and alcohol abuse are some of the issues these programs address.

### 2.2 Supply

- Education and Training

To date, increases in education and training numbers for the established health professions has been the major policy mechanism used to increase health workforce capacity.

The Australian Government has embarked on an expansion of health-related student places in the education and training system. Increases in the number of medical schools and medical students is expected to expand the number of Australian medical graduates from approximately 1300 in 2005 to 2100 early next decade, an increase of more than 60%.

These increases will make a major contribution to addressing health workforce shortages over time.

- Overseas Trained Doctors

Another important policy has been engaging overseas trained health professionals. This is one of the few ways in which the health workforce can be augmented in the short term.

In recent years, the Australian and State/ Territory Governments have introduced a range of measures to boost the recruitment of suitably qualified overseas trained doctors. These policies have attracted increased numbers to the point where these doctors now constituted about 25% of Australia's overall medical workforce.

The Australian Government supports the principles contained in the Commonwealth Code of Practice for the International Recruitment of Health Workers which precludes the targeting of doctors from developing countries in recruitment efforts. The Government is putting in place training and support measures to assist overseas trained doctors choosing to come to Australia to help them integrate into the Australian medical workforce.

- Health Workforce Flexibility

Increased workforce flexibility is a key factor in meeting the increasing demand for health services and avoiding a worsening maldistribution of the workforce. This involves encouraging and equipping healthcare professionals to work at levels that fully use their training, competency and experience. Where appropriate, new classifications of health worker may enhance service delivery options.

The Australian Government has already taken steps to supplement the provision of primary care services provided by GPs with other health professionals, such as practice nurses, allied health workers, and Aboriginal Health Workers. There appears to be scope to build on measures of this kind to improve the flexibility and capacity of the health workforce, as is occurring overseas.

- Regulatory Arrangements

Changed regulatory arrangements would improve health workforce flexibility. The different, complex and profession-based regulatory provisions operating in each State or Territory adversely affects health workforce capacity.

- Workforce Participation

Major workforce participation issues include the decrease in average working hours among doctors and retention rates for nurses.

The reduction in average working hours for doctors from 1997 to 2002 represents a fall in medical workforce availability of over 3,000 persons. This reduction reflects in large part decisions by younger doctors about work life balance that are unlikely to change significantly, combined with increasing female participation in the medical workforce and the safe hours campaign in hospitals.

Large numbers of nurses who have obtained registration or enrolled nurse qualifications no longer practice nursing. The key issues to consider in improving nursing retention rates are those of employment practices and role redesign, which are matters for nursing employers.

### 2.3 Distribution

A range of Government policies currently address workforce distribution problems in rural and remote areas. Most of these begin to take effect immediately, and have met with some success. However, it will take some years to realise the benefits from the education and training strategies which have been put in place to grow and retain the rural health workforce.

Access to health professionals for Indigenous Australians is still significantly below that available for non-Indigenous Australians. This area, along with the outer

metropolitan areas of the major capital cities; aged care facilities; and after hours care, are other health workforce distribution pressure points which will require continuing focus to ensure that health services can be maintained at adequate levels.

#### 2.4 Health Workforce Quality Issues

The separate stages for educating doctors need to be better integrated. In addition changes need to be made to better match the location of specialist medical training with clinical practice; more fully reflect the interdisciplinary care needs of our health system in medical education; and to ensure a robust framework for Continuing Professional Development of medical practitioners.

#### 2.5 Future Directions in Health Workforce Planning

Health workforce planning will remain challenging because of the complexity and changing nature of the health sector, shifts in consumer demand and the lack of agreed benchmarks about the desired level and composition of health services for the community.

There are deficiencies in the availability, quality and timeliness of current workforce statistics and improving health workforce data collections is a priority.

## **Introduction**

Australia's health expenditure as a percentage of GDP in 2002 was 9.5%<sup>1</sup>, similar to most other higher income OECD countries. Australia is close to the OECD average in broad indicators of health such as improvements in life expectancy and infant mortality. A major factor in providing Australians with a high-quality, robust health system has been the development over many years of a well-trained, high-quality health workforce.

Nevertheless, community demand for health services continues to increase and Australian governments, educational institutions and professional bodies face a number of challenges in addressing workforce shortages. This is a workforce which has significant internal professional boundaries and is distributed in ways that do not always adequately reflect the needs of some groups within the community.

Under the Strengthening Medicare Package, the Australian Government is investing about \$1.5 billion in a range of workforce programs over five years, mostly commencing from 2004. These measures include considerable increases in the number of education and training places for doctors; additional funding to support general practices to employ practice nurses and the provision of Medicare items for certain services undertaken by practice nurses; increases in the number of appropriately trained overseas trained doctors practising in Australia; and increased support for rural general practitioners who provide procedural services like obstetrics and minor operations (see section 3 and Attachment A for further detail). Some of these measures are already having an impact, but given that it takes some time to train new health workers, the full effect will not be felt until early next decade.

The aim of this submission is to:

- provide an overview of the current situation in the context of trends in demand for health services and the supply of health professionals in recent years;
- review key developments in workforce planning in Australia;
- consider the major economic and social factors that drive our health system and health workforce;
- outline a range of current health workforce supply, distribution and quality issues; and
- discuss some future directions and strategies for health workforce policy and planning.

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<sup>1</sup> Australian Institute of Health and Welfare (2004) Health expenditure in Australia 2002-2003. AIHW Cat. No. HWE 27, Canberra

## 1. Setting the Scene

### 1.1 Health Service Demand

Strong demand for health services nationally is a dominant factor affecting the current workforce situation. The health workforce, while it has grown substantially, has not been able to keep pace with increased demand for health services.

Total health expenditure in Australia increased from \$35 billion in 1992-93 to \$72 billion in 2002-03, rising from 8.2% of gross domestic product (GDP) to 9.5% of GDP over that period. Average health expenditure per person rose from \$1,996 in 1992-93 to \$3,652 in 2002-03, an overall increase of 83% in current dollars or 38% after adjusting for inflation<sup>2</sup>. This increase was largely a consequence of increases in the volume and changes in the mix of health goods and services being purchased rather than price inflation in the health sector running any faster than in the general economy.

The increase in concern from the community about workforce shortages in recent years indicates that, in a number of regions demand for health services exceeds available supply. In other words, at current prices, consumers would purchase more health services if they could access them.

An Australian Health Workforce Officials Committee (AHWOC) Health Workforce Information paper<sup>3</sup> suggests that health workforce demand growth in the future will be around 2.5% to 3% per year, driven by economic and demographic factors. Maintaining and expanding a workforce of over 450,000 professionals and skilled workers to satisfy community demand growing at this rate will be an ongoing challenge for health policy in Australia.

### 1.2 Health Workforce Supply: Recent Trends

This submission follows the conventional practice of considering each of the major components of the health workforce separately in some sections. However, this does not imply endorsement of a 'silos approach' to the health workforce. Later sections give a greater focus on opportunities for flexibility, cooperation and complementary roles.

The latest data<sup>4</sup> indicates that the overall number of health professionals has grown considerably in recent years. The health workforce grew by 11.4% (i.e. about 2% per year) between 1996-2001 compared with population growth of 6% (about 1% per year) over this period. Most of the key health professional groups shared in this growth.

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<sup>2</sup> Australian Institute of Health and Welfare (2004) Health expenditure in Australia 2002-2003. AIHW Cat. No. HWE 27, Canberra

<sup>3</sup> Australian Health Workforce Officials Committee. Demand for Health Services and the Health Workforce (yet to be published)

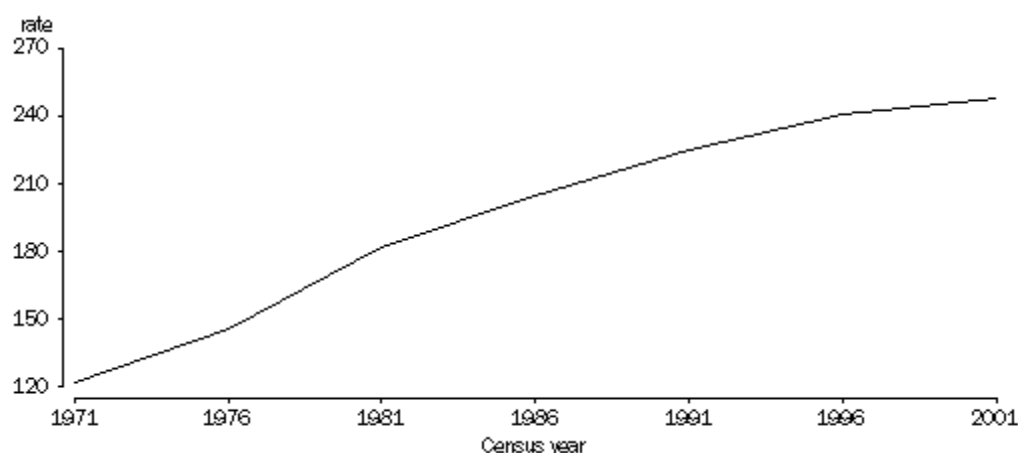
<sup>4</sup> Australian Institute of Health and Welfare (2003) Health and Community Services Labour Force, 2001. AIHW Cat. No HWL 27 and ABS Cat. No8936.0. Canberra



- The Medical Workforce

The medical workforce has increased from about 35,000 in the early 1970s to about 55,000 at the present time. The number of doctors per 100,000 population has doubled from 122 in 1971 to 248 in 2001<sup>5</sup>. Over this period, the fastest growth was in the 1970s with the number of doctors per person increasing to 181 per 100,000 population by 1981. Over the 1980s and the 1990s the rate of increase slowed, particularly in the five years to 2001 with the 248 doctors per 100,000 population in 2001 only slightly higher than the 241 in 1996.

**Graph 1 Medical Practitioners per 100,000 population**



(a) Estimated resident population at 30 June each year.

Sources: ABS 1971-2001 Censuses of Population and Housing; ABS Estimated resident populations at 30 June 1971-2001. (From Australian Social Trends 2003 - Health Services: Medical practitioners)

The annual number of medical graduates stayed relatively stable over the late 1980s and throughout the 1990s, as a consequence of restrictions placed on the number of medical schools and medical undergraduate places at universities. Also, from the mid-1990s, doctors wishing to enter the GP workforce were required to undertake three extra years of training before entering practice with access to higher rates of Medicare rebate. In addition, the number of training places for GPs was capped.

Changes in average working hours of medical practitioners have impacted on the available workforce. In recent years, despite an increase in the number of doctors, the number of full-time equivalent (FTE) medical practitioners has been nearly static<sup>6</sup> as a consequence of a fall in average working hours and increasing numbers of doctors choosing to work less than full-time.

<sup>5</sup> Australian Bureau of Statistics (2003) Australian Social Trends, Health-Health Services: Medical Practitioners accessed at <http://www.abs.gov.au/Ausstats/abs@.nsf/0/44F779A1A264BE31CA256D39001BC344?Open>

<sup>6</sup> Australian Institute of Health and Welfare (2005) Medical Labour force 2003, AIHW Cat No. HWL 32

Average weekly working hours for clinicians fell from 48 in 1997 to 44.6 in 2002, a decline of 3.4 hours or about 7%<sup>7</sup>. This represents a decline in clinical medical workforce availability equivalent to 3,130 doctors or about 500 per year. The significance of this annual workforce loss is illustrated by noting that it is equivalent to nearly 40% of the average annual number of medical graduates, around 1300, over those years.

The fall in average weekly hours reflected both the general decline in the number of hours per week that doctors choose to work and the increased proportion of females in the workforce, as female doctors work (on average) between 10 and 15 hours less per week than their male counterparts.

Average working hours for doctors stayed constant from 2002 to 2003, which may indicate a levelling off in the downward trend observed since the mid-1990s.

As noted earlier, the levelling off in the number of doctors, in FTE terms, over the past decade has coincided with a substantial increase in demand for medical services. The increasing demand, coupled with a stable or slightly declining medical workforce capacity, has led to doctor shortages of varying severity in most medical disciplines.

The Australian Medical Workforce Advisory Committee (AMWAC) has reviewed 11 major medical specialty areas since 2000. In eight of these it has recommended increasing trainee numbers to try to meet shortages. AMWAC also recently concluded a study of the public hospital workforce<sup>8</sup> which showed that all Australian hospitals are experiencing some staffing shortages and difficulties, particularly regional hospitals. AMWAC is expected to publish the results of reviews of the GP and surgical workforces shortly.

As a consequence of difficulties in attracting Australian trained doctors to regional areas, the Commonwealth and State governments have increasingly relied on expanding the overseas trained doctor intake, both permanent and temporary, to fill positions in rural and remote areas (defined under the Rural, Remote, Metropolitan Areas [RRMA] Classification as categories 3-7). Despite immigration restrictions, the number of temporary resident doctors entering Australia each year increased markedly over the 1990s, from 670 in 1992-93 to 2,370 in 1999-2000..

Around 50% of employed medical practitioners in Australia who obtained their initial qualification overseas come from the UK, Ireland and New Zealand, 28% from Asia and 20% from elsewhere<sup>9</sup>.

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<sup>7</sup> Australian Institute of Health and Welfare (2004) Medical Labour force 2002, AIHW Cat.no.HWL 30. Canberra

<sup>8</sup> Australian Medical Workforce Council (2004), The Public Hospital Medical Workforce in Australia, AMWAC Report 2004.3, Sydney

<sup>9</sup> Medical Training Review Panel Overseas Trained Doctor Subcommittee (2004) Overseas Trained Doctor Subcommittee Report to the Medical Training Review Panel

- The Nursing Workforce

Nursing has been the slowest growing of any of the key health workforce groups. The number of nurses actually employed in nursing increased from 220,666 in 1995 to 236,645 in 2003, an increase of less than 1% per year. Once adjustments are made for population growth and changes in working hours, over the period as a whole, the number of full time equivalent nurses per capita did not change<sup>10</sup>.

In March 2004, Access Economics<sup>11</sup> estimated that over the decade from 2003 to 2012 there will be increasing shortages of nurses. The major reasons identified for this are the growing demand for nursing services as the population ages and the increase in the expected number of retirements given the current age profile of the existing nurse workforce.

The residential aged care sector in particular faces significant workforce issues due to the general shortage of trained nursing staff, which is greater in this sector than in other areas of the health system<sup>12</sup>.

- The Dental Workforce

During the 1990s the dental workforce grew faster than population growth (7.4% compared with 6% between 1996 and 2001<sup>13</sup>) but workforce shortages have still emerged.

In 2003, the Australian Research Centre for Population Oral Health published an analysis of the dental labour force<sup>14</sup>. The capacity of the Australian dental labour force to supply dental visits depends upon the numbers of practising dentists, therapists, hygienists and prosthetists (dentists make up 78% of practitioners). The study concluded that the estimated increase in the capacity to supply dental visits (3.6% over the period to 2010) will be insufficient to match growth in demand.

- The Pharmacist Workforce

Similarly, while the pharmacy workforce has grown faster than population growth (13% compared with 6% between 1996 and 2001<sup>15</sup>) there is a current shortage of pharmacists in Australia, with both retail and hospital pharmacy listed on the Migration Occupations in Demand List. Projections on the demand and supply of

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<sup>10</sup> Australian Institute of Health and Welfare (2005) Nursing and Midwifery Labour Force 2003, AIHW Cat. No. HWL 31, Canberra

<sup>11</sup> Access Economics (2004) Employment Demand in Nursing Occupations. A Report for the Commonwealth Department of Health and Ageing

<sup>12</sup> Hogan (2004) Pricing Review of Residential Aged Care

<sup>13</sup> Australian Institute of Health and Welfare (2003) Health and Community Services Labour Force, 2001. AIHW Cat. No HWL 27 and ABS Cat. No8936.0. Canberra

<sup>14</sup> Spencer AJ et al (2003) The Dental Labour Force in Australia: the Position and Policy Directions, AIHW Cat. no. POH 2, Canberra

<sup>15</sup> Australian Institute of Health and Welfare (2003) Health and Community Services Labour Force, 2001. AIHW Cat. No HWL 27 and ABS Cat. No8936.0. Canberra

pharmacists from 2000 to 2010 were published in 2003 by Health Care Intelligence<sup>16</sup>. This study concluded that, while the overall supply of full time equivalent pharmacists would increase from 11,188 in 2000 to up to 14,147 in 2010, the demand for pharmacy services would increase from 13,100 full time equivalent pharmacists to 17,200 in the same time period.

This projected shortage of pharmacists is expected to affect rural and remote areas and the hospital pharmacy sector the most. A study by the Society of Hospital Pharmacists of Australia<sup>17</sup> found that, of the public hospitals pharmacy services it surveyed in 2003, 10% of full time equivalent positions were vacant.

- Other Allied Health Workforces

There has been limited analysis of the other allied health workforces. The Australian Institute of Health and Welfare (AIHW) ran labour force studies on a number of the health professions which are registrable, namely podiatry, physiotherapy and occupational therapy but these have not been updated for some years.

The Health and community services labour force publications, published jointly by the AIHW and the ABS, provide some trend data on the number of persons employed in allied health professions. This data indicates that there have been the following increases in the number of allied health professionals over the period 1996-2001:

**Table 1. Employment Growth in Allied Health Professions 1996 – 2001**

Profession	Number employed 1996	Number employed 2001	% change
Physiotherapists	8,896	10,242	15.1
Pharmacists	12,311	13,911	13.0
Occupational therapists	4,363	5,331	22.2
Speech therapist	2,337	3,011	28.8
Podiatrists	1,462	1,767	20.9
Medical diagnostic radiographer	4,714	5,470	16.0
Radiation therapist	700	808	15.4
Nuclear medicine technologist	397	445	12.1
Sonographer	702	1,418	102.0
Audiologist	685	805	17.5
Clinical Psychologists	5,252	7,567	44.1
Optometrist	2,255	2,695	19.5
Dietician	1,712	1,998	16.7
Orthopist	348	434	24.7
Orthotist	331	364	10.0

Source AIHW/ ABS Health and Community Services Labour Force 2001

<sup>16</sup> Health Care Intelligence (2003) A Study of the Demand and Supply of Pharmacists 2000-2010

<sup>17</sup> O'Leary, K. Allinson, Y (2004) *Snapshot of the Australian Public Hospital Pharmacy Workforce in 2003*, Journal of Pharmacy Practice and Research Vol. 34, No.2

Despite this growth it is generally acknowledged that there is a shortage of a range of allied health professionals in Australia. For example:

- the Report of the Radiation Oncology Inquiry<sup>18</sup> (Baume Report) found that there was a considerable shortage of both radiation therapists and medical physicists. In 2000, there was a vacancy rate of 10%, compared with a vacancy rate of 2% in 1995. In the case of medical physicists there was an overall vacancy rate of 8.9% in 1999.
- As at May 2005 there were 10 allied professions included on the Migration Occupations in Demand List. These were: hospital and retail pharmacy, occupational therapy, physiotherapy, podiatry, speech pathology, medical diagnostic radiography, radiation therapy, sonography and nuclear medicine technology.

### 1.3 Health Workforce Distribution

The second of the seven guiding principles of the 2004 National Health Workforce Strategic Framework<sup>19</sup>, endorsed by Australian Health Ministers states that: “The distribution of the health workforce should optimise equitable access to health care for all Australians and recognise the specific requirements of people and communities of greatest need”.

A number of studies have noted that Australians living in rural and remote regions have, on average, a health status that is not as good as people living in capital cities. These results are, however, influenced by the relatively higher proportion of Indigenous Australians in these areas whose health is significantly worse than for non-Indigenous Australians. A life expectancy of 59.4 years has been reported for all male Indigenous Australians (rural and urban) compared to 76.6 years for all Australian males and for female Indigenous Australians a life expectancy of 64.8 years compared with 82 years for all Australian females<sup>20</sup>.

Most rural people expect to travel some distance for specialist and major hospital services. However, reasonable regional access to primary care, such as general practice and dentistry, and emergency treatment, is very important in ensuring adequate rural health profiles.

In summarising the literature on addressing health inequalities, the authors of *Health Inequalities in Australia*<sup>21</sup> suggest that the most favoured initiatives to reduce inequalities in mortality are: changing macro-level social and economic policies;

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<sup>18</sup> Report of the Radiation Oncology Inquiry (2002) A Vision for Radiotherapy

<sup>19</sup> Australian Health Ministers' Conference (2004) National Health Workforce Strategic Framework, Sydney

<sup>20</sup> Steering Committee for the Review of Government Service Provision (2005) Overcoming Indigenous Disadvantage: Key Indicators 2005, Productivity Commission, Canberra

<sup>21</sup> Draper G et al (2004) Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No.1, AIHW Cat. No. PHE 55, Canberra

improving living and working conditions; involving local communities in health initiatives; changing health damaging behaviour; empowering individuals and strengthening their social and family networks; and improving the equity of the health care system.

The health workforce is a key factor in addressing at least three of the six initiatives.

Workforce distribution is one of the most difficult areas of workforce policy. Health professionals choose to live and work in particular areas for many reasons. These include choices that suit their lifestyle and aspirations, and those of their families, and where their earning capacity matches their income goals. Frequently, areas with workforce shortages, such as rural and remote locations and outer urban areas, do not meet their criteria.

In 2001 the total health workforce in major cities was approximately 3,000 per 100,000 population and this declined to about 1500 per 100,000 population in very remote areas. Information on the number of people employed in health industry categories by location is provided below.

**Table 2. Employed persons per 100,000 population: industry and remoteness**

Health industry	Major cities	Inner regional	Outer regional	Remote	Very Remote
General practice medical services	350.5	280.4	227.5	197.5	109.1
Dental services	168.3	127.0	104.3	71.1	35.4
Physiotherapy services	48.3	37.3	27.2	21.8	7.2

Source: AIHW (2003) Health and community services labour force, 2001

While there is good evidence of health workforce maldistribution, establishing, in quantitative terms, the extent of the disadvantage is not straightforward.

For example, the AIHW notes: “Because of the need for cost-effective utilisation of expensive equipment and/or to achieve and maintain clinical competence in complex and costly procedures, it may be feasible to have only a limited number of health-care establishments, such as hospitals, providing certain specialised health services. These establishments are invariably located in large population centres, which will increase the number of health workers in those places – but these workers may service patients or clients from a much wider area” (Health and community services labour force, 2001: 28).

As discussed later in this submission, the maldistribution of the health workforce in rural and remote areas has been increasingly recognised by governments and a range of policies have been introduced to address it in recent years.

#### 1.4 Health Workforce Planning in Australia

Until quite recently, broad health workforce planning in Australia focused on the medical workforce.

- The Medical Workforce

*Medical workforce planning is about preparing for the long-term health of Australians. It is about planning for the future supply and distribution of properly educated and trained doctors to best meet the population's need for quality health services.*

*(Tomorrow's Doctors, Review of the Australian Medical Workforce Advisory Committee, Canberra 2002 page 12) (Butt Committee)*

Medical workforce planning started to take shape with the introduction of Medibank in 1975. Medibank, a program of universal non-contributory health insurance went through a series of modifications until Medicare was introduced in 1984.

By the late 1970s, governments, facing growing health budgets, started to take a more active interest in the size and composition of the medical workforce. Several committees considered medical workforce issues in the early 1980s. In 1986 the Commonwealth Department of Health sponsored a national workshop on medical education and workforce, the prelude to the comprehensive work of the Doherty Committee in 1988.

The Doherty Committee<sup>22</sup> concluded that there was not an overall oversupply in the specialist medical workforce at that time but that there was evidence of an oversupply of general practitioners in some areas of the capital cities. They also pointed to doctor shortages in country areas.

Concern about oversupply and its impact on Medicare benefits outlays continued through the 1990s. In 1995 the Australian Medical Workforce Advisory Committee was formed by the Australian Health Ministers' Advisory Council (AHMAC) as the key body to improve the quality and timeliness of medical workforce planning, and thereby enable action to be taken to better match the supply of medical practitioners with the demand for medical services in Australia.

While its early analysis identified shortages in a number of specialist areas, the Committee initially formed the view that there was an oversupply of GPs in metropolitan areas which exceeded an undersupply in rural areas. This conclusion led governments to take a conservative view of the number of new medical graduates and overseas trained doctors that would be required to sustain an adequate medical workforce.

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<sup>22</sup> Committee of Inquiry into Medical Education and Medical Workforce (1988) Australian Medical Education and Workforce into the 21<sup>st</sup> Century, AGPS, Canberra

With the benefit of hindsight, it appears that AMWAC may have underestimated both the strength of demand for general practice services and the impact of the decline in hours worked by GPs.

AMWAC studies have mainly focused on individual medical professions. In general, AMWAC's recommendations have been accepted and acted on in terms of establishing increased numbers of training positions for particular medical disciplines. AMWAC has also undertaken on a number of studies designed to help planners and policymakers in understanding changes, developments and attitudes in the medical workforce.

- Other Health Workforces

Workforce planning at the national level for the non medical workforce has only begun recently. The Australian Health Workforce Advisory Committee (AHWAC) was established in 2000 to provide advice on issues relating to the nursing and allied health workforces. Since then AHWAC has focussed on elements of the nursing workforce, for example, the critical care and midwifery workforces.

### 1.5 Overseas Trends in Health Workforce Supply and Demand

*In general, it is not easy to determine what is the right number of physicians and nurses in a country. OECD countries have made different choices about training and recruiting physicians and nurses, choices which have been inspired by different views about the number needed in these professions. So far, there has been little investigation internationally of the consequences of these variations. Meanwhile, whereas a few countries, or areas within countries, are experiencing surpluses of physicians and nurses, it is much more common to find evidence of shortages, partly as a result of rising demand. In response to this, many member countries are seeking to increase the stock and the productivity of their health care workers.*

*OECD Health Project, Human Resources for Health Care: A Progress Report 2002: 5*

A number of countries with very similar health systems to Australia are experiencing shortages of health professionals. In general, the nursing shortage is the most difficult in overall terms. However there are concerns about the supply of medical practitioners and, particularly, about the distribution of doctors to rural, remote and disadvantaged communities.



In the United Kingdom the National Health Service (NHS) Plan of 2000<sup>23</sup> gave high priority to increasing the number of health professionals. Under the Plan, by 2004 the NHS established a goal of employing an additional 7,500 medical specialists, 2,000 GPs, 20,000 nurses and over 6,500 therapists. Also, an additional 1,000 medical school places were to be funded. In 2004 the UK government indicated the plan was on target.

In Canada, the Final Report of the Commission on the Future of Health Care in Canada<sup>24</sup>, outlined concerns about real and perceived shortages of health care professionals, particularly in nursing. Between 1991 and 2000 there was an 8% drop in the number of registered nurses per 100,000 population and a 21% decrease in the number of licensed practical nurses. In the case of doctors, the report identified there was no consensus on whether there was a “crisis” in the supply of physicians, noting that in the period 1991-2000 there was no change in the number of physicians per 100,000 population. However, maldistribution was a serious issue.

In the United States, there has been debate as to whether there will be a shortage of physicians in the future<sup>25</sup>. A number of studies conducted in the 1980s predicted a surplus of physicians and policies were implemented to try and reduce the number of physicians. The number of physicians grew from 202 per 100,000 population in 1980 to 276 per 100,000 population in 2000 and is projected to reach 283 per 100,000 by 2010<sup>26,27</sup>. The Council of Graduate Medical Education (COGME), a national advisory body that makes policy recommendations regarding the adequacy of the supply and distribution of physicians, has recently recommended that by 2015 medical schools should expand the number of medical graduates by 3,000 a year<sup>28</sup>.

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<sup>23</sup> United Kingdom Department of Health (2000) *The NHS Plan: A Plan for Investment, A Plan for Reform*, United Kingdom

<sup>24</sup> Commission on the Future of Health Care in Canada (2002) *Building on Values: The Future of Health Care in Canada – Final Report*

<sup>25</sup> Blumenthal D (2004) *New Steam from an Old Cauldron – The Physician–Supply Debate*, *The New England Journal of Medicine* 350;17:1780-1787

<sup>26</sup> Salsberg E, Forte GJ (2002) *Trends in physician workforce supply, 1980-2000*. *Health Affairs* 2002;21:165-173

<sup>27</sup> Cooper R et al (2002) *Economic and demographic trends signal an impending physician shortage*. *Health Affairs* 2001;21:140-154

<sup>28</sup> Council on Graduate Medical Education (2005) *Physician Workforce Policy Guidelines for the United States, 2000-2020*, U.S. Department of Health and Human Services, Health Resources and Services Administration

*Taken together, the data, forecasts, and signals discussed earlier indicate that physician shortages are upon us and are likely to worsen over time. The picture that emerges is uncomplicated and unambiguous. In simple numeric terms, the number of physicians is no longer keeping up with population growth. The ability to fully service the population is further compromised by the increasing complexity of the care physicians provide and the decreased time commitment that many physicians are willing to make. These limitations collide with economic trends that predict a growing demand for physician services. Recruiters, medical leaders, and patients are already experiencing shortages, and colleagues in other English-speaking countries see a situation in the United States that is all too familiar to them*

*Richard A Cooper MD, Weighing the Evidence for Expanding Physician Supply, Annals of Internal Medicine, 2 November 2004*

There is an estimated shortage of registered nurses in the United States of 6% or approximately 110,000. This figure is expected to double by 2010<sup>29</sup>.

## 1.6 Overseas Trends in Health Workforce Roles

The United States, United Kingdom and Canada have, over a number of years, progressively introduced a range of new health worker roles.

- **Physician Assistants**

The role of Physician Assistants developed in the United States in the 1960s in response to a shortage and maldistribution of primary care physicians. Physician Assistants are health care professionals licensed to practise medicine with physician supervision. They are able to conduct physical examinations, diagnose and treat illnesses, order tests, counsel on preventative health care, assist in surgery, and in virtually all states of the US, they can write prescriptions. Physician Assistants are educated in a medical model which is designed to complement physician training. Most Physician Assistant programs are of two years duration and require students to have had some college education and healthcare experience in order to be admitted to the course.

The American Academy of Physician Assistants (AAPA) estimates that there were 55,601 people in clinical practice as Physician Assistants at the beginning of 2005. A survey of Physician Assistants<sup>30</sup> by the AAPA in 2004 found that 37% of respondents worked primarily in a hospital, with 29% working in physician group practices and

<sup>29</sup> National Center for Health Workforce Analysis (2002) Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020, U.S. Department of Health and Human Services

<sup>30</sup> American Academy of Physician Assistants Website, 2004 AAPA Physician Assistants Census Report, <http://www.aapa.org/research/04census-intro.html>

13% in sole physician practices. A significant number (19%) of Physician Assistants were employed in non metropolitan areas.

- Nurse Practitioners

The Nurse Practitioner role is distinct from the practice nurse role undertaken in general practice in Australia (see page 30). A Nurse Practitioner is defined by the International Council of Nurses as “a registered nurse who has acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which they are credentialed to practice”<sup>31</sup>.

Nurse Practitioners in a range of countries have some ability to prescribe medications (Canada, UK, New Zealand, US, Spain and Sweden) and refer to other health professionals, (Canada, UK, New Zealand, Ireland, US), although generally in limited circumstances.<sup>32</sup>

In the United States, Nurse Practitioners were introduced in the 1960s. The American Academy of Nurse Practitioners describes the role<sup>33</sup> as a nurse generally involved in health promotion and maintenance, disease prevention and the diagnosis and management of acute and chronic disease. In undertaking this role they are able to take patient histories, conduct physical examinations, order, supervise, perform and interpret appropriate diagnostic and laboratory tests, prescribe medications and treatments for managing the conditions they diagnose. The extent to which they are under the supervision of medical practitioners varies between the States.

Nurse Practitioners generally work in the primary care setting. However, as nurses are regulated at the State level, their scope of practice varies between jurisdictions. In 2000 there were approximately 88,000 nurse practitioners in the United States.

- Medical Assistants

Medical Assistants are health professionals who perform both administrative and clinical duties. In the United States the clinical duties that they are able to undertake varies from State to State but include taking patient histories, preparing patients for examination, drawing blood, taking electrocardiograms, removing sutures and changing dressings. There were about 365,000 Medical Assistants employed in the US in 2002 and the US Department of Labour predicts that Medical Assistants will be the fastest growing health occupation over the 2001-12 period<sup>34</sup>.

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<sup>31</sup> International Council of Nurses website, <http://icn-apnetwork.org/>

<sup>32</sup> Buchan J, Calman L (2005) Skill Mix and Policy Change in the Health Workforce: Nurses in Advanced Roles, OECD Health Working Papers No.17, OECD, Paris

<sup>33</sup> American Academy of Nurse Practitioners (1998) Scope of Practice for Nurse Practitioners, <http://www.aanp.org/NR/rdonlyres/edhltucoxqd2xnrfwbve26d3cowleh5rqqcfmhlcoi3sp7ihpzxy7rdqtkewz5zvpgxsuc7z4iao/scope%2bof%2bpractice%2bv2.pdf>.

<sup>34</sup> Bureau of Labour Statistics, U.S. Department of Labour, Occupational Outlook Handbook 2004-05 Edition, Medical Assistants, on the internet at <http://www.bls.gov/oco/ocos164.htm>.

There are some specialist medical assistant positions. These include podiatric medical assistants who can make castings of feet, expose and develop x rays and assist podiatrists in surgery and ophthalmic medical assistants who can conduct diagnostic tests, measure and record vision and test eye muscle function.

- Other Roles

The 2000 United Kingdom NHS Plan<sup>35</sup> stated that increasing the number of health care professionals, while important, would not of itself deliver accessible and responsive health services based on patient need. Consequently, the Plan also focused on the redesign and extension of the roles of health care professionals. Employers were required to facilitate appropriately qualified nurses, midwives and some allied health professionals performing a wider range of tasks including making and receiving referrals, admitting and discharging patients, ordering investigations and diagnostic tests such as pathology tests and x rays, and prescribing drugs.

To help implement this Plan, a Modernisation Agency was established in 2001, with workforce redesign as one major area of responsibility. The Changing Workforce Programme<sup>36</sup>, managed by the Agency, aimed to help NHS organisations develop new roles through skill mix changes, expanding the depth and breadth of jobs and shaping tasks and skills around particular client needs. This has involved working with a range of organisations, including regulators and professional bodies, to build a framework for role redesign with development work being undertaken in coronary heart disease, neonatal care and dementia.

Other programs being implemented include the Practitioner with a Special Interest (PSI) and the National Practitioner Program. The PSI program has focused on primary care practitioners with special interests, enabling them to undertake outpatient appointments and developing primary care facilities to accommodate these additional services. Areas that have been identified for general practice include ophthalmology, orthopaedics, dermatology and Ear Nose and Throat.

Through the National Practitioner Program, the focus has been on developing Advanced or Assistant Practitioner roles in the acute sector. Practitioners are qualified professionals who, after training, can function at a broader level of responsibility. As part of these arrangements, the surgical care practitioner role is being developed in the UK. Surgical care practitioners are healthcare professionals, such as nurses and physiotherapists, who undertake specific training to develop skills and competencies in surgery. Surgical care practitioners work under the direction of a surgeon who retains overall responsibility for patient care. The NHS released a consultation document<sup>37</sup> on the development of a curriculum framework for surgical care practitioners early in 2005 in order to formalise the role.

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<sup>35</sup> United Kingdom Department of Health (2000) The NHS Plan: A Plan for Investment, A Plan for Reform, United Kingdom

<sup>36</sup> Information on the Initiatives under the Changing Workforce Programme can be found at [http://www.wise.nhs.uk/cmsWISE/Workforce+Themes/Using\\_Task\\_Skills\\_Effectively/roleredesign/Introduction/Introduction.htm](http://www.wise.nhs.uk/cmsWISE/Workforce+Themes/Using_Task_Skills_Effectively/roleredesign/Introduction/Introduction.htm)

<sup>37</sup> The Curriculum Framework for the Surgical Care Practitioner, March 2005

## 2. The Economic Framework

### 2.1 Key Factors Affecting the Demand for Health Services

Successive Australian Governments have given high priority to providing access to good quality health services for the entire community. In doing so, they have responded to community demand. As a result, whether a health workforce is 'adequate' or not depends as much on the level of community demand for health services as it does on the supply or availability of health care workers. Early workforce studies that focused on the ratio of doctors to population usually underestimated future workforce requirements, in part, because they did not anticipate the magnitude of the increase in demand over time.

Demand is not the same thing as actual health service use. The level of demand is the quantity of health services that consumers would like to buy if they could, at current income levels and prices. One of the indicators of a workforce shortage is consumers in, say, a particular region, being unable to access or obtain the services that they would like to purchase if they were available, i.e., demand exceeds supply in this situation.

Total expenditure by consumers on health will, other things being equal, rise more rapidly than national income because, as people become wealthier, they spend a higher proportion of their disposable income on health services. From 1998-99 to 2003-04 household expenditure on medical care and health expenses rose by 41% compared to a 26.4% increase in total household goods and services expenditure over the period. The Consumer Price Index for health rose by 18.7% from 1998-99 to 2003-04, only slightly above the average of 17.7% for all groups so the relative increase in expenditure largely reflected increased purchases of health services. Expenditure on medical care and health expenses as a proportion of total goods and services expenditure rose from 4.3% to 5.2% over the five year period, an increase of 12.6%.<sup>38</sup>

Demand for health services also varies inversely with price. Therefore, government spending on health which reduces the direct cost to patients of a visit to a doctor, nurse or allied health professional will tend to stimulate demand. While there are strong social reasons for governments to subsidise health services, including equity of treatment and achieving gains in public health, a result is a high level of consumer demand.

If the cost to patients of drugs, services and tests is relatively low, health professionals may also feel less constrained in the procedures and treatments that they order.

Other factors affecting demand include population growth, changes in the age distribution of the population, technological change, changing community expectations of the health system and differences in the health status of various groups in the community.

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<sup>38</sup> Australian Bureau of Statistics (2005) Household Expenditure Survey 2003-04, ABS Catalogue No 6535.0.55.001, Canberra

With respect to new technology, the rules governing access to new drugs, diagnostic tests and procedures can significantly affect workforce demand in certain areas or specialties. At the same time, expanding internet technology enables patients to be better informed about the range of procedures, treatments and drugs that can be available.

Government policy can influence these 'demand factors' although sometimes the policies are outside what has been traditionally regarded as health policy. For example, immigration policy, family policies and regional development policies will affect population growth, distribution and ageing and will impact on the demand for health services. Similarly, taxation arrangements and welfare subsidies impact on personal income growth and on the demand for health services by different groups within society.

The combined economic impact of the above factors has been growth in demand for health services (and in the need for additional health workforce capacity) at a much faster rate than population growth alone.

## 2.2 Key Factors Affecting the Supply of Health Services

In general there is no shortage of well qualified school leavers wishing to embark on a career in the health workforce. Professional health workers have good social standing, remuneration which, generally, ranges from average to high compared to the general community and a challenging, transferable and flexible vocation and career path.

Governments subsidise health education to meet a range of objectives. Most importantly, they aim to ensure that graduate numbers meet health workforce needs and, in addition, that workforce entry is based on merit and aptitude rather than purely financial factors.

When concerns developed in the 1980s and early 1990s that there might be an oversupply of medical graduates, the Australian Government imposed restraints on a number of medical schools and medical student intake. However, with workforce shortages emerging in recent years, governments have encouraged expanding the education and training system for doctors, nurses and other allied health workers.

- **Distribution**

In most cases health workers have considerable choice, within their workforce sector, about the type of work they undertake and where they choose to work. The principal exceptions are overseas trained doctors required to work in areas of workforce shortage, and medical students with bonding arrangements which specify working in areas of workforce shortage for a minimum period of time on completing their studies (see pages 37 and 40-41).

As a natural consequence of this market based framework, health care workers, like most other professionals, tend to choose the areas within their profession and the

physical locations which will provide them with the combination of remuneration and other lifestyle factors closest to their personal and family goals.

The challenge for governments is to develop a training system and a suite of incentives and regulations that will align a market based health workforce distribution with needs based health delivery objectives. These objectives require a somewhat different distribution than the market provides, if the health needs of the community are to be effectively met.

- **Workforce Flexibility and Cooperation**

In contrast to the degree of flexibility within particular health occupations, the main sectors of the health workforce have, traditionally, had clearly defined roles and professional boundaries, often set out in legislation and regulations. These are overseen by a range of Government bodies and, in many cases, controlled by the professional organisations that represent the individual groups. However, in practice, the actual tasks that each group can competently undertake often overlap. For example, appropriately qualified nurses are capable of carrying out a number of routine GP services, under the overall direction of a general practitioner.

In principle, in order to maximise the productivity of the health workforce, all health workers should be encouraged to develop and use their professional skills to their capacity. The focus should be on competency, teamwork and multi-disciplinary care.

Adoption of modern internet and computer technology should encourage a range of new approaches by enabling health professionals to maintain good communications while working in separate locations, possibly many kilometres apart.

Importantly, the regulatory, education and training systems will need to promote flexibility and cooperation between various health workforce segments. A major challenge for future health policy will be to extend the capacity of the health workforce through flexibility and cooperation without compromising clinical standards. Workforce shortages create pressures to economise on services and relax rules. Any changes to clinical arrangements must be clearly in the patients' interests and not result in an inadequate quality of treatment.

- **Workforce Participation and Retention**

Workforce participation and retention refers, here, to two things. First, the proportion of professionals trained in a particular discipline that are actually working in that part of the health workforce and, secondly, to the average working hours the health professionals choose to practice in their discipline each week.

Changing social priorities, gender mix, working conditions and remuneration all contribute to the level of participation and retention. For example, increasing female participation, the trend to group medical practices and traditional fee-for-service arrangements all encourage a flexible approach by GPs to weekly working hours while many registered nurses are able to earn equivalent or higher salaries in other occupations which do not involve the demands of shift work.

### 3. Policy Issues

National health workforce policy has undergone a shift since the 1990s, from a concern about oversupply (particularly in the general practice medical workforce in urban areas) and a focus on maldistribution in rural and remote areas, to concerns about shortages across a wider range of health workforces and locations.

#### 3.1 Demand

As noted in earlier sections, the increase in community demand for health services is a primary driver of the current and projected health workforce shortages. However, for the most part, the issue of health workforce management has been addressed from a 'supply side' perspective. There are demand side measures that can improve health outcomes and better equip consumers and the community to make more informed decisions about their health care in order to use existing workforce capacity more efficiently and effectively. Examples of such approaches are: improving consumer health information; encouraging and supporting patient self-management and strengthening health promotion and prevention.

- Improving Consumer Health Information

Every individual in the community requires health information to achieve good health across their lifespan, particularly early in life. People need to be equipped and motivated to achieve and maintain healthy lifestyles through information, advice, skill development and support that are accessible, personally relevant and culturally appropriate.

Many attitudes and behaviours that impact on adult health are formed in childhood (eg in relation to smoking, poor diet and nutrition, lack of physical activity, obesity and alcohol abuse). The school years are, therefore, an ideal time to encourage the uptake of healthy behaviours and attitudes.

- Encouraging and Supporting Patient Self-management

Self-management puts the patient at the centre of their health care. It comprises all the skills and resources that a person needs to navigate the health system and maximise their quality of life by appropriately accessing resources across the health spectrum. Self-management involves the patient, their family and/or carers, service providers, and the health system working together to achieve better health outcomes.

A range of self-management interventions have shown positive outcomes in terms of health and well-being benefits for consumers as well as reduced demand for the services of health professionals and associated cost savings to the health system<sup>39</sup>.

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<sup>39</sup> Lorig et al. Evidence suggesting that a chronic disease self-management programme can improve health status while reducing utilization and costs: A randomized trial. *Med Care* 1999, 37(1):5-14.



For example, under the Australian Government's *Sharing Health Care Initiative*, a range of chronic condition self-management interventions were tested in urban, rural and remote locations. All interventions showed a positive health and wellbeing outcome for participants and reported reductions in GP visits and hospital stays. The findings are consistent with overseas self-management research. The most sustainable Australian models appear to be those involving Divisions of General Practice. All the interventions were supported by self-management education and training programs and assessment tools for GPs and other health providers, including Aboriginal and Torres Strait Islander Health Workers.

There are opportunities for self-management approaches to become more fully established as an integral component of the health care system, in order to realise the potential benefits of this approach.

- Strengthening Health Prevention Initiatives

Australia is making significant progress in preventing chronic diseases, both in terms of reduced economic costs and improved individual wellbeing. Falling mortality rates for some diseases, such as cardiovascular disease, are also key pointers.

Australia has initiated a wide range of prevention strategies, and both the Australian and State/Territory Governments are contributing to these. Recent national strategies have focussed on smoking, harmful alcohol use, early childhood and childhood health, exercise, nutrition, mental health, and drug-related harm, as well as strategies focussed specifically on prevention approaches for diabetes, cardiovascular disease and cancer.

The potential benefits of effectively reducing risk and increasing protective factors for chronic disease are recognised nationally and internationally. In particular, major gains are possible by focussing on the common risk factors that underlie a range of chronic diseases. In addition to improvements in health outcomes, this results in reduced requirements for health professionals to treat and manage a range of chronic disease problems.

There may be opportunities to build on these successes and achieve improved health outcomes and more efficient use of the health workforce through increased investment in prevention. Wider approaches could be considered ranging from increasing community awareness and knowledge of health risks and healthy behaviours, to creating healthy environments, to improving early detection and early treatment which has the potential to reduce mortality, complications and co-morbidities as well as improving quality of life.

### 3.2 Major Current Policies to Increase Workforce Capacity

To date, the major policy mechanisms used to increase health workforce capacity have been increases in education and training numbers for the established health professions (medical, nursing, etc) and increased use of overseas trained doctors and other overseas trained health professionals.

- **Increases in Education and Training Numbers**

The number of health-related student places being made available in the education and training system has expanded over the last few years, due to Government initiatives as well as providers responding to increased student demand. In the higher education sector, health-related student places have increased from 37,900 in 2001 to 43,167 in 2004, a growth of 14%.

Since 2000 the number of publicly funded medical places provided by the Australian Government across the tertiary sector has increased by more than 30%. Five new medical schools have been established since then and three further new medical schools are being established over the next few years. These initiatives, combined with the introduction of some full fee paying medical places for Australian students from 2005, will expand the number of Australian students completing university medical studies from approximately 1,300 in 2005 to 2,100 early next decade – an increase of over 60%.

From 2004, the Government has also expanded the number of vocational training places available for GPs from 450 to 600 – an increase of one third.

These increases in doctors being educated and trained will make a major contribution to addressing medical workforce shortages over time. However, there will be a considerable lag before their impact is felt, as it takes 10-15 years to fully educate and train medical professionals. This fact highlights the importance of also utilising other policy tools with a shorter term impact on medical/primary care workforce capacity to address medical workforce shortages.

As part of the Government's Higher Education Reforms, there are also considerable increases occurring in the number of publicly funded higher education sector places being made available across a range of other health disciplines. The number of additional places for nurses will increase from 210 in 2004 to 4,798 by 2008, and there will be an additional 3,631 places over this period in health disciplines such as dentistry, physiotherapy, occupational therapy, speech pathology and pharmacy.

Further detail on the increases occurring in higher education places for these other health disciplines is in Attachment B.

The Minister for Education, Science and Training is to allocate a further 2,800 new publicly funded places, across all higher education disciplines, for 2007 and 1,800 more for 2008. Consideration is being given to also allocating a proportion of these places to health disciplines.

In vocational education and training, the number of new apprenticeships commenced in the health sector has increased from 15,090 in 2002 to 17,220 in 2004, a growth of 14%. More increases are anticipated as Government initiatives to increase opportunities in community services and nursing take effect.

The increases in the number of nursing and other health professionals now being educated and trained through the higher education and vocational education and training sectors will, as for medicine, assist in addressing workforce shortages. However, unlike medicine, they will impact in the short to medium term as average education and training times for health professionals, other than doctors, is around 3-4 years.

- Overseas trained doctors (OTDs)/ International Medical Graduates (IMGs)

The intake of overseas trained health professionals represents one of the few ways to augment the medical workforce in the short term. It has assisted in addressing medical shortages, and will remain important in addressing such shortages in the short to medium term.

In recent years, Australian and State and Territory Governments have progressively introduced a range of measures designed to encourage and facilitate the recruitment of suitably qualified overseas trained doctors to work in areas of workforce shortage, in particular rural and remote areas and the public hospital system. These policies have attracted increased numbers of overseas trained doctors, to the point where they now constitute about 25% of Australia's overall medical workforce and a significantly higher percentage of doctors in rural and remote areas.

The Australian Government's Strengthening Medicare package, announced in November 2003, included a range of measures to increase the opportunities for appropriately qualified overseas trained doctors to practise in Australia. These include international recruitment strategies; opportunities for doctors to stay longer or obtain permanent residency; improved training arrangements and additional support programs. As a result of these measures, an additional 725 appropriately qualified overseas trained doctors are expected work in Australia by 2007. (See Attachment A, which outlines the full range of workforce measures introduced as part of the Government's Strengthening Medicare Package, for further information on these measures).

An important policy issue is the ethics of recruiting doctors from developing countries to Australia. The Australian Government supports the principles contained in the Commonwealth of Nations Code of Practice for the International Recruitment of Health Workers<sup>40</sup>, which precludes targeting doctors from developing countries in recruitment efforts. International medical recruitment agencies contracted by the Australian Government, as part of its Strengthening Medicare measures, are

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<sup>40</sup> The Commonwealth Code of Practice for the International Recruitment of Health Workers can be accessed at <http://www.thecommonwealth.org/Templates/Colour.asp?NodeID=34044>

prohibited from undertaking recruitment marketing activities in, or approaching doctors residing in, developing countries.

Some overseas trained doctors from developing countries have, however, directly approached Australian employers and/ or Australian Government contracted medical recruitment agencies for help in entering the Australian medical workforce. Assisting these individuals is consistent with the Commonwealth Code which indicates that governments should not limit or hinder the freedom of individuals to choose where they wish to live and work.

Other issues concern the initial assessment processes used for deciding whether overseas trained doctors are suitable to practise in Australia, and the training and support arrangements for overseas trained doctors who do take up practice in Australia.

State and Territory Medical Registration Boards have the responsibility for ensuring that overseas trained doctors who enter Australia meet appropriate quality standards before being allowed to practice here. It is important to have in place a registration process for overseas trained doctors that is robust, transparent and consistent.

There are currently differences between the assessment arrangements used by the Boards. Some Boards include structured clinical assessments as well as paper based assessments (eg certificate of good standing and referee reports). Others have relied on the interviews and assessments made by the prospective employer, particularly in the case of hospital medical officers.

The State and Territory medical boards have acknowledged the need to work towards a nationally consistent approach and some progress has been made in this regard through, for example, the introduction of a national, standard English language requirement.

Adequate continuing training and support arrangements need to be in place for overseas trained doctors to help them integrate into the Australian medical workforce, especially given the large number working in rural and remote areas without the support structures available in major cities. The Australian Government is addressing a number of these requirements through the Strengthening Medicare arrangements. For example, it is

- Funding upskilling positions in public hospitals for overseas trained specialists seeking Fellowship of the relevant specialist colleges;
- Providing funding to assist doctors on the Five Year Overseas Trained Doctor Program and the Rural Locum Relief Program to obtain Fellowship of the Royal Australian College of General Practitioners; and
- Funding the Queensland Centre for International Medical Graduates to develop and maintain a national online cultural orientation program.

International competition for doctors (and other health professionals) is intensifying. For example, the British Government has adopted a number of strategies to attract

physicians from abroad, including global and targeted recruitment campaigns and special arrangements that foster international cooperation and shared learning between health systems. Currently, the British Department of Health has specific international recruitment agreements with Spain, Germany, India, Austria and Italy. It has also implemented programs such as the "Golden Hello" scheme which provides grant funding to general practitioners who are newly appointed to the National Health Service. Medical recruitment advertisements from Britain regularly appear in the Australian medical press.

The future number of overseas trained doctors and other health professionals that can be attracted to Australia depends on Australia remaining an attractive destination for health professionals from other countries, and on their acceptance by the Australian community. More successful competition from other countries and/or a negative attitude towards overseas health professionals in this country could result in a significant decline in the intake which has become important to maintaining the medical workforce, particularly in areas of workforce shortage, in recent years.

### 3.3 Other Policies to Increase Health Workforce Capacity

An increased emphasis will need to put on other policy tools for increasing health workforce capacity to effectively meet Australia's future requirements for health services. Areas which need further examination are improvements to workforce flexibility; changes to the regulatory arrangements for the health workforces; increases in the participation rates for the health workforces; improved service delivery arrangements; and better use of information technology.

- Health Workforce Flexibility

In order to help meet the increasing demand for health services in the future and avoid a worsening maldistribution of the workforce, health care workers will need to be enabled and encouraged to work at a level that fully utilises their training, competency and experience. As noted by the OECD<sup>41</sup>, this process can, over time, produce improvements in the efficiency of the health workforce by more closely aligning tasks with training and experience and by ensuring that resources are deployed to their best advantage.

For example, there is a number of primary care health services carried out by GPs which could be carried out by other qualified health professionals, hence freeing up GPs to focus on more complex clinical tasks. These include the protocol based management of many chronic diseases such as hypertension and lipid disease, as well as relatively straight forward procedures such as pap smears, injections and simple suturing.

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<sup>41</sup>OECD (2004) The OECD Health Project: Towards High Performing Health Systems, OECD, Paris

The Australian Government has already taken some steps to supplement the provision of primary care services provided by GPs with those of other health professionals. For example:

- Funding is available to general practices to employ practice nurses and Allied Health Workers in urban areas of workforce shortage to provide primary care services.;
- MBS rebates are available for certain services provided by a practice nurse on behalf of a GP. Immunisation and wound management services, and Pap smears in rural areas, are covered by MBS items;
- As part of Enhanced Primary Care (EPC) multidisciplinary care, patients with chronic conditions and complex needs who are being managed under a multidisciplinary care plan by their GP have been eligible for Medicare rebates for up to five allied health services from a range of allied health providers and three dental services per year on the MBS. The EPC care planning items have recently been replaced by broader arrangements for Chronic Disease Management, with access to allied health and dental services being available for patients requiring multidisciplinary, team-based care under these arrangements;
- The More Allied Health Services (MAHS) Program provides funding to Divisions of General Practice to purchase a range of additional allied health services in rural areas; and
- The Better Outcomes in Mental Health Care initiative provides funding to allow GPs to refer patients with mental health problems to allied health professionals such as psychologists and social workers.

Further detail on these measures is in Attachment C.

In Australia to date, GPs have retained a large degree of control over allocating Government funding for primary care services provided by nurses and allied health professionals. For example, MBS services accessed by practice nurses are performed “for and on behalf” of a GP whose patients claim for them. Practice nurses cannot prescribe or refer patients to specialists. Similarly, MBS items claimed by allied health workers are for services identified in a multidisciplinary care plan approved by GPs for patients with chronic conditions and complex care needs; and the Better Outcomes in Mental Health Care and More Allied Health Services funding is allocated through the local Division of General Practice.

This has considerably boosted GP support for these initiatives. It has also assisted in promoting a more team-oriented approach to providing primary medical services in areas where GP services are available. Where GP services are not available, such as in some rural and remote locations, including Indigenous communities, this model is not as effective.

Developing the Aboriginal and Torres Strait Islander Health Worker role is another example of progress in developing a new health workforce role which provides a

close fit between the healthcare needs of the population being serviced and the clinical competencies and other skills of the workforce providing them.

The Australian Government has contributed to the role of the Aboriginal and Torres Strait Islander Health Worker as a recognised, trained health professional to meet the needs of the Aboriginal and Torres Strait Islander peoples in a range of settings. Aboriginal Health Workers operate within existing health services (varying from remote settings that do not have a resident doctor to large urban medical services) alongside other health professionals or as outposted officers.

There are about 850 Aboriginal and Torres Strait Islander Health Workers Australia wide delivering a range of primary health care services. Roles such as health screening, wound management, chronic disease management, immunisation, rehabilitation and prescription of basic medications can be provided by Aboriginal and Torres Strait Islander Health Workers who have adequate training and support. Importantly, Aboriginal and Torres Strait Islander Health Workers typically live in their communities and are well placed to understand local health needs.

Consideration is currently being given to extending the MBS items for immunisation and wound management services provided by a practice nurse, to registered Aboriginal Health Workers in the Northern Territory. This could potentially also be extended to Aboriginal Health Workers in other parts of Australia if registration for this group is introduced in those States and/ or the ACT.

As discussed earlier in this paper (see pages 18-20), a number of overseas jurisdictions have developed new health workforce roles to improve the overall capacity and efficiency of their health workforces. Against this background there appears to be scope to build on initiatives of the kind outlined above. For example:

- Allied health professionals such as dieticians, diabetes educators, podiatrists, psychologists and physiotherapists can provide a number of primary care services currently being met to a lesser or greater extent by GPs.
- Nurse practitioners could provide a number of clinical services currently met by others. Legislation in most States and Territories allows nurse practitioners to undertake clinical functions outside the traditional scope of nursing. While these functions vary across jurisdictions they can include prescribing medications; ordering diagnostic imaging and pathology tests; and providing referrals to specialists. However, to date, use of nurse practitioners has been low. They would appear to be well suited to areas experiencing particular difficulties in obtaining medical professionals such as aged care facilities and some rural and remote locations. A trial of the use of nurse practitioners in aged care facilities is currently being conducted in the ACT (see page 48).
- The mid level clinical care role, performed by physician assistants in the USA and elsewhere, could be developed in Australia. Physician assistants, working under the supervision of a medical practitioner, could be suited to working in a range of areas in both the primary care and acute care sectors.

- The Medical Assistant role is well developed in the primary care area in the USA and some other overseas countries. Medical Assistants undertaking a mix of administrative and clinical support roles (for example sterilisation, cold chain monitoring and basic patient care) could provide a flexible resource for use in primary practice. The Brisbane North Division of General Practice has recently obtained accreditation for a course in medical assisting in Queensland, which began this year through Southbank TAFE in Brisbane. The Community Services and Health Industry Skills Council is currently examining national accreditation for this course.

In further developing arrangements that encourage health professionals to fully utilise their training, competencies and experience, a number of issues need to be considered. These include the regulatory arrangements, education and training systems and remuneration systems that support them.

- Regulatory Arrangements for the Health Workforce

A focus of AHMAC's initial submission to the Productivity Commission was on regulatory changes needed to improve health workforce efficiency. These include: their complexity; emphasis on individual occupations rather than competencies; and limited opportunities for market forces to affect outcomes (see pages 5-6 of initial AHMAC submission<sup>42</sup>).

The separate, complex and profession-based regulatory provisions currently operating State –by State adversely affect health workforce capacity. A nationally consistent approach to regulatory arrangements for health care professionals which is centred on individual competencies would encourage portability, workforce flexibility and help address workforce distribution issues. Agreement has recently been reached on introducing nationally consistent arrangements for the medical profession, but not for any of the other major health professions.

- Workforce Participation Issues

Workforce participation issues include the decrease in average working hours among doctors, the apparent lack of attractiveness of some medical specialties, and retention rates for nurses.

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<sup>42</sup> Australian Health Ministers Advisory Council (2005) Australian Health Workforce System Productivity Commission Study: Initial AHMAC Submission



➤ Hours Medical Professionals Work

*Twenty eight hospitals (out of thirty-four) identified that newer generations of doctors differed from previous ones in their emphasis on family and lifestyle issues, and that this affected recruitment and retention. Many newer trainees and resident medical staff were less willing to work the long hours of their predecessors and to accept unpaid overtime. The increasing number of female medical graduates is one factor which had prompted increasing demand for part-time work and traineeships and the ability to move in and out of the workforce easily. The option to work fewer hours was more available to urban than rural doctors, further disadvantaging rural areas in their recruitment efforts. Lifestyle factors and working hours were also seen as influencing choice of training programs leading to shortages in some areas. The Safe Working Hours initiative has also led to reduced working hours and requires hospitals to employ more staff to cover the same amount of work.*

*AMWAC Report on the Public Hospital Medical Workforce Page 47*

The experience of the public hospitals quoted above is typical of the medical profession generally. Average working hours have declined significantly in most segments of the medical workforce but particularly among younger doctors, female doctors and doctors nearing retirement. This has largely offset the net additions to the workforce over the last few years.

National average doctors' hours are now comparable with other professional groups but there is a very wide distribution, with male doctors in the 45 to 55 age bracket working around 50 hours per week while female doctors aged 35 to 45 work around 35 hours per week. Overall, male doctors work about 10 to 15 hours a week longer than female doctors<sup>43</sup>.

In the future, as an increasing proportion of the medical workforce comes within the female part-time category this will affect workforce planning, distribution and the type of medical practice undertaken. If tomorrow's graduate intends to work about 75% of the hours of his or her predecessor, workforce planning must take this into account.

Younger doctors, especially GPs, are also less likely to want to own a practice than their predecessors. This is giving rise to increasing numbers of group practices and a decline in solo GP arrangements. It is much easier for group practices to accommodate part-time work, leave, training programs, employ practice nurses etc and they benefit from lower costs due to economies of scale.

<sup>43</sup> Australian Institute of Health and Welfare (2004) Medical Labour force 2002, AIHW Cat.no.HWL 30. Canberra

The increased focus on urban part-time practice has, as noted by AMWAC<sup>44</sup>, had a particular effect on outer urban and rural and remote regions, leaving the doctors in those areas often more stressed, working long hours and, in the outer urban areas, with a high level of patient throughput.

The factors underpinning the fall in hours worked for medical practitioners appear in large part to reflect decisions by younger doctors about work-life balance that are unlikely to change significantly, combined with the increasing female participation in the medical workforce and the safe hours campaign in hospitals.

It has been suggested that one factor which may have contributed to reductions in hours worked for some GPs in recent years is remuneration levels. While GPs are not prevented from privately billing under Medicare, many GPs rely on the Medicare rebate as a major source of income. For example, for the March quarter of 2005, 90% of income derived from GP consultations was through the MBS benefits paid by the Australian Government<sup>45</sup>.

In recent years GPs who relied solely or heavily on bulk billing, and especially those who did not have the benefit of the economies of scale of a 4 or 5 doctor practice, have argued that their costs have been rising and their income has been falling relative to other professionals groups.

It is not clear that this contributed to reduced working hours. On the one hand remuneration growth which falls short of expectations can lead to reduced GP consultation hours because the remuneration received for each hour of work is less than anticipated and the opportunity cost of not working is similarly reduced. On the other hand it can lead to increased hours of work for those seeking to maintain a target level of income and who do not have alternative income generating employment opportunities.

Importantly, the bulk billing (and other) incentives recently introduced by the Government have significantly increased Medicare payments for GP-services. These measures are outlined at Attachment D.

#### ➤ Level of Attractiveness of Some Medical Specialties

Some consultation-based medical specialties have trainee supply problems at present. These include geriatric medicine, rehabilitation medicine, psychiatry and renal medicine. The apparent relative lack of attractiveness of these specialties has been linked, in part, to the current MBS structure.

The MBS forms the basis of patient reimbursement for all medical services and (indirectly) provides the great bulk of doctor's gross incomes. Changing medical technology and treatment regimes have meant that the relative weight or values given by the MBS to the various procedures in consultations no longer, in some instances, appropriately reflects current clinical practice. It is acknowledged that this is a

<sup>44</sup> Australian Medical Workforce Advisory Committee, *The General Practice Workforce in Australia: Supply and Requirements 2003-2013*, yet to be published

<sup>45</sup> Primary Care Division, Department of Health and Ageing, 2005

disincentive in attracting medical graduates to some consultation-based specialties, and that this reduces the overall efficiency and effectiveness of the distribution of the medical workforce.

The Department of Health and Ageing is reviewing the payment methodologies used under the MBS and is obtaining information from a range of sources, with a view to better aligning these with contemporary clinical practice.

➤ **Nursing Retention Rates**

A number of nurses who have obtained registration or enrolled nurse qualifications no longer practice nursing. About 10% of currently registered or enrolled nurses are not actually employed in the nursing workforce and it is estimated that there are almost as many formerly registered or enrolled nurses as there are nurses in the current workforce<sup>46</sup>.

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

A recent report on nursing, the National Review of Nursing Education, which was jointly commissioned by the Minister for Health and Ageing and the Minister for Education, Science and Training, highlighted the importance of better addressing job satisfaction issues<sup>47</sup>.

These are matters which need to be addressed by nursing employers, such as the public hospital sector and aged care providers.

➤ **Improvements to Service Delivery**

Another way of enhancing outcomes with the existing health workforce is by improving service delivery.

For example, there is currently considerable interest among a range of stakeholders in exploring integrated primary care models which might involve greater co-location of GPs with state funded primary care providers, as well as use of common systems and shared infrastructure. Linkages and co-location with acute care services in, say, a broader, integrated primary care service hub is possible or along the lines of existing GP/Emergency Department after hours clinics (see also pages 49-51). Such models provide scope for triaging patients to ensure that existing workforce capacity is used more efficiently.

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<sup>46</sup> Community Services and Health Industry Skills Council (2005), *Industry Skills Report, Community Services and Health*, May 2005, <http://www.cshisc.com.au/docs/upload/CSHIndustrySkillsReport-FINAL160505.pdf>

<sup>47</sup> National Review of Nursing Education (2002) *Our Duty of Care*, Australian Government, Canberra

The availability of better infrastructure, administrative and professional support, including GP and practice networks, could aid recruitment and retention as well as provide an environment conducive to new, innovative, team-based approaches. In developing any such models it will be important to ensure consultation with existing GP services and that they are set up in a way that complements rather than competes with existing services.

Issues that require further consideration include governance arrangements, information management including privacy and consent arrangements, professional role delineation and infrastructure and capital environments.

➤ Better Use of Information Technology

Well-deployed information technology provides opportunities to improve the management of healthcare delivery and make better use of existing health workforce resources.

The last ten years have seen a rapid growth of information technology systems in the health care setting. The role of information technology in day-to-day clinical practice is becoming increasingly important for accessing and communicating health-related information in an efficient manner.

Major investments in information management infrastructure in the health sector have included:

- over the years from 1999-00 to 2003-04, the Australian Government has invested \$441.6 million in the Information Management/Information Technology element of the Practice Incentives Program (PIP) to assist with the computerisation of general practice. As at May 2005, 93% of PIP practices were using bona fide electronic prescribing software to generate the majority of prescriptions and 92% of PIP practices used a computer/s connected to a modem to send and/or receive clinical data;
- over the financial years 2001-02 to 2007-08, \$170 million will be invested in *HealthConnect*, the national electronic health record initiative; and
- the \$35 million three year Broadband for Health Program announced by the Minister for Health and Ageing in July 2004 will support the uptake of business grade broadband services for general practices and Aboriginal Community Controlled Health Services (ACCHS). In February 2005, a further \$14.5 million was announced to support broadband uptake for community pharmacies.

An important element in realising the benefits of health information management and information technology in terms of improving patient outcomes and health workforce efficiency is to ensure the health workforce has adequate information and training in the practical applications of information technology across the continuum – from basic computer and information technology skills to specialist clinical information use and information management expertise. In addition, there will need to be a framework which encourages health professionals to effectively utilise this new technology.

### 3.4 Workforce Distribution Policies

This section of the paper focuses on policies to address health workforce distribution/shortage issues in rural and remote areas; Indigenous health; outer metropolitan areas of the major capital cities; aged care; and after hours care.

- **Rural and Remote Areas**

The Australian Government has introduced a range of mechanisms designed to improve health workforce distribution in rural and remote areas. These are discussed below, and set out in more detail at Attachment E. While some initiatives have taken effect immediately, others have longer lead times and will take some years to fully realise the benefits.

- **Regulation**

The regulatory mechanism used by the Australian Government to improve workforce distribution in rural and remote areas is the restrictions placed on overseas trained doctors who enter Australia to practice either as temporary or permanent residents. These doctors are required to practise in districts of workforce shortage in order to obtain access to the MBS, generally for a minimum of ten years in the case of permanent residents, and indefinitely for temporary residents. Eligible districts of workforce shortage have been largely focussed in rural and remote areas.

This policy has been effective. For example, in remote areas of Australia, overseas trained doctors with restricted Medicare provider number approvals now account for more than 30% of the general practice workforce. On 30 June 2005, there were a total of 2,557 overseas trained doctors Australia-wide with restricted access to Medicare approvals, allowing them to work in areas of workforce shortage. This total represented a 26% increase over the previous 12 months. This figure includes both specialists and GPs, and 1,713 (66%) of these had approvals to work in rural and remote areas (RRMA 3-7)<sup>48</sup>.

The States and Territories also apply regulatory restrictions on overseas trained doctors aimed at directing them to areas of workforce shortages in their public hospitals and elsewhere. These operate through Area of Need approvals required as part of the medical registration process. Overall, more than one third of all doctors (specialists, general medical positions, interns and vocational trainees) working in public hospitals in the rural and remote areas of Australia are overseas trained doctors, compared to 11% in the capital cities.

It is clear that, without the presence of overseas trained doctors who are required to work in rural and remote areas of need, the national doctor distribution would be more uneven, with higher unmet demand in rural areas.

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<sup>48</sup> Health Services Improvement Division, Department of Health and Ageing, 2005

➤ Financial Incentives

The Australian Government also offers a range of financial incentives to encourage doctors to provide services in rural and remote areas. In particular, general practitioners in rural and remote regions are able to access a number of payments in addition to their usual fee for service income.

Key measures include:

- Rural retention payments of up to \$25,000 per year, currently paid to more than 2000 long serving general practitioners in rural and remote Australia. Over the period 1990-2000 to 2003-04 \$73.8 million was spent on retention payments.
- The Practice Incentives Program (PIP) provides a weighted rural loading payment for practices in more remote areas in recognition of the difficulties of providing care, often with little professional support, in small country towns or isolated communities. In 2004-05, \$23 million was paid in rural loading payments, with rural GPs receiving on average \$27,000 per annum in loading payments.
- A procedural incentive payment of up to \$5,000 per GP per annum is available through PIP in recognition that rural GPs are often required to deliver a range of services such as obstetrics, surgery and anaesthetics, which are more typically the province of a specific referral based specialty and \$15,000 per annum is available to cover their training, upskilling and skill maintenance costs. Funding of \$10 million over 4 years is available for the procedural incentive payment while funding of \$75 million over 4 years is available for the training program.
- Additional financial assistance to rural procedural general practitioners to cover the medical indemnity insurance costs.
- Payments through PIP of up to \$40,000 per annum for rural general practices to employ practice nurses.
- Varying the level of bulk-billing incentives offered, with higher incentives offered to practices in rural and remote areas.
- A range of other targeted recruitment and retention incentives provided through Rural Workforce Agencies. Funding of \$16 million was provided to Rural Workforce Agencies in 2004-05 to support these activities.

From 2005-06, funding of up to \$200,000 is being made available to assist small rural councils to establish 'walk in/ walk out' community medical facilities, to make it easier to recruit and retain general practitioners. Funding of \$15 million over three years has been provided for under this program.

The regulatory policies for overseas trained doctors and these financial assistance strategies have together assisted in achieving an improvement in the distribution of GPs over time. For example, over the period 1995-96 to 2003-04 rural general practitioner numbers increased by 21.1% in full time equivalent (FTE) terms, including a 10.6% increase over the last 3 years. This compares with an increase in FTE numbers for urban GPs of around 0.5% over the same period<sup>49</sup>. More detailed figures are provided in Attachment F.

However, given the perceived attraction of urban over rural practice, it is clear that significant and continued financial incentives will be needed to attract adequate numbers of doctors to rural and remote areas.

Some rural GPs and their organisations have been advocating rural and remote loadings within the MBS for some time as a means of recognising the costs associated with rural practice.

The Government is aware of the additional pressures faced by rural general practices and recognises the difficulty in providing care, often with little professional support, in small country towns or isolated communities. While it has introduced a number of measures to supplement remuneration and income for rural GPs, it has preferred mechanisms outside the MBS specifically targeted at promoting government objectives around recruitment and retention and access, affordability and quality for consumers. The approach has been to complement Medicare with a range of support programs that will assist rural GPs to make best use of Medicare.

On the face of it, paying higher rebates in locations of workforce shortage would appear to be an administratively efficient way of supporting better recruitment and retention in such areas.

However, as indicated above, alternative approaches seeking to pursue the same result through more targeted programs appear to be working effectively with considerable success in increasing the number of GPs practising in rural areas.

The differential rebates model may be relatively blunt as a mechanism to achieve the same objectives. Rurality is at best only a proxy for issues that place pressure on recruitment and retention. It may be less effective and efficient to spread available funds across a large segment of the rural and remote GP workforce rather than target funding at particular areas, groups of doctors and specific issues where intervention will have most effect.

The differential rebates model also does not sit well with the general approach to setting Medicare rebates – with a few exceptions, these are largely based on the complexity of the service and not the location in which they are provided. This approach recognises the additional complexity of procedural work which tends to be important to rural and remote GPs.

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<sup>49</sup> Primary Care Division, Department of Health and Ageing, 2004

The use of a differential rebate would still link additional payments to volume of services across rural and remote areas. Service volumes vary significantly and therefore the level of assistance for higher subsidies would vary substantially. In these circumstances direct assistance is more beneficial. As indicated above, this assistance is considerable.

➤ Education and Training

The Australian Government has also made considerable use of education and training initiatives to promote the improved distribution of the medical workforce in rural and remote areas over the medium to longer term. These strategies comprise:

- Supporting students from rural backgrounds to study health disciplines, on the basis that these students are much more likely than students from urban backgrounds to work in rural areas on completion of their studies. For example, the Rural Undergraduate Support and Coordination (RUSC) Program provides funding to medical schools to increase the proportion of students from rural backgrounds to at least 25% of total students enrolled; and the Rural Australian Medical Undergraduate Scholarship Scheme provides 500 scholarships worth \$10,000 per annum to medical students from rural backgrounds. The value of the scholarships provided since the scheme began in 2000 is \$30 million. Similarly, in the nursing area, a range of undergraduate, post graduate and continuing education scholarships are available to students from rural areas/ nurses working in rural areas.
- Establishing undergraduate higher education training infrastructure in rural areas on the basis that students who undertake significant training in rural areas are more likely to take up employment in these areas (in addition the additional health infrastructure enables more health services to be provided in rural areas). A network of ten rural clinical schools has now been established across Australia and this is soon to be expanded into the Northern Territory with significant numbers of medical students now undertaking half of their clinical training at one of these locations. Funding of over \$244 million will be provided under this initiative over the period 2001-02 to 2007-08. Similarly, a network of 10 University Departments of Rural Health across Australia provides opportunities for a range of students from health disciplines, including, nursing, dentistry, pharmacy, physiotherapy, podiatry and occupational therapy to undertake clinical placements in rural areas. Since 1996-97 over \$94 million dollars in recurrent funding has been provided under this program.
- A separate Rural Pathway has been established for medical graduates interested in a career in rural general practice, with trainees choosing this pathway undertaking the majority of their training in rural and remote areas.
- Bonding of medical students through the Medical Rural Bonded Scholarship Scheme (MRBSS) and the Bonded Medical Places (BMP) Scheme. Under these schemes, from 2004, around 20 per cent of commencing medical school



students are bonded to work in rural, regional or outer metropolitan areas of workforce shortage for a minimum of 6 years on completion of their training.

It is too early to make any judgements on the overall success of these education and training initiatives because of the time lags involved in medicine between starting and completing their studies. For example, the first group of students operating under the Government's Medical Rural Bonded Scholarship Scheme will not be fully qualified until 2008 at the earliest and will not complete their bonding requirement until 2014.

However, the measures, taken together, have the potential to further improve the distribution of the health workforce over time.

Unlike undergraduate medical training and training for General Practice, vocational training for medical specialists is still focussed in major public teaching hospitals located in inner metropolitan areas of the major capital cities. Providing more of this training in regional hospitals would reinforce the rural education and training strategies outlined above.

#### ➤ Alternative Service Delivery Models

A number of rural and remote areas do not have the general population base, or ready access to the full range of health professionals, to support mainstream service delivery mechanisms. In these circumstances alternative service delivery arrangements are another means for maintaining and improving access to health professionals and services.

Alternative delivery mechanisms in rural areas funded in whole, or in part, by the Australian Government include Aboriginal community controlled health services; the Medical Specialists Outreach Assistance Program; the Multipurpose Services Program; the Regional Health Services Program; and telehealth initiatives:

- Aboriginal community controlled health services are autonomous organisations that are governed by bodies elected by the local Aboriginal and Torres Strait Islander communities to deliver primary health care services. They provide comprehensive primary health care for Aboriginal and Torres Strait Islander people, encompassing clinical/medical care, illness prevention services, population health programs, access to secondary and tertiary health services and client/community support and advocacy. These services are provided by a variety of staff and may include Aboriginal and Torres Strait Islander Health Workers, nurses, doctors, allied health workers, and emotional and social well-being workers. Funding of over \$850 million was been provided to these services (including those located in metropolitan areas) between 2000-01 and 2004-05.
- Areas with population catchments of less than 10,000 are considered too small to sustain any resident medical specialist services. The Medical Specialists Outreach Assistance Program (MSOAP) provides a range of medical specialist outreach visiting services to rural and remote areas like this, or with limited specialist services. Support is offered to medical specialists to address some of the financial disincentives faced when

providing outreach services. There are currently over 1000 services operating across Australia. Specialists such as general surgeons, dermatologists, cardiologists, psychiatrists, paediatricians and ear, nose and throat surgeons provide outreach services under the Program. MSOAP was allocated \$48.5 million in funding over the period 2000-2004.

- The Multipurpose Services (MPS) Program is designed around a model of health service delivery where the health services in a rural community come together under one management structure. The MPS Program receives Australian Government funding for flexible aged care places and State/Territory Government funding for a range of health services, and the MPS is able to move funding between these services based on the requirements of the population serviced. There are currently 92 operational MPS nationally.

#### **Case study: MPS for Walwa, Victoria**

Walwa is a small country town near the NSW border in the Victorian Alps. In late 2002, the town's private nursing hospital was facing closure. The service was reduced to four private hospital beds and was unable to secure enough income to cover its costs.

A solution was developed in conjunction with Upper Murray Health and Community Services (UMHCS), a MultiPurpose Service (MPS) located at Corryong, thirty minutes drive from Walwa. When the hospital beds closed, care for the remaining residents was provided through UMHCS. Because MPS funding can be used flexibly across community care, residential care and health services, Walwa hospital was then able to reach agreement with UMHCS to sub-contract delivery of a wide range of services to meet the continuing needs of the Walwa community.

The services delivered under this arrangement include community transport, district nursing, palliative care, adult day activity, meals on wheels, homecare, support for socially isolated people, personal care and support with community access. These are services which were not formerly available to this community. Services are arranged and delivered locally through the former hospital infrastructure, under the guidance of a local committee, which reports on services and expenditure to UMHCS.

- The Regional Health Services (RHS) provided funding in 2004-05 for the delivery of primary health services to more than 1000 rural communities. The program supports community identified primary health care priorities relating to the prevention and treatment of illness in small and rural remote towns of less than 5000 population. It provides access to community nurses and allied health professionals but not to doctors. The funding is channelled through a range of organisations including State and Territory health departments, rural Divisions of General Practice and not-for-profit non-government organisations located in the areas concerned. Funding of over \$144 million has been provided under this program between 2001-02 and 2004-05.

**Case study: RHS Primary Health Care Nurse Project**

The Riverina Division of General Practice in NSW guides and runs this service. The aim is to help a number of small communities (Ungarie, Tallimba, Weethalle, Barmedman, Ardlethan, Ganmain, Aria Park, Stockinbingal, Talbingo, Tarcutta, Brungle, Humula and Rosewood) improve their access to primary health care services.

Registered nurses each work with a cluster of 4-5 communities. The nurses provide primary health care nursing support and assessments at outreach clinics, running chronic disease management programs, targeting diabetes, arthritis, asthma, cancer and cardiovascular disease; and health promotion and education.

- Telehealth initiatives can also support the provision of health services in rural and remote areas. Funding is provided under the MBS for telepsychiatry (which allows access to a psychiatrist via a video link) and teleradiology (which allows the electronic transmission of radiological images, such as x-rays and MRIs, from one location to another for the purposes of interpretation and/or consultation). Additionally, there are also MBS items for case conferencing, which may occur through telephone or video link or a combination of these.

There is potential to further use and improve alternative service delivery arrangements in rural areas, over time, to make more efficient use of the available health workforce capacity and enhance health services to rural and remote communities.

- **Workforce Shortages in Indigenous Health**

The Aboriginal and Torres Strait Islander population has significant burden of disease, with high rates of chronic and infectious diseases, compared to other Australians. Increasing the capacity of the workforce in Indigenous health is an essential part of improving health outcomes for Aboriginal and Torres Strait Islander people.

Recent statistics indicate that only 0.5% of the total health workforce was working in Australian Government funded Aboriginal and Torres Strait Islander Health primary health care services. There were 166 vacant full time equivalent positions in these services that were vacant for a total of 3136 weeks. Of this, 16 doctor positions were vacant for an average of 27 weeks, 34 nurses positions vacant for an average of 12 weeks and 36 Aboriginal and Torres Strait Islander Workers positions vacant for an average of 23 weeks. The average length of time a position was vacant was 19 weeks.

There has been considerable work undertaken specifically addressing parts of the workforce in Indigenous health, and access by Australian Government funded Aboriginal and Torres Strait Islander primary health care services to the range of programs dealing with workforce shortage and distribution, but there is still considerably more to be done in areas such as education and training and the recruitment and retention of health professionals.

➤ Increasing the Indigenous health workforce:

According to ABS data, the main occupations for Indigenous Australians in the health sector are: nursing (1,114), personal care and nursing assistance (800) and Aboriginal and Torres Strait Islander Health Workers (853). Data on Indigenous Australian doctors shows that there are 76 medical graduates with 102 medical students studying<sup>50</sup>.

Aboriginal and Torres Strait Islander people represent 2.4% of the Australian population, but only 1.2% of all health students<sup>51</sup>. Aboriginal and Torres Strait Islander students are under-represented in most fields of health education, particularly Pharmacy, Dental Studies, Optical Science, Radiography and Public Health.

Appropriate marketing strategies for recruiting Indigenous Australians to health science courses are needed. This requires developing career pathways and engagement with secondary schools, the VET sector, health services and Indigenous communities. There is also a need to promote role models in the Indigenous community in health. Further pressure could be brought to bear on universities to increase the intake of Indigenous students and modify the environment to retain Indigenous students.

The recruitment of Aboriginal and Torres Strait Islander students into health sciences is problematic not only in terms of education levels but also the environment in which learning and support is provided. A culturally safe environment for Aboriginal and Torres Strait Islander students needs to be established.

There is a need to revisit the current “special entry” provisions used by many universities. Indigenous Australians frequently do not meet the entry requirements for many health science courses. As a result, special entry processes often relax the entry requirements, but fail to adequately prepare an applicant who does not possess the pre-requisite skills or knowledge. Early intervention is needed, particularly to prevent attrition and failure, and to help undergraduates continue along a pathway towards a career in health. In the longer term, through programs that target primary and secondary school students, there should be increasing numbers of Indigenous students who meet the entry requirements for many health science courses.

There is also a need to strengthen partnerships between universities and Indigenous Australians at the local level. A good example of this is the Sydney University Bachelor of Nursing (Indigenous Australian Health) course that was designed in consultation with the local Aboriginal community. It is a four year multidisciplinary course including Indigenous Australian history, society, community development and law subjects as well as nursing. In 2003 50% of students were Indigenous Australians.

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<sup>50</sup> Unpublished, Australian Indigenous Doctors Association, Best Practice, 2005.

<sup>51</sup> Australian Bureau of Statistics 2003

➤ Increasing the capacity of the general health workforce to work in Indigenous health

Implementing strategies to provide all health professionals with appropriate education about Indigenous health issues and health care can also improve Indigenous health. While recruiting Indigenous Australian health professionals is a high priority, the high demand for skilled professionals with a knowledge and understanding of Indigenous health needs cannot be met by an Indigenous Australian health workforce alone. Therefore, it is important that students in the health sciences are adequately prepared for working with Indigenous Australians and communities, and that some are encouraged to work in Indigenous health for at least a part of their careers.

The Committee of Deans of Medical Schools Indigenous Health Framework has been a watershed in curriculum development. The Australian Nursing and Midwifery Council have also endorsed Indigenous curricula in all nursing courses and all nurses who teach nursing courses have to undergo cultural awareness training. Some allied health courses have included Indigenous health in their curriculum but considerable work is required to establish a curriculum framework for allied health.

Overall, further work in vertical integration between undergraduate, post-graduate and college training is important to get improved results for Indigenous Australians and non-Indigenous medical graduates.

➤ Recruitment and Retention Issues

There is a need to improve the attraction of practice in Indigenous health, particularly in rural and remote areas.

Many practitioners believe that they will receive less remuneration and become professionally isolated as a consequence of moving to a rural and remote area to work with Indigenous people. When the practitioners move back to work in metropolitan areas they can also find it difficult to obtain the recognition for their expertise in Aboriginal health.

The industrial awards for health practitioners vary considerably from State to State, particularly for allied health practitioners. Some states, such as Queensland and Victoria, are moving to address the problem of fixed incentives and career structures in order to reward practitioners working in rural practice. They are providing greater access to career structures within their clinical specialities and to commensurate remuneration. Other jurisdictions need to consider these developments

Many rural practitioners are required to provide a teaching role. Recognition and support is important for these practitioners so that they are encouraged to improve their teaching skills and remain in rural practice. Academics who have worked in rural Indigenous health have a full understanding of the real issues and are able to provide practical solutions and support.

- Outer Metropolitan Areas

Another area of health workforce shortage that has developed in recent years is in the outer urban districts of the major capital cities. Often these are relatively new suburbs where housing is less expensive but which have less well developed public transport and infrastructure and relatively low socio-economic indicators.

Australian Government programs introduced in recent years to improve access to doctors in these areas have made progress. For example:

- The More Doctors for Outer Metropolitan Areas Program, introduced in 2003, provides financial incentives for doctors to relocate from better supplied inner metropolitan areas to outer metropolitan areas or to increase their hours of work in the latter areas; as well as training placements for GP registrars and specialist trainees in outer metropolitan locations. As at June 2005, 218 doctors had agreed to relocate to, or significantly increase their hours of work in, outer metropolitan areas under the program.
- As part of the Strengthening Medicare measures, the Australian Government provided \$139.1 million over four years to allow general practices, located in urban areas of workforce shortage, to employ practice nurses and/or allied health workers. By May 2005, there were around 574 urban practices participating in this initiative. This represents approximately 50% of eligible practices.
- Practices in outer metropolitan areas of workforce shortage are now able to employ overseas trained doctors who are subject to the Medicare provider number restrictions.

However, access to medical and other health services in outer metropolitan areas remains in most cases below that in inner urban areas.

- Aged Care

The aged care sector is an area of workforce pressure. The ability of the health workforce to adequately care for the needs of an ageing population that has a greater life expectancy and which will have increasingly chronic and complex care needs is an important issue.

Currently aged care services are provided either in the community setting to assist older people to live in their own homes or in residential aged care facilities when the aged can no longer be cared for at home. The increasing dependency and frailty of residents who move to aged care facilities will have implications for the composition and skills mix of that workforce.

The Pricing Review of Residential Aged Care<sup>52</sup> found that the shortage of trained nursing staff is greater in the residential aged care sector than in other areas of the

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<sup>52</sup> Hogan (2004) Pricing Review of Residential Aged Care,

health system. Even in geographic areas that are relatively well supplied with health professionals, aged care service providers can experience difficulties in recruiting health workers, particularly nurses, and in the case of residential aged care facilities accessing GP services. This can be partly attributed to the fact that aged care is generally viewed by health professionals as a less attractive area of employment, especially in the case of nursing where the remuneration is significantly lower than in the acute sector.

A National Aged Care Workforce Census and Survey<sup>53</sup> was conducted in 2004. The results of the survey indicate that residential aged care facilities were a major employer (116,000 direct care employees) of the health workforce. Over half (58%) of these employees were personal care workers, 21.5% were registered nurses and 13% enrolled nurses. There were also 9,000 allied health workers, mainly diversional and recreational therapists. The workforce is overwhelmingly female (94%), has an older age profile (particularly nurses) than other industries in Australia and is largely employed on a permanent part time basis (70%).

There are no data about the health workforce that delivers aged care services in the community. This has implications for developing possible models of aged care service delivery in the future, as the preference of the ageing population is to remain in their own homes for as long as possible. It is also current Australian Government policy to support this approach.

While aged care workforce issues are predominately the responsibility of aged care service providers, the Australian Government has supported the aged care workforce in varied ways. These include:

- Higher payments to providers to enable them to pay more competitive wages to improve the quality of care and maintain and attract qualified staff (\$877.8 million over 4 years).
- Aged care nursing scholarships which are aimed at encouraging more people to enter aged care nursing and increasing the skills of nurses working in the aged care sector, particularly in rural and regional Australia (\$26.3 million over four years).
- Funding for vocational training places for aged care workers, up to enrolled nurse level (\$55.7 million over 4 years).
- Training to Care for People with Dementia, including providing dementia specific training for up to 9,000 community care staff and residential care workers, and up to 7,000 extra carers and community workers, such as police and transport staff (\$25.0 million over 4 years).
- Aged Care GP Panels, which encourage partnerships between GPs, aged care homes, and the Divisions of General Practice.
- The introduction of a new MBS item for Comprehensive Medical Assessments (CMAs) for permanent residents of aged care homes. The new item involves a personal attendance by the resident's GP to undertake a full systems review, including an assessment of the resident's current health and physical and psychological function.

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<sup>53</sup> Richardson S and Martin B (2004) *The Care of Older Australians: A Picture of the Residential Aged Care Workforce*, National Institute of Labour Studies, Adelaide

- 1,700 new nursing places at universities that demonstrate their ability to meet aged care nursing education benchmarks (\$36 million over 4 years).
- Supporting the Aged Care Workforce Committee to develop the National Aged Care Workforce Strategy which identifies the workforce profile of the residential aged care sector and its needs until 2010.

Further information on these measures is contained at Attachment G.

The Pricing Review of Residential Aged Care examined the issues facing the residential aged care workforce, now and in the future. It found that the industry needed to adopt more innovative practices that offered employees better pay and working conditions, and improve the image of working in aged care. Currently, some employers are impeded in their ability to adjust workforce structures and practices to cope with the changing profile of consumers, by the regulatory barriers which hamper the effective use of the skills of the whole aged care workforce. For example there is no uniformity between States and Territories in their approaches to the administration of medications by enrolled nurses. In some instances the existing regulatory arrangements have encouraged situations where personal care workers, who are unlicensed, to take on new roles by default without professional support, clinical guidance, and in some instances, without appropriate training.

However, innovative models are being tested. A pilot is currently being conducted in the ACT of the use of nurse practitioners across a range of aged care health care settings, (the community care setting, an aged care facility and the acute hospital setting). The pilot is jointly funded by the Australian Government and the ACT Government and has been received positively.

Nurse practitioners have the potential to improve health outcomes for the aged (including for example reduced acute care admission rates, improvements in health related quality of life, and better management of challenging behaviours associated with dementia, etc), and to provide an enhanced career path for nurses working in aged care.

As the population ages the care needs of the elderly will change. Frail elderly people with chronic conditions will increasingly prefer to remain in the community, and residential aged care facilities will be home to those with serious complex chronic conditions that cause severe disability. This has implications for the training of the future health workforce. Currently education and training of health professionals is generally focussed on the acute sector. However, curricula for all health disciplines needs to be developed which include a component relating to caring for the aged in the community, particularly in disciplines such as physiotherapy, occupational therapy and medicine.

The aged care sector, both community and residential, is largely reliant on personal care workers, who have no professional representation, to provide basic health care to the elderly. It is important that this group of workers has in place the appropriate skills to perform their role, mechanisms in place to ensure competency, professional support and leadership, and training that has consistent standards and outcomes.



- Delivery of After Hours Primary Care Services

The Terms of Reference for the Productivity Commission Study requested, at paragraph 5, that it “provide advice on 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”.

The Commonwealth Fund Report (2004) highlighted that access to primary care at nights, or during weekends or holidays, was a significant concern for Australians<sup>54</sup>.

Workforce shortages, combined with issues of financial viability, are often reducing after hours services. Both general GP workforce shortages and younger GP expectations of shorter working hours, and reluctance to undertake after hours work, make after hours care an area of growing workforce pressure.

State and Territory governments are also attributing pressures in the Emergency Departments (ED) to the declining availability of after-hours GP services and have been seeking to establish GP after hours clinics in or near public hospital EDs as a means of dealing with these pressures. However, available evidence on this is inconclusive:

- Studies undertaken and cited by the Australasian College for Emergency Medicine suggest that just over 10% of ED patients are low acuity and could be treated by a GP<sup>55</sup>.
- While other reports suggest the proportion may be higher<sup>56</sup>, it is widely accepted that access to after hours GP services is not the major pressure on EDs: access blocks, overcrowding in wards and ambulance diversion are more important<sup>57</sup>.
- The Australian Government’s experience with after hours trials in the Hunter and co-located after hours clinics in Western Australia public hospitals suggests that these services have not significantly reduced pressures on EDs.
- While recent data suggests high growth in the number of patients presenting at emergency departments, well in excess of population growth, there is no evidence of any disproportionate increase in lower acuity patients.

The Australian Government has introduced a range of measures that target after hours care. These are summarised in Attachment H, and include the provision of funding to maintain existing after hours services, establishing new services and trialling different models of after hours care; the provision of higher Medicare rebates and Practice Incentive Payments for after hours care; and access to overseas trained doctors subject to Medicare provider number restrictions for after hours care.

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<sup>54</sup> Schoen et al. (2004) Primary care and health system performance: Adults’ experiences in five countries. Health Affairs, Web Exclusive, W4-487.

<sup>55</sup> The relationship between emergency department overcrowding and alternative after-hours services. Australasian College for Emergency Medicine, August 2004.

<sup>56</sup> Health Services Union Submission to the Senate Select Committee on Medicare, October 2003.

<sup>57</sup> The relationship between emergency department overcrowding and alternative after-hours services. Australasian College for Emergency Medicine

While there is some capacity for after hours services to be set up in or near hospitals with the support of these programs and MBS funding, the provision of State support in combination with MBS funding can in some cases have implications under subsection 19(2) of the *Health Insurance Act 1972*. This subsection of the Act aims to prevent double dipping in respect of professional services, by ensuring that services are not funded through Medicare when they are already funded through some other government mechanism.

The 2004-05 Budget Measure *GP Services – Improving After Hours*, provides for Medicare access through exemptions under this legislation for up to 10 after hours GP clinics set up with assistance from the States. Establishment grants of \$50,000 per clinic are also available. The aim of this initiative is to improve access to after hours GP services while also potentially reducing some pressure on EDs. To date, four clinics have been approved in Western Australia and two in Victoria, with discussions continuing on a possible three clinics in New South Wales and a clinic in Queensland.

A comprehensive strategy for improving access to after hours primary medical care needs to consider the diversity of service delivery models that operate and will continue to operate, reflecting local conditions and the preferences of local GPs and communities. Encouraging the most effective use of the available GP workforce is important, given both the lifestyle costs for the GPs associated with delivering services after hours and existing workforce shortages. An additional consideration in improving access to after hours services is the obvious tension between making it more attractive to GPs to provide services after hours and encouraging a shift of non urgent activity from within hours as a result of additional financial incentives and patient convenience.

After hours clinics in or near hospitals are just one of a number of after hours models being supported. Early evidence suggests that while these clinics can provide a practical model for after hours services, they are not having a significant impact on easing ED pressure. Depending on how they are established, there is also the potential for negative impacts on the existing GP after-hours workforce and it is therefore important they are set up in cooperation rather than competition with existing providers. Given that this model represents only one of a number of models currently being examined, the Department does not consider there to be a strong case for specific initiatives to encourage more co-located clinics at this time.

Models involving local GPs pooling their effort and working cooperatively through joint rostering arrangements appear to work very effectively, contributing to an areas capacity to recruit and retain GPs. Such models can enable GPs to reduce the amount of after hours services they need to provide, therefore reducing pressure and allowing them to better balance work and lifestyle issues. Co-operative arrangements along these lines can be particularly important for rural and remote areas. Opportunities for supporting such models are being provided under the current *Round the Clock Medicare* initiative. The potential for call centres to assist appropriate triaging, particularly of after hours care, is also significant.

In summary, substantial efforts are already being made in the area of after hours services. An external evaluation covering much of the existing after hours effort is

underway, expected to report by September 2005. More generally, the overall after-hours effort is still being implemented through the *Round the Clock Medicare* initiative. Given the current level of activity, it would appear premature to consider further after hours initiatives at this stage.

### 3.5 Health Workforce Quality Issues

The importance of education and training in terms of tackling overall health workforce supply and distribution problems are discussed earlier in this submission (see pages 26-27 and 40-41). This section focuses on issues around the quality of education and training, in particular for the medical workforce.

The structures which determine the shape of the education and training of the health workforce in the higher education sector are complex. Governments need to be confident that these structures are responding and adapting to changing community health service needs, changes in the health system framework and in health service delivery arrangements.

There are a number of issues associated with the current medical education and training structure.

Importantly, ways need to be found to better coordinate and integrate the three separate tiers for educating a doctor: undergraduate, pre-vocational training in a public hospital, and vocational training. Medical education is a continuum but, to date, each of these sectors has operated largely independent of the other resulting in a medical education system that is not integrated. This is recognised by all major stakeholders and moves are now beginning to address this problem.

Beyond this, the major education and training issues are:

- The fact that medical specialist training is focussed on large public teaching hospitals whereas, increasingly, clinical practice is occurring in private hospitals, private practice and other community based settings;
- How to more fully reflect the interdisciplinary care needs of our health system in medical education; and
- The need for a more robust framework for Continuing Professional Development (CPD) for doctors.

- Medical Specialist Training

Patterns of health services delivery have changed, with less emphasis on public hospital settings and trainee doctors need to be exposed to the broadest possible range of patient care issues.

- In 2001-02, 45% of all same day separations took place in private hospitals<sup>58</sup>.

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<sup>58</sup> Australian Institute of Health and Welfare (2003) Australian hospital statistics 2001-02. Health Services Series no. 20. AIHW cat. no. HSE-25. AIHW: Canberra.

- As a result, for example, orthopaedic surgery trainees lack exposure to common conditions such as foot problems or shoulder instability which are often not treated in the public sector.
- Similarly, the most prevalent psychiatric conditions of anxiety and depression are largely treated in private practice.

A new framework is being developed to address these training needs. In October 2003 the Australian Health Ministers' Advisory Council established the Medical Specialist Training Taskforce, which is being chaired by the Australian Government's Chief Medical Officer, Professor John Horvath, to explore opportunities for training to be undertaken in a more diverse range of settings. In November 2004, the Taskforce presented to AHMAC a new training model for medical specialists that incorporates networks of training settings across public hospitals, private hospitals, private practice, community and non-clinical settings. Under this model trainees will be able to move flexibly between these various settings in accordance with their clinical training needs, while maintaining a single employer.

Further work is currently being undertaken on the new model, at AHMAC's request, with a view to putting detailed proposals to the Council in the first half of 2006.

- Interdisciplinary Care Needs

Medical and professional groups, governments and training providers acknowledge that health services require a shift towards chronic disease management. As a corollary of this, multi-disciplinary and team based approaches have become more important.

The major cause of death in Australia has shifted from infectious disease to chronic disease. Chronic diseases presently make up more than 80% of Australia's overall disease burden due to death, disability and diminished quality of life<sup>59</sup>. Although acute medical problems and illnesses will always require medical attention, an education and training model that is focused on managing acute symptoms is insufficient to address the concerns of the growing population of patients with chronic conditions<sup>60</sup>.

Chronic disease management frequently requires close cooperation within the interdisciplinary team where treatment occurs: doctors, nurses, pharmacists and allied health professionals. These interdisciplinary requirements are not however, strongly reflected in the education of medical and other health professionals.

As well as treating chronic disease, the future medical and other health workforces will need skills in delivering interventions to address the major risk factors for chronic disease (smoking, poor nutrition, risky and high risk alcohol use and physical inactivity). In particular, as there are growing health care costs associated with

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<sup>59</sup> Australian Institute of Health and Welfare (2002) *Chronic Diseases and Associated Risk Factors in Australia*, 2001 Canberra AIHW

<sup>60</sup> World Health Organization (2005) *Preparing a health care workforce for the 21st century: the challenge of chronic conditions*. Geneva, Switzerland

increasing prevalence of obesity and the resultant impact on morbidity, mortality and chronic disease, further capacity needs to be developed in nutrition and physical activity. The chronic disease workforce will need to include people who are specifically equipped to address the major risk factors, such as dietitians and nutritionists. However, it will also need to include members of the broader health workforce such as general practitioners, who are often the first point of contact for consumers.

The Australian Government contributes towards addressing these issues through the Public Health Education and Research Program (PHERP). PHERP was introduced to increase training of public health personnel and research effort in public health issues. Phase Three of this \$55 million Program (2001-2005) provided funding for innovative capacity building projects to address high priority public health needs, including public health nutrition. There remains a need for further development of the public health workforce to ensure that there is a critical mass, especially in the important areas of nutrition and physical activity.

In this context, a new, expanded education and training model, based on a set of core competencies, could better prepare the health care workforce to care for patients with chronic conditions. The common competencies could be included in the education modules across a variety of professional groups.

- **Continuing Professional Development**

Medical technology and treatment regimes are being enhanced constantly and this means that medical education must be a continuum that is upgraded throughout a doctor's working life. This brings into focus the importance of the medical colleges requiring the maintenance of strong Continuing Professional Development programs for their members.

Work on this is areas is progressing but a number of the colleges do not mandate the maintenance of an adequate Continuing Professional Development Program as a condition of retaining Fellowship. In these circumstances, an alternative approach which could be considered is to make the maintenance of satisfactory Continuing Professional Development activities a condition of registration by the Medical Boards.

### 3.6 Future Directions in Health Workforce Planning

As discussed earlier in this submission (pages 15-16), health workforce planning in Australia has been enhanced since the mid 1990s.

However, health workforce planning will remain challenging because of the inherent difficulty of forecasting demand for and supply of particular health services in the future and the lack of agreed benchmarks about the desired level and composition of health services for the community. In regard to the latter, when a workforce shortage occurs in a community (eg long waiting times and unavailability of services) this

indicates that demand is exceeding supply but not how many health care workers that community “needs” in order to maintain a good health status. Conversely, a community may have a quantum of health services well above the national average and no signs of shortages, but this does not necessarily provide a basis for arguing that it has more services than it “needs”.

There is also a range of other practical issues;

- Governments have to cope with some long lags in addressing workforce problems. For example, the long lead times for medical education and training, mean that policy changes take 15 years or more to fully realise results, whereas changes in the demand for medical services and in some supply factors (eg hours of work) can shift over much shorter time periods.
- Health workforce planning to date has very largely been conducted on a profession specific basis, rather than looking at the needs of all of the professions required to deliver particular services. However, for the latter approach to be effective, some agreement is needed about suitable models of care for the delivery of particular health services.
- Data lags and deficiencies. National medical, dental, nursing and pharmacy labour force collections produced by the Australian Institute of Health and Welfare are two or more years old (although data on MBS billing doctors is much more current), and no equivalent national labour force collections are available for the remaining health workforces

Effective workforce planning requires considerable investment in developing a sound analytical framework incorporating the key social and economic factors which influence supply and demand for health services and up-to-date, reliable data. Forecasts need to be frequently reviewed and planners must be prepared to adapt to the changing environment in areas such as technology, service delivery and disease patterns.

It is also important to recognise that, in view of factors of the kind outlined above, health workforce planning has real limitations. There is a view that health workforce planning is better suited to providing the broad trends that are likely to emerge rather than being used as a micro level estimating tool to try and predict precise health workforce requirements in particular areas. This highlights the importance of maintaining a flexible health workforce which can quickly adjust to changes in the level of demand over time for particular health services. This flexibility is required to adjust for shortages or overprovision in specific areas not predicted in workforce planning models.

- Data Improvements

Improved data collection for the health workforce is a priority.

With respect to existing national health labour force collections, reliance is placed on a voluntary questionnaire sent out by the Australian Institute of Health and Welfare with the registration renewal form. The response rate to this questionnaire is variable, particularly for doctors. The data is collected by the Registration Boards, passed for processing and then sent to the AIHW for editing and publication. While improvements in the collection and processing of this information are occurring (for

example the recent introduction of centralised processing of nursing data), in practice the information is not available for some time after it is collected and then additional time is required for analysis of policy implications.

Shorter time frames could be placed on the Boards and others for the provision of this information. Alternatively, consideration could be given to supplementing the national medical and nursing labour force collections with periodic, stratified, sample surveys designed to provide a rapid response in terms of trends and changes in the key components of these workforces, such as changes in hours worked.

The introduction of regular national labour force collections for those allied health workforces where they are currently not available, such as physiotherapy and podiatry, would also be of benefit for future health workforce planning. The AIHW, with additional resources, could provide such collections on a regular basis for the major allied health occupations that are registered at a State and Territory level.

As indicated at page 47, an area with particular problems with health workforce data is the community based aged care sector. The 2004 census and survey of residential aged care provided valuable data on this workforce to guide decision makers about improving recruitment to and retention of the workforce by the aged care industry. The next survey of the aged care workforce is planned for 2007 and could also include a stratified sample of the community care workforce in order to obtain baseline data on this area. A survey of the community care workforce would assist in workforce planning for a part of the industry that is set to expand, and is consistent with the objectives of the National Aged Care Workforce Strategy.

## **4. Conclusion**

Consumer demand will continue to create pressures for a larger health workforce in Australia for the foreseeable future. An older, wealthier population with higher expectations will demand more from a health system which is able to offer a progressively wider range of procedures, treatments and medicines. Expenditure on health services per capita and as a proportion of GDP will continue to increase.

These demand pressures are being added to by some significant supply side pressures, such as reductions in average hours of work for the medical profession.

The Strengthening Medicare package contains a range of measures to increase the medical workforce in areas of shortage. Major efforts are being made to increase health workforce capacity through increases in education and training numbers for the established health professions and increased use of overseas trained doctors. These will mean that the health workforce will grow considerably by the early part of the next decade with, for example, Australian medical graduates increasing by more than 60% by 2011.

An increased emphasis is now emerging on using other policy tools for meeting Australia's future health workforce requirements. On the supply side, workforce productivity, particularly workforce flexibility, will be important.

Health professionals need to be able to work to the level of their competence within an appropriate framework that ensures professional support, good quality and safety standards. This can produce significant improvements in the efficiency of the health workforce by more closely aligning tasks with training and experience and by ensuring that resources are used to their best advantage.

Experience in similar developed countries indicates that there is scope to further develop the flexibility of the health workforce in Australia, through the introduction of new and expanded health workforce roles. This would build on initiatives already developed in this area, such as those introduced by the Australian Government to support the provision of primary care services provided by GPs through the use of practice nurses and allied health professionals.

Measures to moderate demand growth without adversely affecting health outcomes through health promotion and prevention, patient self management and improving consumer health information will also be necessary.

While progress is being made, achieving an adequate distribution of the health workforce will continue to require focussed effort in a number of areas, in particular rural and remote locations; Indigenous health; aged care; outer metropolitan suburbs of the major cities; and after hours health services.

Improved data collections are a priority to enable better health workforce planning. Workforce planning will need to be supplemented by a health workforce which is able to adjust in a timely way to shifts in the demand for particular health services. The system needs to be flexible enough to respond to both shortages and surpluses which



will inevitably occur in the provision of a large, complex health workforce to meet changing community needs.

Changes to the way that medical and other health workforce professionals are educated and trained to better align them with the clinical needs of patients, will also need to be made if the health workforce is to adequately meet the future health needs of the population.

## ATTACHMENT A

## Strengthening Medicare Workforce Initiatives

TITLE	DESCRIPTION	FUNDING
<b>Education</b> Bonded Medical Places Scheme	The Australian Government made available an additional 234 publicly funded medical school places in 2004, increasing to a total of 246 places each year from 2005. These places have been provided under the Bonded Medical Places Scheme which requires the students to work for a minimum of six years in a district of workforce shortage on completing of their training.	\$43.4 million over the first four years.
More GP training places, and support for practices and GP supervisors	The Government has substantially increased the number of vocational training places on the Australian General Practice Training Program, expanding the number of places available from 450 to 600 from 2004. The additional training places are being targeted to areas of workforce shortage, particularly outer metropolitan and rural areas. Funding has also been provided for a range of GP training support measures, including additional supervisors, and increases in the teaching allowance.	\$200.6 million over 5 years.
<b>Practice Nurses</b> Support for Practice Nurses through new Medicare items	Since 1 February 2004, an MBS rebate can be claimed when a practice nurse delivers a wound management or immunisation service on behalf of a GP	\$104.1 million to 2007/08.
	Since 1 January 2005, a Medicare rebate has been available for practice nurses taking Pap smears on behalf of a GP in a regional, rural or remote (RRMA 3-7) area.	\$17.8 million over five years to 2008-09
Support for Practice Nurses through incentive payments to practices to employ practice nurses	Grants are available to practices located in identified urban areas of workforce shortage to employ practice nurses and/or allied health workers. This initiative complements the grants already available for this purpose in rural and remote areas.	\$82.0 million over 5 years.

## ATTACHMENT A

## Strengthening Medicare Workforce Initiatives

TITLE	DESCRIPTION	FUNDING
<p><b><u>Overseas Trained Doctors</u></b> International medical recruitment strategies</p>	<p>The Australian Government has contracted 16 medical recruitment agencies to assist in the recruitment of overseas trained doctors to districts of workforce shortage in Australia.</p> <p>As at 21 July 2005, 186 overseas trained doctors have been placed in areas or workforce shortages as a result of this initiative. Another 156 doctors have signed employment contracts and will commence work soon</p>	<p>Funding for all of the Strengthening Medicare overseas trained doctors measures comprises \$43.7 million in direct funding and \$388.8 million in flow on funding from Medicare between 2004 and 2007.</p>
<p>Opportunities for overseas trained doctors to stay longer or obtain permanent residency</p>	<p>The maximum visa validity period for temporary resident doctors (subclass 422) visa was extended from two to four years in December 2003. Since then, over 1500 temporary resident doctors have been granted a visa for greater than two years.</p> <p>Medical practitioners are now listed on the Skilled Occupations List used for the General Skilled Migration Program,, This change came into effect in May 2004 and means that medical practitioners who satisfy state and territory medical board requirements for general medical registration will no longer require a sponsor to migrate to Australia.</p> <p>From April 2005, sponsors and doctors have been able to apply for a Temporary Business Entry (subclass 457) visa on the internet. The Department of Immigration and Multicultural and Indigenous Affairs has also introduced priority processing of visa applications for medical practitioners</p>	

## ATTACHMENT A

## Strengthening Medicare Workforce Initiatives

TITLE	DESCRIPTION	FUNDING
Reducing Red Tape	<p>Selected specialist medical Colleges are being funded to enable the Colleges to establish rapid assessment units within their College. Funding agreements have been finalised with the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Australian and New Zealand College of Psychiatrists, the Royal College of Pathology of Australasia and the Royal Australian and New Zealand College of Radiologists.</p> <p>The Australian Medical Council (AMC) has streamlined their examination processes which will increase the number of overseas trained doctors being eligible, to gain medical registration in Australia. The AMC has:-</p> <ul style="list-style-type: none"> <li>-changed the format of the multiple choice questionnaire from a paper and pencil examination to a computer based assessment;</li> <li>-changed the clinical exam to a single format multi-station clinical examination; and</li> <li>-during 2005 the multiple choice questionnaire will be trialled offshore.</li> </ul> <p>An additional 220 -250 overseas trained doctors per year are meeting their requirements as a result of this streamlining.</p>	
Identification, Assessment and Counselling Permanent Resident Overseas Trained Doctors Not Currently in the Australian Medical Workforce	<p>The Australian Government has engaged the Royal Australian College of General Practitioners to identify, assess and counsel those permanent resident overseas trained doctors not currently in the medical workforce and determine which of them could potentially practice medicine in Australia. The College will identify their strengths and weaknesses and develop an individual learning plan for each doctor.</p>	

## ATTACHMENT A

## Strengthening Medicare Workforce Initiatives

TITLE	DESCRIPTION	FUNDING
Overseas Trained Specialist Upskilling Program	The Department is providing funding to support the establishment of skilling positions to provide overseas trained specialists with up to 24 months of additional training to assist them with gaining College Fellowship. Twenty one positions have been established to date in New South Wales, Victoria, South Australia, Western Australia and the Northern Territory.	
Support for the Five Year Overseas Trained Doctor Program and the Rural Locum Relief Program	Funding is being provided to overseas trained doctors working under these two programs for training and mentoring to assist them achieve Fellowship of the Royal Australian College of General Practitioners.	
DoctorConnect	<p>DoctorConnect was launched in May2005 and provides assistance to appropriately qualified overseas trained doctors to enter the Australian medical workforce. The website also contains information for employers wishing to recruit an overseas trained doctor. The website is supported by an email contact and call centre facility.</p> <p>An online cultural training program will be accessible through DoctorConnect and negotiations are currently underway to allow access to some specialty-specific on-line orientation modules for overseas trained specialists in the future.</p>	

## ATTACHMENT A

## Strengthening Medicare Workforce Initiatives

TITLE	DESCRIPTION	FUNDING
<b>Other Initiatives</b> Bringing more graduate doctors to outer metropolitan, regional, rural and remote areas	Provides 280 three monthly placements in general practice each year in outer metropolitan, regional, rural and remote areas, which is the equivalent of around 70 full-time doctors every year. Also provides funding to states and territories to release junior doctors from hospitals for general practice placements.	\$94.8 million over 5 years.
Supporting Rural and Remote GPs, especially procedural GPs	This initiative involves three separate measures: <ul style="list-style-type: none"> <li>- funding to support procedural GPs in rural and remote areas (RRMAs 3-7) to develop and maintain their skills. The support is in the form of a grant to a maximum of \$15 000 per financial year for up to 10 days of training. The grant is intended to assist with the costs associated with attending the training activity including the required locum relief;</li> <li>- additional funding for GPs who provide a minimum of 10% of their total MBS workload through procedural services; and</li> <li>- continuation of increased retention payments of up to \$25,000 per year (provided under the Rural Retention Program) rewarding long serving GPs for working in rural and remote regions.</li> </ul>	\$133.3 million over 5 years.
Better access to medical care for residents of aged care homes	A new Medicare item now covers comprehensive medical assessments for residents of aged care homes. As well, GPs are being funded to work with aged care homes to improve access for residents of aged care homes who do not have, or cannot access, their regular doctor, and to improve quality of care for all residents.	\$68.1 million over 5 years.
GPs Re-entry Program	Regional training providers offer refresher training and associated support to qualified general practitioners aiming to re-enter the workforce.	\$38.6 million over 5 years.
Specialists Re-entry Program	Refresher training and associated support is provided to qualified specialists aiming to re-enter the workforce.	\$6.9 million over 5 years.
Higher rebates for patients of non-vocationally registered GPs	This measure provides higher (A1) rebates for patients of non-vocationally registered GPs who have worked in areas of workforce shortage for at least five years.	\$29.0 million over 5 years.

## ATTACHMENT B

## Increases in Higher Education Places for Health Disciplines Announced in 2004

## Additional health profession university places, pipeline after 4 years (in 2008)

Discipline	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust
General nursing	689	523	773	150	186	137	13	109	2580
Aged care nursing	396	273	273	68	178	0	14	0	1203
Midwifery	164	0	0	68	68	0	0	0	300
<b>Total nursing</b>	<b>1249</b>	<b>796</b>	<b>1046</b>	<b>286</b>	<b>432</b>	<b>137</b>	<b>27</b>	<b>109</b>	<b>4082</b>
Dentistry	0	22	55	96	41	0	0	0	214
Dental hygiene	137	0	0	0	0	0	0	0	137
Oral health	55	0	0	0	0	0	0	0	55
Community health	27	0	0	0	0	0	0	0	27
Environmental health	55	0	0	0	0	0	0	0	55
Exercise and sport	55	0	0	0	0	0	0	0	55
Forensic health	27	0	0	0	0	0	0	0	27
Health promotion	0	0	164	0	0	0	0	0	164
Health science	82	82	0	0	27	27	0	0	218
Human movement	27	0	150	0	0	41	0	0	218
Information management - health	27	0	0	0	0	0	0	0	27
Medical science	155	0	150	0	0	0	41	0	346
Nutrition & dietetics	27	0	0	0	0	0	0	0	27
Occupational therapy	0	192	0	0	55	0	0	0	247
Paramedic studies	0	41	82	123	0	0	0	0	246
Pharmacy	314	27	192	0	55	33	0	0	621
Physiotherapy	41	178	164	0	55	0	0	0	438
Podiatry	22	0	0	0	82	0	0	0	104
Psychology	14	0	177	0	41	0	0	0	232
Public health	0	0	0	109	0	0	0	0	109
Radiography/radiation therapy	137	55	0	0	68	0	0	0	260
Social work	14	41	68	41	69	0	0	27	260
Speech pathology	73	0	55	0	0	0	0	0	128
Vision sciences	14	0	0	0	0	0	0	0	14
<b>TOTAL - HEALTH</b>	<b>2552</b>	<b>1434</b>	<b>2303</b>	<b>655</b>	<b>925</b>	<b>238</b>	<b>68</b>	<b>136</b>	<b>8311</b>
<b>TOTAL - ALL</b>	<b>8851</b>	<b>2622</b>	<b>6571</b>	<b>1539</b>	<b>4391</b>	<b>1004</b>	<b>561</b>	<b>547</b>	<b>26086</b>
% health	28.8	54.7	35.0	42.6	21.1	23.7	12.1	24.9	31.9

Note general nursing includes indigenous nursing and mental health nursing

Source: Department of Education, Science and Training

**ATTACHMENT C****Measures to Supplement the Provision of Primary Care Services Provided by GPs with Other Health Professionals**Nurses in General Practice

Practice Nurses assist GPs by contributing to a range of services, including chronic disease management and population health activities. The Australian Government has been supporting the work of Practice Nurses through a range of programs.

Under the Practice Incentives Program Practice Nurse Initiative funding is provided to support GPs to employ a practice nurse. The practice nurse initiative provides an incentive of around \$8,000 per full time GP to employ and engage the services of a practice nurse for a minimum of one day per week. The incentive increases with the size of the practice to a maximum of \$40,000 per year, for which a practice would have to employ a full time nurse. This Initiative was originally established in rural and remote areas but was extended under the Strengthening Medicare package to urban areas of workforce shortage with a lower socio-economic status. Under the practice nurse initiative, practices in rural locations can employ an Aboriginal Health Worker and eligible urban practices can employ a range of Allied Health Workers.

Additionally, as part of the Strengthening Medicare Package, the Government introduced, from 1 February 2004, rebates for practice nurses to administer vaccinations and provide wound management services on behalf of a GP. The Government has also introduced, from 1 January 2005, a Medicare rebate for practice nurses to take Pap smears in regional, rural and remote areas. This is to help women in rural communities who do not have the option of seeing a female GP. As at 31 May 2005, 3.57 million claims for immunisation, wound management and Pap smear services had been received attracting benefits of \$33.0 million.

Through the 2001-02 and 2005-06 Federal Budgets the Australian Government has also provided \$28.0 million over eight years for training and professional support of practice nurses under the Additional Practice Nurses for Rural Australia and Other Areas of Need measure. The aims of the training and support component of the measure are to:

- ensure general practice, nursing and consumers are well informed about the measure;
- build the capacity of Divisions of General Practice to work with nursing in general practice;
- ensure training and upskilling options for both nurses and general practitioners working together are available and accessible;
- develop networks for practice nurses and effective mentoring systems; and
- ensure effective evaluation and research to monitor and guide further development.



**ATTACHMENT C****Measures to Supplement the Provision of Primary Care Services Provided by GPs with Other Health Professionals**MBS Items for Allied Health Professionals

As part of the Strengthening Medicare package, Medicare now provides rebates for up to five allied health consultations to be delivered to patients with a chronic condition and complex care needs, on referral from a GP, through MBS items. Where the patient also has a dental condition that is exacerbating their chronic medical condition, Medicare items support access to up to three dental consultations. These items have been available since 1 July 2004 to patients whose GPs are managing their health under an Enhanced Primary Care Plan (EPC) multidisciplinary care plan. The EPC care planning items have recently been replaced by broader arrangements for Chronic Disease Management, with access to allied health and dental services being available for patients requiring multidisciplinary, team-based care under these arrangements (see below).

MBS Items for Chronic Disease Management

New EPC Medicare items available from 1 July 2005 provide rebates for GPs to manage chronic disease by preparing, coordinating, reviewing or contributing to CDM plans. These items replace the existing EPC care planning items and make multidisciplinary care planning and access to allied health services easier for GPs and their patients.

GPs can now prepare and review GP Management Plans for patients with chronic (or terminal) medical conditions, including patients with asthma, cancer, arthritis, diabetes, heart disease, mental illness and other chronic medical conditions.. GPs can also coordinate Team Care Arrangements and reviews for patients who also have complex needs requiring multidisciplinary care.

Practice nurses, Aboriginal Health Workers or other health professionals in the GP's medical practice or health service can assist GPs with CDM services. This can include, for example, assistance with patient assessment, identification of patient needs and making arrangements for services. The GP must review and confirm all assessments and elements of the CDM service and must see the patient.

Patients with multidisciplinary care needs who are being managed by their GP under a GP Management Plan and Team Care Arrangements are eligible for the MBS allied health and dental care items.

## ATTACHMENT C

### **Measures to Supplement the Provision of Primary Care Services Provided by GPs with Other Health Professionals**

#### More Allied Health Services Program

The More Allied Health Services (MAHS) Program aims to improve the health of people living in rural areas through allied health care, with linkages between allied health care and general practice. Program funding is used to provide clinical care by allied health professionals to rural communities. Needs assessments work out where and what types of allied health services are most needed. General practitioners refer clients to allied health professionals, based on patient need, and the GP provides ongoing medical care and assessment. The client generally receives treatment from the allied health practitioner free of charge.

Funding goes to 66 Divisions of General Practice with at least 5% of their population living in rural areas

210.5 full time equivalent allied health positions have been funded in rural areas in 2003-04. These positions include Aboriginal health workers, audiologists, dietitians, physiotherapists, occupational therapists, podiatrists, psychologists, diabetes educators and nurses.

#### Better Outcomes in Mental Health Care Program – Allied Health Component

The Better Outcomes in Mental Health Care Program has been continued and expanded with funding of \$142.5 million over the four years to 2008-09. This Program aims to improve community access to primary mental health services by providing better education and training for general practitioners and more support for them from allied health professionals and psychiatrists.

The Program has five major components, one of which is Access to Allied Psychological Services. This component enables general practitioners registered with the Initiative to access focussed psychological strategies from allied health professionals to support their patients with mental health problems. This component is operated by Divisions of General Practice.

Under this Program, allied health professionals include psychologists, mental health nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers.

## ATTACHMENT D

### **Bulk Billing and Other Incentives**

#### Strengthening Medicare Bulk Billing incentives

As part of the Strengthening Medicare package, the Government has introduced additional incentives to encourage GPs to bulk bill patients. Since February 2004, GPs have received an additional payment when they bulk bill Commonwealth concession card holders or children aged under 16. This payment is currently \$5.10 in urban areas and \$7.65 in rural areas, Tasmania, and eligible metropolitan areas with below average bulk billing rates and below average doctor-to-population ratios.

#### 100% Medicare Rebate for GP Services

From 1 January 2005, the Medicare benefit for most services provided by a GP was increased from 85% to 100% of the Medicare schedule fee. The rebate applies to attendances provided by both vocationally and non-vocationally registered GPs as well as services provided by a practice nurse on behalf of a GP.

#### Round the Clock Medicare

From 1 January 2005, GPs have been able to claim new items for most after hours attendances. The Medicare benefit is \$10 higher than for the corresponding items used during non-after-hours periods.

## ATTACHMENT E

## Australian Government Measures Policies to Improve Rural Workforce Distribution

Regulatory

<b>TITLE</b>	<b>DESCRIPTION</b>	<b>FUNDING</b>
Medicare Provider Number Restrictions for Overseas Trained Doctors.	Since 1996, overseas trained doctors have been restricted to accessing Medicare in areas districts of workforce shortage. There are now more than 2,500 current approvals for overseas trained doctors to work in these areas.	This is a regulatory program. Cost to the Government is for administration and the cost of access to Medicare rebates for approved doctors.
Rural Locum Relief Program	Medicare provider number restrictions prevent doctors without Fellowship of a medical college from accessing Medicare, unless they are on an approved training or workforce program. The Rural Locum Relief Program is one such program, which permits doctors to access a provider number to practise in rural areas. Rural Workforce Agencies are the delegated authorities and there are more than 400 doctors on the program across rural Australia.	The Government provides funding to the Rural Workforce Agencies who administer the scheme.
Five Year Overseas Trained Doctors Scheme	Overseas trained doctors operating under this Scheme agree to work in certain difficult to recruit for rural and remote locations for a minimum of five years (in return for which they can obtain an unrestricted Medicare Provider Number after five, rather than ten years). They are required in this time to achieve permanent residency and Fellowship of the Royal Australian College of General Practitioners.	Up to \$2million over three years for training and mentoring.

**ATTACHMENT E****Australian Government Measures Policies to Improve Rural Workforce Distribution**Financial

<b>TITLE</b>	<b>DESCRIPTION</b>	<b>FUNDING</b>
Rural Retention Program	<p>This program recognises and retains long-serving general practitioners in rural and remote communities that may experience significant difficulties in retaining general practitioners. Doctors can receive up to \$25,000 per year depending on eligibility criteria. Payments under the Program are made through two mechanisms:</p> <p>The Central Payments System administered by the HIC automatically assesses doctors' eligibility and payment level based on Medicare data of their services in rural and remote locations.</p> <p>The Flexible Payments System administered by state and territory-based Rural Workforce Agencies caters for doctors who are not billing Medicare including those working in Aboriginal Medical Services, the Royal Flying Doctor Service, or as state-salaried doctors.</p>	\$20.5 million in 2005-06
Rural and Remote General Practice Program	Australian Government funding to the Rural Workforce Agencies in each state and the Northern Territory to attract, recruit and retain doctors throughout rural and remote Australia.	\$16.3 million in 2005-06

## ATTACHMENT E

## Australian Government Measures Policies to Improve Rural Workforce Distribution

Financial

TITLE	DESCRIPTION	FUNDING/ COMMENTS
Practice Incentives Program (PIP)	<p>The PIP is part of a blended approach for general practice. Payments made through the program are in addition to other income earned by the GPs and the practice, such as patient payments and Medicare rebates. The PIP provides a number of incentives that support general practices to improve the quality of care provided to patients. Practices must be accredited or working towards accreditation against the RACGP Standards for General Practice to participate in the Program.</p> <p>One of the incentives under the Program is a rural loading. This loading provides practice payments in recognition of the difficulties of providing care, often with little professional support, in small country towns, remote areas, or isolated communities.</p> <p>The PIP also provides an incentive to encourage general practices to provide procedural services</p> <p>The PIP Practice Nurse Initiative aims to improve access to medical services for patients in rural Australia by supporting GPs to employ a practice nurse. Payments of up to \$40,000 per annum are available for rural general practices to employ practice nurses. Under the Strengthening Medicare package, the practice nurse initiative was extended to urban areas of workforce shortage with a lower socio-economic status.</p>	<p>Funding of \$340 million in 2005-06. Around 4,680 general practices are participating in the PIP. These practices provide 80% of GP patient care in Australia.</p> <p>The average PIP payment per full-time GP in 2004-05 was higher in rural and remote areas. The average payment was \$18,641 and in RRMA 3-7 locations was \$27,301. This is a significant component of the income of a rural general practice.</p> <p>\$3 million in 2005/06</p> <p>In February 2002, 53% of rural practices received a payment for the employment of a practice nurse. In May 2005, this had increased to 75%. In May 2004, 43% of eligible practices in urban areas received a payment for the employment of a practice nurse. In May 2005, this had increased to 48%.</p>

## ATTACHMENT E

## Australian Government Measures Policies to Improve Rural Workforce Distribution

Financial

TITLE	DESCRIPTION	FUNDING/ COMMENTS
Other Support for Procedural GPs	<p>Along with the PIP incentives other measures to support procedural GPs include:</p> <ul style="list-style-type: none"> <li>– Funding to support procedural GPs in rural and remote areas (RRMAs 3-7) to develop and maintain their skills. The support is in the form of a grant to a maximum of \$15 000 per financial year for up to 10 days of training. The grant is intended to assist with the costs associated with attending the training activity including the required locum relief</li> <li>– Assistance with the cost of medical indemnity. The Premium Support Scheme is an Australian Government scheme that helps eligible doctors with the costs of their medical indemnity insurance. Under this scheme the Government is providing funding via medical indemnity insurers for 75 per cent of the difference between premiums for procedural GPs working in rural areas and those for non-procedural GPs in similar circumstances (ie same location, same insurer, same income).</li> </ul>	
Rural Medical Infrastructure Fund	<p>In some rural areas, the cost of establishing and maintaining suitable premises and facilities has a heavy impact on the viability of general practice. The high cost is a deterrent for doctors to establish private practices in these areas. An increasingly mobile general practitioner workforce also means some doctors are reluctant to make such a significant and long-term investment. The Rural Medical Infrastructure Fund is a three year initiative providing funding to small rural councils to help establish 'walk-in walk-out' community medical facilities, making it easier to recruit or retain general practitioners.</p>	

Information on bulk billing arrangements for rural areas is at Attachment D

**ATTACHMENT E****Australian Government Measures Policies to Improve Rural Workforce Distribution**Education and Training

<b>TITLE</b>	<b>DESCRIPTION</b>	<b>FUNDING</b>
Rural Australia Medical Undergraduate Scheme	This scheme was introduced in the 1999/2000 Federal Budget with the first scholarships awarded in 2000. It provides \$10,000 per year to students from a rural background, with a demonstrated financial need, to assist with their travel and accommodation costs while studying for a medical degree. The scheme has 500 scholarships with approximately 130 new scholarships available each year.	\$5.53 million in 2005-06
John Flynn Scholarship Scheme	This scheme provides medical students with an opportunity to spend eight weeks working in rural or remote areas during their medical studies. By undertaking a placement in the same community, for a minimum of two weeks per year for four years, students build up a relationship with the community. The scheme has 600 scholarships with approximately 150 new scholarships available each year.	\$2.12 million in 2005-06
Medical Rural Bonded Scholarship Scheme	This scheme was introduced in the 2000/01 Federal Budget with the first 100 scholarships awarded in 2001. It provides an indexed scholarship, of \$21,800 in 2005, to support students during their undergraduate medical degree. In return, on completion of their Fellowship (specialist qualification) scholars commit to work in a rural area for six years. Each year 100 new scholarships are awarded with a total of 500 scholars in the scheme in 2005.	\$10.67 million in 2005-06
Australian General Practice Training Program - Rural Pathway	The Rural Pathway is designed for doctors willing to commit to undertake the majority of their training in rural and remote areas of Australia. Registrars are required to complete two years of their general practice training in these areas	



## ATTACHMENT E

## Australian Government Measures Policies to Improve Rural Workforce Distribution

Education and Training

TITLE	DESCRIPTION	FUNDING
Rural Undergraduate Support and Coordination Program	<p>The Rural Undergraduate Support and Coordination (RUSC) Program is an initiative to increase the number of medical graduates adopting a career in rural medicine. The Program provides targeted funding to Australian medical schools to facilitate and enhance change in three key areas: rural student selection; the enhancement of support systems for students and rural GP educators; and the coordination of rural curriculum placements for medical students.</p> <p>The guidelines for this program specify that Universities should aim to increase the proportion of students from rural backgrounds to at least 25% of students enrolled in medical schools. Information supplied by medical schools has shown that the proportion of first year medical students coming from rural backgrounds has increased from around 8% in 1996, to over 25% in 2003.</p>	\$4.3 million over three years, 2005-06 to 2007-08.
Rural Clinical Schools Initiative	<p>This was announced in the 2000/01 Federal Budget. It is a long-term initiative that aims to improve access to medical services by people living in rural areas by increasing the recruitment of medical professionals to rural Australia. This program encourages medical professionals to take up a career in rural clinical practice. It provides education and training for medical students in a rural setting, and support for rural health professionals who are currently working in rural and remote areas. A network of ten Rural Clinical Schools has now been established across Australia with the principal sites located at Rockhampton/Toowoomba, Coffs Harbour, Dubbo, Wagga Wagga, Shepparton, Moe, Burnie, Renmark, Whyalla and Kalgoorlie. At least 25% of medical students at participating universities will undertake a minimum of one year of their clinical training in rural areas by the time they graduate.</p>	\$46.13 million in 2005-06

**ATTACHMENT E****Australian Government Measures Policies to Improve Rural Workforce Distribution**Education and Training

<b>TITLE</b>	<b>DESCRIPTION</b>	<b>FUNDING</b>
University Departments of Rural Health Program.	<p>This is a long term strategy which aims to increase the recruitment and retention of rural health professionals and to improve the quality and appropriateness of health care for rural and remote communities. The program encourages students of medicine, nursing and allied health disciplines to pursue a career in rural practice by providing opportunities for students to practice their clinical skills in a rural environment. It also supports those health professionals who are currently practicing in rural settings. Funding is provided for teaching and administration activities as well as student accommodation. University Departments of Rural Health are located in every state and the Northern Territory, at Broken Hill, Launceston, Mt Isa, Alice Springs, Geraldton, Whyalla, Warrnambool, Lismore, Shepparton and Tamworth.</p> <p>From 1 January 2004 to 31 December 2004 3,002 undergraduate health sciences students attended a University Department of Rural Health placement during the year. Of these 33% were medical placements, 37% were nursing placements and the remaining 878 29% were allied health professionals. These students spent 13,485 weeks (average of 4.5 weeks per student) in placements facilitated by UDRHs.</p>	\$15 million in 2005-06

## ATTACHMENT E

## Australian Government Measures Policies to Improve Rural Workforce Distribution

Education and Training

<b>TITLE</b>	<b>DESCRIPTION</b>	<b>FUNDING</b>
Advanced Specialist Training Posts in Rural Areas (ASTPRA) Program	The ASTPRA Program aims to support the recruitment and retention of medical specialists in rural and remote areas of Australia through funding accredited advanced specialist training in these locations.  The program funds 30-35 specialist training positions at any one time.	The program is funded by the Australian Government on a cost shared basis with the States and Northern Territory. Currently the Australian Government provides \$2 million annually to the Program.
Rural Advanced Specialist Training Support (RASTS) Program	The Australian Government provides funding to a number of specialist medical colleges with a significant rural presence to enable them to provide support and training for advanced specialist trainees to prepare them for rural practice.	Funding of \$500,000 per annum is distributed to Specialist Colleges.
Australian Rural and Remote Nurse Scholarship Program	The Program offers scholarships and support to nurses wishing to pursue or build on a career in rural and remote nursing. The Program consists of four different schemes – undergraduate, postgraduate, re-entry/upskilling and enrolled nurse to registered nurse. Over 2,500 scholarships have been awarded since 1998.	\$20.6 million from 2005/06 to 2007/08.

## ATTACHMENT F

## Growth in GP Numbers by Geographic Area

Year	Urban <sup>1</sup>			Rural and Remote <sup>2</sup>		
	Headcount <sup>3</sup>	FTE <sup>4</sup>	FWE <sup>5</sup>	Headcount	FTE	FWE
<b>Number</b>						
1995-96	18,959	10,416	12,501	5,417	3,120	3,551
1996-97	18,937	10,599	12,719	5,589	3,164	3,596
1997-98	18,524	10,659	12,791	5,706	3,216	3,641
1998-99	18,208	10,613	12,754	5,968	3,232	3,635
1999-00	18,024	10,587	12,761	6,210	3,287	3,672
2000-01	17,905	10,555	12,668	6,363	3,417	3,825
2001-02	17,719	10,564	12,731	6,588	3,555	4,005
2002-03	17,521	10,506	12,654	6,739	3,660	4,118
2003-04	17,482	10,468	12,608	6,841	3,778	4,263
<b>% change on previous year</b>						
1996-97	-0.1%	1.8%	1.7%	3.2%	1.4%	1.3%
1997-98	-2.2%	0.6%	0.6%	2.1%	1.6%	1.2%
1998-99	-1.7%	-0.4%	-0.3%	4.6%	0.5%	-0.2%
1999-00	-1.0%	-0.2%	0.1%	4.1%	1.7%	1.0%
2000-01	-0.7%	-0.3%	-0.7%	2.5%	4.0%	4.2%
2001-02	-1.0%	0.1%	0.5%	3.5%	4.0%	4.7%
2002-03	-1.1%	-0.5%	-0.6%	2.3%	3.0%	2.8%
2003-04	-0.2%	-0.4%	-0.4%	1.5%	3.2%	<b>3.5%</b>
<b>% change on 1995-96</b>						
2003-04	-7.8%	0.5%	0.9%	26.3%	21.1%	<b>20.1%</b>

<sup>1</sup> **Urban** Defined as RRMA1 (Capital City – State and Territory capital city statistical divisions) and RRMA 2 (other metropolitan centre – one or more statistical subdivisions that have an urban centre with a population of 100,000 or more)

<sup>2</sup> **Rural and Remote** Defined as RRMA3 (Large rural centre - SLAs where most of the population resides in urban centres with a population of 25,000 or more); RRMA 4 (Small rural centre - SLAs in rural zones containing urban centres with populations between 10,000 and 24,999); RRMA 5 (other rural area – All remaining SLAs in the rural zone); RRMA 6 (Remote centre – SLAs in the remote zone containing populations of 5,000 or more; and RRMA 7 (Other remote area – all remaining SLAs in the remote zone)

<sup>3</sup> **GP headcount** A count of all GPs who have provided at least one Medicare Service during the reference period.

<sup>4</sup> **FTE (Full-Time Equivalent)** FTE is an alternative measure to head counts as it measures the number of doctors working full-time and the partial contribution of part time doctors. FTE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing of full-time doctors, then the FTE is capped at one.

<sup>5</sup> **FWE (Full-Time Workload Equivalent)** FWE is a measure of service provision because it takes into account doctors' varying workloads. FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing of full-time doctors, then the FTE is capped at one but the FWE is not.

## ATTACHMENT G

## Australian Government Initiatives to Support the Aged Care Workforce

TITLE	DESCRIPTION	FUNDING
Investing in Australia's Aged Care, More Places, Better Care Package	Assistance for up to 15,750 care workers to access recognised education and training opportunities such as Certificate Level III or IV in aged care work, up to enrolled nurse.	\$101.4 million over four years from 2004-05
	Assistance for up to 8,000 aged care workers to access the Workplace English Language and Literacy (WELL) program).	
	Assistance for up to 5,250 Enrolled Nurses to access recognised and approved medication administration education and training programs.	
	Funding for up to 1,700 (full/part-time) new nursing places at Universities that demonstrate their ability to meet aged care nursing education benchmarks.	
More Aged Care Nurses Initiative	Provides up to 1,000 aged care nursing scholarships to encourage more people to enter or re-enter aged care nursing and to assist existing registered /division 1 nurses to undertake further education, especially in rural and regional areas	\$26.3 million over four years from 2002-03
	Assistance to current scholarship recipients to access quality clinical placements in the aged care sector during their education and training to become an aged care nurse and access to support programs and aged care nursing mentors for the duration of their studies.	
	Assistance for the development of a Principles Paper which outlines the core values and learning outcomes for aged care education within undergraduate nursing curricula and assistance to facilitate the implementation of some of the recommendations from the report.	
	Assistance to explore the role of aged care nurse practitioners in the care of older people and to identify benefits to the health of older people and the health care sector more broadly. The pilot is also exploring the potential for providing an enhanced career path for nurses working in residential aged care.	

## ATTACHMENT G

## Australian Government Initiatives to Support the Aged Care Workforce

TITLE	DESCRIPTION	FUNDING
Support for Aged Care Workers	Provides assistance to care workers in smaller less viable homes to access training and education opportunities – already benefiting over 470 homes and 5,700 care workers through 70 education and training programs.	\$21.2 million over four years from 2002-03
Aged Care GP Panels	<p>Aged Care GP Panels, part of Strengthening Medicare, aim to improve access to GPs for residents of aged care homes, and improve the quality of care for all residents. Aged Care Panels are groups of GPs, convened by a local division of General Practice. As at 31 March 2005, 169 Panels were operational with 870 GP members.</p> <p>Practical, new activities are being developed through Panels such as:</p> <ul style="list-style-type: none"> <li>• Medical care for residents whose usual GP arrangements have broken down;</li> <li>• Education and training support for GPs and staff of aged care homes; and</li> <li>• Working with aged care homes on quality</li> </ul>	This initiative, combined with the Comprehensive Medical Assessments (details below), will cost \$68.1 million over 5 years from 2003/2004.
Comprehensive Medical Assessments	From 1 July 2004 a new Medicare item is available for comprehensive medical assessments for permanent residents of aged care homes. This item provides a Medicare rebate for a full systems review, including an assessment of the resident's health and physical and psychological function. It involves a GP taking a detailed relevant medical history, conducting a comprehensive medical examination, developing a list of diagnoses or problems, and providing a written summary of the outcomes of the CMA for the resident's records.	

## ATTACHMENT G

## Australian Government Initiatives to Support the Aged Care Workforce

TITLE	DESCRIPTION	FUNDING
National Aged Care Workforce Strategy	<p>The Australian Government facilitated the development by the aged care industry of a National Aged Care Workforce Strategy in planning for a sustainable aged care sector. The Strategy proposes a series of actions to be taken in response to each of the objectives the Strategy identifies and those responsible for action.</p> <p>The Strategy was released by the Minister for Ageing on 21 April 2005. A Strategy Implementation Group has been formed to start work on the order of priorities. The Strategy is for the sector to use to ensure an effective and appropriately skilled workforce is available to deliver quality care services to older Australians.</p>	
Census and Survey of Residential Aged Care Facilities	<p>To rectify the gap in the existing level of knowledge about workers in aged care, the Department of Health and Ageing, acting on behalf of the Aged Care Workforce Committee, commissioned a census and survey of aged care facilities and their employees.</p> <p>The Census and Survey, which is the first ever analysis of the whole residential aged care workforce, covered all Australian Government funded residential care aged care facilities and 6,199 direct care workers employed by them. The next Census and Survey will be in 2007.</p>	
Training to Care for People with Dementia	Providing dementia specific training for up to 9,000 community care staff and residential care workers, and up to 7,000 extra carers and community workers, such as police and transport staff.	

**ATTACHMENT H****Measures to Target After Hours Care**

The Australian Government has put in place a range of initiatives to increase the community's access to quality after hours primary care and to strengthen and support the primary care workforce in the after hours setting. These include:

After Hours Primary Medical Care (AHPMC) Program

Through this initiative, a range of models of after hours service provision have been trialled, including rural tele-triage and dedicated after hours clinics. Funding has also been provided to support the quality of care provided in the after hours period.

Round the Clock Medicare: Investing in After Hours GP Services

This measure supports the growth of after hours general practice through three new funding components: operating subsidies; start up grants; and supplementary grants. The funding components target areas of 'community need' where establishment or extension of after hours services will have the support of the local GP community without placing unfair competition pressure on existing services. Also, as part of this measure, a host of Medicare incentives are available to GPs who provide after hours services, including a \$10 loading to Medicare rebates for after hours GP attendances. This measure has capacity to support after hours services in or near hospitals.

After Hours Other Medical Practitioners Program

From 1 January 2005, eligible non-vocationally recognised medical practitioners have been able to access the higher Medicare rebate for the after hours general practice services they provide through an accredited general practice or accredited Medical Deputising Service.

Practice Incentive Program after hours incentive payments

These payments are intended to help resource a quality after hours general practice service. They also compensate GPs who make themselves available for longer hours in recognition of the additional pressures this entails. This includes practices, such as those in rural and remote areas, that have no choice but to cover their patients themselves.

2004-05 Budget initiative: GP services – improving after hours access

While there is some capacity for after hours services to be set up in or near hospitals with Medicare access and the support of the above programs, the provision of State support can in some cases have implications under subsection 19(2) of the *Health Insurance Act 1973* (the Act). This Budget initiative allows for the Australian Government to provide exemptions from subsection 19(2) of the Act on a case-by-case basis to allow up to 10 after hours GP clinics to be set up with assistance from the States and to access Medicare. While the primary aim is to improve access to after hours GP services, there may also be potential to reduce pressure on hospital EDs.

Medicare Provider Number Restrictions

Overseas trained doctors subject to the Medicare provider number restrictions are able to access Medicare for after hours only work.